MICHAEL GARD AND CAROLYN PLUIM

SCHOOLS AND PUBLIC HEALTH

Past, Present, Future

Schools and Public Health

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From Michael
For Ralph Gard, my father and best friend

From Carolyn
To my very precious boys, Jared and Calvin

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FROM MICHAEL

On the way home after a hellish road trip around northeastern North America in the second half of 2008, I somehow washed up, tired and emotional, at a favorite café in the waterfront area of inner city Leeds. Hiding from the December cold and seeking the consolation of a rare decent cup of European coffee, I pulled out the laptop. I can't remember what got me there, but I recall reading a rather terse review of a book that seemed designed to help school principals turn their schools into quasi weight-loss clinics. I liked the cut of the reviewer's jib so I immediately e-mailed to offer compliments of the season and my congratulations. Five years on and Carolyn Vander Schee, now Carolyn Pluim, is still answering my e-mails. Thank you, Carolyn, for the rewarding work we have done together, for educating me about American educational politics, and for always being a patient, reliable, and brilliantly insightful colleague and friend.

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Both Carolyn and I want to offer special thanks to Eric Wrona and all at Rowman & Littlefield. As authors, we have particularly appreciated the timely, consistent, and highly professional way they have corresponded with us and, of course, their ongoing support for this project.

I am forever in the debt of my former landlords, Peter and Rose Barnett, during three recently completed happy years in Bangalow. As well as nursing me through the trauma of a bothersome back injury, their unstinting generosity made my North Coast life peaceful, happy, and productive.

As with most of my work, a great deal of this book was written in cafés. This being so, the staff of three of Paddington's best, the Java Lounge, Monty's Chocolates, and Little Brew, deserve mention. Thanks for keeping the lattes coming and—despite me regularly setting up camp and taking up way too much space for hours on end—not throwing me out.

The year 2013 saw me altering life course yet again, moving from the serenity of Bangalow to the funkadelity of Brisbane's inner northern suburbs. A place called Coole Cottage is now my home; and my cool companion in this adventure, Eimear Enright, lived the highs and lows of the final months before this book's manuscript was delivered. For this and much else, she has my thanks and a promise of less stressful times ahead.

Finally, my father, Ralph, has continued to make everything I do possible. My thanks and love go to him.

FROM CAROLYN

I am deeply indebted to numerous friends and colleagues, both in and outside my academic institution. In particular, the wonderful faculty in

the foundations of education program area—Leslie Sassone, Linda O'Neill, Marc VanOverbeke, Hide Shimizu, Kerry Burch, and Cynthia Taines—I thank you for your friendship, intellectual curiosity, commitment to critical inquiry, and willingness to ask the kinds of questions about schools, education, and society that are rarely posed. A number of others in the department have also shared in this journey. M. Cecil Smith and Stephen Tonks; I am not sure what I would have done without those very necessary morning coffee runs; our talks and walks were both caffeinating and encouraging. My appreciation to Lee Shumow, Jennifer Schmitt, and Christine Kiracofe for generously offering your professional wisdom to a new faculty member who was trying to navigate the (at times) crazy academic world we find ourselves in. My very deep gratitude must also be given to dear Jessica Heybach for being such a sweet friend, ally, and perhaps the best beta-babysitter in the state of Illinois. Jess, if it weren't for you, life would be way too serious—thank you for all the love, laughter, and camaraderie. Other good friends—both familiar and new—Leslee Grey, Susan Talburt, Deron Boyles, Benjamin Baez, Eric Sheffield, Deana Leahy, Emily Gray, and Lisette Burrows—in your own way you have each positively touched my life and influenced my work and ideas.

Many thanks also to Brian Vander Schee for picking up the slack with our boys when deadlines were pressing—I really appreciate it. I am very fortunate to have a wonderful family that has provided me unconditional love and guidance—even during some of the more difficult times. Thanks to my mom, Marilyn Pluim, for her generous encouragement. You regularly remind me that I am deeply loved and valued. Thanks also to my dad, Wietze Pluim, and Bea Myers. You have both supported me in many ways—you have taken an authentic interest in my world and have provided love, affection, and sage advice. My siblings—Alison Pluim, Laura (Lou) Callaghan, and Aaron Pluim—you have been my cheering squad for some time now—thank you all. (And to all in my family—now that the book is complete, I promise to call more often and actually put birthday cards in the mail—I know I'm three years behind!)

This book would have never been possible without the guidance and keen sensibilities of my good friend Michael Gard. Thank you for inviting me to participate in this project, sticking with it, and offering encouragement during those times when I felt as though I may have been intellectually stumbling. I have been a great beneficiary of your belief in my ability and your clear and constant conceptualization of this work.

Finally, I want to express my gratitude and love to my boys, Jared and Calvin. Jared, you have a kind and gentle spirit. You astound me with your curiosity about the world—please never stop asking great questions, even if I have to say, "I don't know," these days more often than not. Calvin, I am inspired by your passion, creativity, and love for life. Your inventions are amazing; keep them coming.

ONE
Fear and Loathing in Seattle

By the last decade of the nineteenth century, medicine's battle with infectious disease was finally starting to tip in its favor. At the same time, there remained much to disagree about. Although gaining momentum around the Western world, the science of bacteriology was still not universally accepted, even among the medical profession itself. Groups like the Anti-Vaccination League were active in Britain and the United States and continued to campaign, in some cases successfully, against compulsory vaccination statutes beyond the turn of the new century.

This unfinished shift in medical knowledge partly explains why, on the morning of May 17, 1895, police and members of Seattle's municipal health board were stationed at both Rainer and South School, elementary schools in Seattle's poor southern suburbs. In the middle of the latest scarlet fever outbreak, the board had demanded that the two schools be closed. Aware that resistance was likely, the authorities arrived early to post signs and turn people away. In defiance, the principals of both schools instructed teachers and students to use their weight of numbers to storm and occupy the buildings.

As Peter Woolworth explains in his article "'The Warring Boards': Sanitary Regulation and the Control of Infectious Disease in Seattle Public Schools, 1892–1900,"[1] this was only the latest twist in an ongoing power struggle between Seattle's newly formed board of health, a local municipal authority, and individual school boards whose authority derived partly from state law. In early 1891, members of the board of South School had been sensationally arrested for refusing to follow a health board directive to remedy the appalling condition of its water closets. With both sides unwilling to compromise, the matter went to trial in June 1892. On something of a technicality, the court found the defendants not guilty, effectively frustrating health officials in their campaign to improve

school sanitation and leaving the jurisdictional uncertainty between health and educational authorities unresolved.[2]

Matters came to a head in the 1895 confrontation. While the police officer at South managed to convince students and teachers to go home without incident, Rainer was a different story. First the principal, Walter Gerard, and four teachers slipped into the school by a back entrance. A short time later, Gerard emerged to address a crowd of several hundred. The effect was immediate; authorities were insulted, windows were broken, and children poured into the building to join their teachers.

The events that Woolworth describes were not simply the result of differences of opinion about the causes of, and appropriate responses to, diseases like scarlet fever. For one thing, it is not difficult to appreciate the suspicion of parents concerned about remote government authorities inserting needles into their children's bodies. The syringe was, after all, a relatively new technology, and some people would have known very little about it or its contents. But many other factors were also at play including the fact that school leaders were paid according to the number of children who attended. Above all though, Seattle's warring boards is a chapter in the interwoven histories of the rise of bureaucratic culture and the power of professions. As a number of scholars have pointed out, crises in social policy are often the catalyst for institutional realignment and legislative adjustment, usually resulting in the clarification and expansion of the reach of the state and its agencies.[3]

With the benefit of hindsight, commentators have usually cast the kind of disputes that unfolded in Seattle as pitting enlightened medicine against parochial education.[4] There are obvious reasons for seeing it this way. However, as educators working in the twenty-first century, what strikes us about this period of history is that open resistance to public health measures on the part of schools was actually possible and thinkable.

THE RISE OF PUBLIC HEALTH

While not always getting the headlines it deserves, for well over a century public health has been among the most transformative of all global social movements. Distinct from modern medicine's mission to cure the sick, public health is a field of study and practice that has attempted to keep healthy people healthy by shaping their behavior and the conditions of daily life. Seatbelts in cars, the quality of the water we drink, and increasing life expectancy in many parts of the world are all evidence of public health's colossal influence on human experience.

Part of the reason for public health's success has been its central insight that health is more than the absence of disease. Rather, it sees health as a positive state that can be enhanced as well as lived at different

degrees; we can be more or less healthy without actually being sick. An extension of this idea is that virtually any human activity can be thought of in terms of its effect on health and that health can be pursued virtually anywhere. Perhaps not surprisingly then, one of the places nations pursue the goals of public health is in schools. In America this has been true since the birth of mass schooling in the nineteenth century and continues to the present day. The nature of the overlapping histories and trajectories of schools and public health is our subject in this book.

Put simply, this book is a meditation on the past, present, and future of the relationship between public health and American public schools. While easy to say, there is no escaping the daunting complexity of both public health and public education in America as fields of study, let alone their interconnections. Happily, these two multifaceted social movements are now served by substantial historical literatures from which a large part of the narrative of this book springs. Useful as they are, however, it is noticeable how little interest is generally paid by one to the other; while some educational historians acknowledge the impact of health concerns in the development of American educational systems, schools scarcely rate a mention in the various histories of public health. We think there are important insights to be gleaned from the uneven way these two fields have related to each other, both in their material practices and the way their respective histories have been told.

We are acutely aware of the complexity, not to mention the existing vested interests that pervade the field of school-based public health and we make no claim to the last word on any part of this multilayered relationship. However, for reasons that we will explore in more detail, we think there is an urgent need to consider the place of public health in schools. And although this is essentially a statement about the present, we think it is both impossible to understand the present without a sense of how we got here and a somewhat pointless exercise without reference to the future.

In part, the urgency of our subject matter flows directly out of both public health's conspicuous success and the proliferation of health matters that have been drawn into its orbit. On the one hand, health is something of a sacred cow; being against health is neither easy nor popular and yet the reluctance we might feel in raising questions and doubts about it—or at least the way the concept of health is used and understood—can mean that important questions go unasked. On the other hand, health's expansion as a field of knowledge and professional activity has created a set of colonizing tendencies which may not always be in everybody's or in fact anybody's interest.

The term "colonizing tendencies" will not mean very much to some readers and is worth dwelling on for a moment because it was a fundamental motivating concern for writing this book. The story with which we began describes a particular moment in American history when the

spheres of responsibility for state and local boards of health *and* education were relatively small, somewhat ill-defined, but growing. Understood this way, it was probably inevitable that they would eventually find themselves claiming jurisdiction over the same bureaucratic territory. The dispute was as much as anything else a clarifying moment. With neither side prepared to yield ground to the other, it was left to the courts to adjudicate. And while the tension between American health and education authorities would linger for some time, the building intellectual and institutional power of scientific medicine, and to a somewhat lesser extent its close relative in public health, was irresistible. Over time, the idea that schools could or should resist the encroachment of the health professions simply became less and less conceivable.

The contrast between Seattle's "warring boards" and the present day seems stark indeed. That schools can and should play an ameliorative role in a vast array of health and general well-being matters is now continually asserted by politicians, journalists, academics from a range of fields, school administrators, and teachers themselves. These historical differences are not simply quantitative but qualitative as well. In the working-class areas of Seattle in the 1890s, clean toilets and immunization were quite literally matters of life and death. Today, the banner of health is used to implicate schools in shaping children's dispositions and emotional responses to the myriad prosaic ups and downs of daily life. While once the health-related responsibilities of schools were relatively narrow and distinct, they have mushroomed and become, it seems, all-encompassing.

Consider also that in the case of Seattle's warring boards, health authorities were proposing only to enter schools in order to carry out medical procedures that were, by then, relatively commonplace in the community. In particular, as far as we can tell they did not presume to instruct teachers about what and how they should teach children. By contrast, medical groups now routinely pronounce on the classroom work of schoolteachers. The 2012 meeting of the American Medical Association (AMA), for example, passed a motion that called for mandatory yearly instruction on the causes, consequences, and cures for obesity for *every school grade*.[5] Quite apart from the obvious risk that yearly obesity instruction would be counter-productively boring and repetitive, in this book we want to bring back into focus the strangeness and sheer presumptuousness of medical professionals assuming the right to encroach into another professional domain. Did AMA members, for example, stop to think about the pressure to improve test results that many teachers are under or consider which parts of an already crowded curriculum would be jettisoned to make way for yearly compulsory obesity education? Some critical reflection on this tendency to colonize the work of schools and teachers is, we think, well overdue.

To put the point plainly, what is striking about the current situation is the ease and regularity with which the work of schools and teachers is assumed by others to be an instrument of public health policy. This observation should not be misinterpreted as a desire to render the work of teachers private and beyond the scrutiny or input of others. Rather, our concern is twofold. First, there is surely something unhelpful about a habit of mind that automatically turns to schools whenever a new health concern emerges. Second, while the "give it to schools" reflex may in most instances stem from well-meaning intentions, it is also apparent how rarely the effect of school-based public health interventions on teachers and their core business of educating children is considered. In a perfect world, teachers would play a vital role in producing broadly educated, well-adjusted, healthy young people. In the world we live in, however, schools must prioritize a long list of competing imperatives often in extremely challenging circumstances.

An extension of this point is that there are obvious grounds for questioning the efficacy of schools as an instrument of public health policy. In fact, in this book we will argue that a curious paradox now exists in which the capacity of schools to intervene in public health is probably declining at the same time as the calls for them to do so steadily increase. Once again, we suspect that our point will be misunderstood as taking an absolutist stance against school-based health programs and initiatives. This is not our position, and yet we think that a rational assessment of what public health contribution schools can realistically make, and under what circumstances, is a reasonable goal. Although often controversial, using schools as a venue for vaccinating large numbers of children seems to have been a sensible course of action and is generally credited with helping to retard the spread of diseases like smallpox and scarlet fever in America. But what if your intention is to influence the way young people eat, exercise, feel about themselves, conduct their relationships, and make decisions about drug use? In many states of America there are now officially endorsed programs designed to shape the "character" of students. These programs usually elaborate a long list of qualities and aptitudes, both moral and more obviously health-related, to be inculcated. To a greater or lesser extent, these are programs that need to be developed, written, paid for, publicized, distributed, and taught. As we will show, despite the expenditure of all this administrative and bureaucratic energy, there is often little evidence upon which to base a judgment about the effectiveness of these programs.

The question of efficacy is all the more pressing given the amount of evidence that casts doubt on school-based public health, particularly in complex areas of human behavior such as drug and alcohol use and sexual behavior. Alcohol education, in particular, which has a history stretching back to the beginning of American public education itself, was the subject of virtually unbroken critical commentary during the twenti-

eth century. No matter what form it has taken—and alcohol education has blown hither and thither with the winds of social change and intellectual fashion—there are few signs that it has made an appreciable difference to the quantity or nature of young people's alcohol use.[6]

Alcohol education is an interesting example for another reason in that its presence in schools has usually gone hand in hand with other causes. On one level, this is hardly a contentious claim. For at least the first hundred years of American public education, instruction about alcohol was largely the domain of evangelical Christianity. The most well-known example of this is probably the Woman's Christian Temperance Union crusaders of the late nineteenth and early twentieth centuries who tethered their religious mission in schools to an idiosyncratic set of ideas about the effects of alcohol on healthy human functioning.[7] More generally, throughout the twentieth century ideas about the changing health risks faced by young people, and by extension the role of schools, continued to spring explicitly or implicitly from a variety of ideological, political, and economic agendas. Today, school health is both big business and a useful public relations vehicle for corporations intent on rehabilitating their tarnished image.[8] There are, in other words, many reasons other than health that motivate some people to advocate for health programs in schools.

Questions about the efficacy and co-option of school-based health initiatives are linked in important ways. In particular, while a happy symbiosis is theoretically possible, there is always the risk that trying to serve multiple masters will dilute the educational value of any program or intervention. In fact, the situation is possibly more serious than this. After all, if it is the case that some school-based public health initiatives are being used merely as a pretext to conceal or obscure some other motivation, then rigorous evaluation of these initiatives, at least in terms of their health or educational worth, is less likely and may even be actively resisted. And while this may seem an overly conspiratorial line of reasoning, our argument in this book will be that it is the very commonsense appeal of health as a universal—we might even say sacred—human aspiration that tends to deflect scrutiny of its use in schools. In other words, if one's goal was to gain access to public schools without drawing undue attention to one's underlying ideological or religious or commercial motives, wrapping one's enterprise in the language of health would have obvious strategic appeal.

So far we have tiptoed around the vexed issue of the explicit and official purpose for doing public health in schools. In one sense, everything we have talked about so far leads to this question. That is, our conclusions about whether school-based public health "works" or is ethical or is good value for money or is a reasonable imposition on teachers probably rest on what we take its purpose to be; what, exactly, can and should we expect from schools? Should we expect them to make a mea-

surable difference to children's short- and long-term health outcomes, or is it enough to treat health as just another area of study about which students might become more knowledgeable? This is important because although many school-based health initiatives at least claim to be able to improve the health of young people, some do not even do this. If some readers find this surprising it is worth emphasizing a point widely acknowledged among health promoters and educators that access to information does not guarantee good health; educating people about health may, in fact, make no difference to their health decisions or actions.

There are many who study and write about school health who appear to think the tension between health and educational goals has been, or at last can be, satisfactorily resolved.[9] We have doubts about this view, primarily because we think these two visions represent fundamentally divergent understandings of the role of the teacher and the purpose of public education. These are not idle academic quarrels. As we hope to show, whatever we do in the name of health in schools will have immediate and important consequences for students and teachers. In an educational environment in which teachers are constantly expected to demonstrate their effectiveness to an increasingly distrustful world, it seems reasonable to ask the advocates for school-based public health to rigorously justify its presence in schools.

THE SCOPE OF THIS BOOK

Broadly, then, this book has two purposes. First, we develop a historical account of the way schools have been used in the public health policy arena in America. We begin in chapter 2 by focusing on the history of public health itself and the different ways we might understand it. This is important because our ultimate goal is a critical understanding of the different reasons for doing public health in schools, an impossible task if we cannot first see that there are many different possibilities. In the next three chapters we consider the nineteenth- and twentieth-century histories of American public education and public health, both as fields of knowledge and spheres of professional action.

With this as our foundation, we offer answers to the question: why have schools so readily been drawn into public health policy formulations? In brief, we suggest two answers. On the one hand, we show how looking to schools is a long-standing "habit of mind" that discourages careful consideration of alternative public health strategies as well the efficacy of using schools. On the other hand, we argue that schools have been implicated in public health policy in strategic ways by actors often with unstated political, cultural, and financial motivations. In some cases there is clear evidence that saddling schools with public health responsibilities has been less about a careful assessment of the issue at hand,

and more a matter of expediency. Perhaps just as important, our historical analysis also shows that the birth of the idea that schools can and should prosecute the goals of public health needs to be understood alongside broader anxieties about the health of Americans. In fact, the impetus for having and maintaining a publicly funded mass school system was, in part, bolstered by a lack of progress in public health policy. From their beginning, public schools were asked to achieve things that the rest of society either thought were too difficult, expensive, or intrusive to do. Right through to the end of the nineteenth century, it was possible to imagine schools miraculously producing a generation of healthy and moral Americans, and yet impossible in most of the country to raise sufficient taxes to build safe and sanitary housing for the poor, maintain systems to deal with contagious disease, or even to organize the disposal of dead animals lying in the streets.

The second broad purpose of this book is to look in detail at more contemporary examples of school-based public health policies and initiatives in order to come to a judgment about whether and to what extent it makes sense to use schools in this way. In chapter 6 we discuss the general neoliberal turn in public policy in the West, its implications for schools, as well as what has come to be known as the "new public health." Taken together, these broad sociopolitical forces brought about a sea change in the philosophy and goals of public health and marked a determined shift away from seeing health in predominantly medical terms toward a more accessible and everyday concern. Part of the rationale for this repositioning was to help people to think about their own health and that of their community as things they could actively influence. In the case of the new public health, this was seen as a democratizing, even radical, project. However, as many scholars have argued, it was a project that was almost seamlessly taken up by neoliberal ideologues in the 1980s and 1990s, the result of which was an intensified focus on the individual and their "lifestyle." It is no coincidence that this was also a period in which ideas about the role of schools in promoting health proliferated.

In chapters 7 through 9 we describe how a wide coalition of stakeholders has enthusiastically embraced schools as the "ideal" place to curb rising rates of obesity. But in the rush to act, we show that the apparent common sense of this policy direction completely overlooks the political and economic complexities involved as well as the obvious and widespread capacity constraints inside schools. In stark contrast to most experts operating in this field, we suggest that it is not at all obvious that schools are the "ideal" place to wage war on obesity.

Taking this book's two primary concerns together—the first with explanatory historical and cultural forces, the second with contemporary practical realities—we conclude by calling for a more sophisticated approach to public health policy in schools and suggesting some criteria for

judging the potential efficacy of school-based interventions. In short, though, the potential effectiveness of proposed interventions needs to be assessed not only against existing historical evidence. It also needs to be considered against the competing roles we expect schools to play as well as the working-life realities for those charged with implementing public health policies in schools. These are inevitably questions of resources and power. However, we also think there are fundamental issues of justice here that relate to the professional autonomy of teachers and the educational experiences of children. When calling for schools to be involved in public health policy, we need not only to consider the policy issue on its own public health terms, but also to look at it through the prism of schools and existing educational knowledge. At present, the implications of this second, education-centric view are rarely, if ever, factored in as policy makers go on adding to the existing social policy burden that schools already carry.

Finally, for brevity's sake, we will generally use the term "school health" to refer to the full range of health interventions that schools are likely to be involved in. This includes official health-related curriculum, government legislation, school-based public health policies, private programs and other one-off interventions. Although we will obviously not be able to discuss everything health-related that happens in American schools, there is no reason to quarantine any of these examples from the questions we pose.

Not long after beginning work on this book the sheer breadth of the task we had set ourselves came starkly into view. So much happens in the name of health in American schools—initiated by a bewildering variety of stakeholders and targeted at the full spectrum of modern health concerns—that even a book-length treatment was never going to do the topic justice. At the same time, we noticed that the ways in which public health was reshaping American schools were going essentially unnoticed in both educational and public health scholarship. Perhaps the silence was the product of the amorphous and, paradoxically, taken for granted nature of our subject matter or the traditionally low educational status of health and physical education. Whatever the reason, the current enthusiasm for doing public health in American schools has apparently crowded out discussion of the shifting assumptions, motivations, and effects of doing so.

We expect that much of what we say in this book will be unpopular and contentious. Partly this will be because in our efforts to draw general conclusions we necessarily gloss over what some readers will see as important exceptions. Readers will simply need to judge for themselves the degree to which they think we have been fairly or unfairly selective. Although squarely acknowledging this limitation, we would also want to at least register the point that bad policies and good outcomes are not

necessarily mutually exclusive. In this book we adopt a predominantly top-down perspective; what interests us is the way the actions of actors outside of schools impact on what happens inside schools. And yet even in the most toxic of policy environments, teachers and students might still respond in positive and creative ways, making the best of a difficult situation. Perhaps closer to the situations we describe in this book, most policies are neither inherently good nor bad but are open to multiple interpretations and enactments. Our point here is that we do not think it necessary to account for every individual response to a given policy in order to arrive at a judgment about that policy. *Of course* bad policies can sometimes lead to good outcomes, but this is hardly a reason to stop asking questions about them.

A few other qualifications are in order. First, a huge amount of recent scholarship has been devoted to what is sometimes called the global educational reform movement (or "GERM") and the political, economic, and ideological forces driving it. In particular, this scholarship has focused on the impact of neoliberalism and the marketization of American education. While we draw extensively on this work we also need to stress that only a little of it deals with the overlap between public health and educational change and that which does has mostly concerned itself with the behavior of large corporations. The corporatization of school-based public health is an important dimension of our story, but there is also much else that we will need to leave unsaid on this subject.

Second, there are many writers who have offered critical accounts of specific health-related issues in schools such as sex education or obesity. Locked within a single orbit, this work tends to deal with the specifics of "what works." We certainly consider questions of efficacy in this book and we agree that this is one of the elements that need to be factored into any understanding of school-based public health. In general, we are inclined to accept that, given ideal conditions, many (although not all) public health goals could be addressed in schools and that it is not unreasonable to try to describe what these conditions should be. However, our perspective in this book is more global. We will suggest that both the breadth and nature of the health-related concerns that schools are burdened with should give us pause for thought. It is striking how rarely the problem of competing health priorities is meaningfully tackled in the school health literature. What is more, the laudable goals of single-issue advocates almost never take account of the kinds of day-to-day places schools are or the impact of non-health-related imperatives that contradict or crowd out spaces for doing health. In short, most writers in this field simply assume that schools are an obvious place for doing public health and then sally forth from there.

Finally, not for the last time, we will emphasize that this book does not try to show that using public schools to do public health work is always and everywhere a bad idea. Our goal is far more modest than this.

We simply think that a more rational and educationally rigorous approach to school health than currently exists is both possible and desirable, and we invite readers to join us in wrestling with the difficult questions that arise once we begin imagining a future different from the present.

NOTES

1. Stephen Woolworth, "'The Warring Boards': Sanitary Regulation and the Control of Infectious Disease in the Seattle Public Schools, 1892-1900," *The Pacific Northwest Quarterly* 96, no. 1 (2004/2005): 19.

2. Ibid., 14.

3. In particular, Robert Higgs, *Crisis and Leviathan: Critical Episodes in the Growth of American Government* (New York: Oxford University Press, 1987). Also see Ballard C. Campbell, "Federalism, State Action, and 'Critical Episodes' in the Growth of American Government," *Social Science History* 16, no. 4 (1992): 561.

4. John Duffy, "School Vaccination: The Precursor to School Medical Inspection," *Journal of the History of Medicine and Allied Sciences* 33, no. 3 (1978): 355.

5. Lindsey Tanner, "Obesity Education Should be Provided to Kids and Teens, American Medical Association Says," *The Huffington Post*, last modified June 20, 2012, http://www.huffingtonpost.com/2012/06/20/obesity-education-american-medical-association-kids-teens-ama_n_1612906.html.

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7. See Jonathan Zimmerman, *Distilling Democracy: Alcohol Education in America's Public Schools, 1880-1925* (Lawrence, KA: University Press of Kansas, 1999).

8. Lori Dorfman et al., "Soda and Tobacco Industry Corporate Social Responsibility Campaigns: How Do They Compare?" *PLoS Medicine* 9, no. 6 (2012): e1001241.

9. Katherine Weare, "The Contribution of Education to Health Promotion," in *Health Promotion: Disciplines, Diversity and Developments*, ed. Robin Bunton and Gordon Macdonald (London: Routledge, 2002), 103.

TWO

A Process, Not a Thing

Mistakes are inevitable in any large scholarly undertaking and we will no doubt have committed our fair share in producing this work. One mistake that we will not make, however, is to rush to narrow definitions about our subject matter. Scholars and commentators in the fields of health or education will know that the accusation of selectivity awaits anyone who tries to question long-held assumptions. Probably because of their size and complex histories, criticisms of the status quo in health and education tend to be rejected on the grounds that they use isolated examples to unfairly tar the entire enterprise or that they begin from maliciously narrow assumptions and definitions. An obvious example of this has been played out in debates about race and education; are historical instances of racist conduct by teachers and administrators proof of an inherently racist institution or just the inevitable anomalies that occur in any large-scale human endeavor?[1] In other words, the simplest way to dismiss dissident thinkers is to accuse them of having some ideological agenda.

Schools and public health are, and have been, many things to many people. American public schools, for example, have been celebrated as a force for social advancement and nation building[2] and condemned as an instrument of both benign neglect and outright oppression.[3] Most obviously, one's judgment on these matters might partly be a consequence of when and where one looks; the post-Civil War educational experience of poor black rural children is a very different sociohistorical matter to those attending affluent white suburban schools in the late twentieth century. Differences of perspective might also be philosophical or even epistemological. The "correct" definition—and therefore purposes and methods—of education and health-related institutions are matters people of goodwill can legitimately disagree about. Likewise, the kind of evidence we

might call upon to support our opinions is also potentially contentious. For example, people who are inclined to see the emergence of the modern bureaucratic state and its various organs as essentially coercive tend to use history illustratively, pointing to a long list of past prejudices and crimes. Is this reasonable? Are public institutions always and evermore simply an extension of their flawed pasts? How far back into history can we search before this becomes an irrelevant or misleading exercise? At what point can we say that a break from the past has truly been made and that things really are different now?

These matters are especially important given the task we have set ourselves in this book. In particular, one's judgments about the public health role of schools will surely rest largely on what one takes to be the core mission of schools and one's feelings about the general wisdom of public health as an enterprise. Taking this point a step further, we can imagine at least two potential, although admittedly polarized points of view. On the one hand, there will be those who think that the promotion of health is a fundamental reason for sending children to school; they will see no contradiction at all between the health and educational mission of schools and may even wonder why we would bother raising questions about it. On the other hand, while philosophically committed to the state's responsibility to educate children and foster the population's health, others might decide that these are largely, if not completely, unrelated areas of state policy. A person who favors a rigorously demanding academic approach to school education might be inclined toward this view because they worry about distractions from schools' core academic purpose.

These are both philosophical and practical issues to which we will return. For now, it is enough to say that these two hypothetical orientations by no means exhaust the diversity of opinion that is possible. Over the following chapters we will suggest that, on balance, a consistent theme in American history is the relatively muted suspicion of state involvement in educational matters compared with health. Put somewhat crudely, there exists a tradition for seeing education as the legitimate business of governments but health as a primarily private concern for individuals. Seen this way, public health activity in schools might be seen at least by some people as an unwelcome intrusion.

Our point here is to begin to sketch out the tangled conceptual and political background to the ideas and conclusions offered in this book. As we alluded to above, we suspect that some readers will question or reject our motivations. This chapter, in particular, is where we begin to set out our case that there are, in fact, important reasons to think about the relationship between schools and public health. In part, we think that undisturbed assumptions and a distinctly ahistorical bias serve to insulate this field of study against many important critical questions.

The remainder of this chapter, then, explores the question "what is public health?" We mean to move beyond the assumption that schools and public health go naturally together by at least probing what, precisely, people have in mind when they make this assumption. By asking what *kind* of thing public health is we should then be in a better position to talk about what kind of thing public health in schools is. No doubt a lengthy list of candidate answers will emerge. What matters though is that we end up with some specific ideas that we can discuss and agree or disagree about.

Rather than a dry exercise in defining one's terms, our intention is also to generate questions that might facilitate new ways of seeing and thinking. In drawing on an eclectic range of scholarship we were especially interested in exploring the legitimacy of a variety of viewpoints, not necessarily so that we might convince the reader of their merit, but in order to prize open spaces for questioning that we exploit in later chapters. In this sense, questions are important not because we have the answers, but because of the journey they invite us to take.

BEYOND DEFINITIONS

In his encyclopedic work, *Public Health: What It Is and How it Works*, Turnock[4] points out that the term "public health" tends to be understood in one of five distinct and yet interrelated ways. First, there is the somewhat vernacular sense, literally meaning the health of the public. Used this way we might talk about the quality or level of public health enjoyed by a particular nation or population. A second and similarly nontechnical usage understands public health as a broad social enterprise; something that a wide range of individuals and institutions pursue. Of course, there will always be disagreement about what does and does not fit under this definition. For example, homeless shelters, water infrastructure, and health insurance schemes come quickly to mind as important pillars of modern public health systems. But if we accept that happiness, pleasure, and human interaction play a role in human health, we might also ask whether public libraries, art galleries, or live music venues also qualify. What about institutions that regularly save lives, like police forces and fire brigades, but which are not normally discussed in medical or health terms? Either way, this broad social enterprise definition, probably more than any other, captures a robustly collective understanding of public health. And if public health *is* a broad social enterprise, why wouldn't we include schools?

Turnock then proposes two closely related and more concrete definitions. In a relatively narrow sense we could think of public health as a particular set of professions and the people who populate them. Again, the boundaries of this definition are debatable; community nurses and

medical practitioners are obvious inclusions while, depending on your point of view, town planners may not be. However, for many people the names of specific professions will be much less obvious and meaningful than their actual experiences and interactions with the public health system. The human experience of public health, then, gives us a fourth definition; the actual services a public health system provides and people's experiences of them.

Last, Turnock suggests that public health can also be understood as a set of methods. Here he is referring to the techniques that public health professionals use in their work to help people, as well as the techniques for collecting information and the knowledge that these techniques produce. This may seem a slightly esoteric way of thinking about public health. As we will see later in this chapter, though, bodies of knowledge, like people, have histories that often precede and outlive the people who use them. In fact, existing knowledge about human health, regardless of how well founded or misguided, has regularly been far more consequential than the creative or spontaneous actions of individuals and institutions. There may even be grounds for suggesting that ideas about what knowledge and techniques do or do not belong in public health are the most salient factor in determining its material effect on people.

Some of the connections between these five different understandings of public should be reasonably self-evident. judgments about the overall health of a particular population usually rest on some form of preexisting knowledge—perhaps a statistic—that, in turn, has been generated by people using certain information-gathering techniques. Knowledge about the health of a population may lead to a specific action such as the creation of a health service. New knowledge might also alert us to the existence of a previously unknown health need and even lead to the emergence of a new professional group who specialize in this area of knowledge.

All of these definitions of public health, and the connections between them, are relevant to this book. In fact, they are more than just relevant; they help to shape the questions we ask about the public health role of schools. For example, do schools have sufficient skills and resources to be considered part of America's public health system? What knowledge should we draw from in order to make a judgment about this? What methods should schools use when doing public health work? Perhaps most important of all, what are the limits to public health? Is it something to which all professional groups can and should make a contribution even if doing so impinges on what we might see as that profession's "core business"? A recent study published in the *British Medical Journal* compared the number of calories in preprepared meals available in three English supermarket chains with meals cooked by some well-known celebrity chefs on their television shows.[5] The researchers found that the celebrity chef meals were "less healthy" and concluded by discussing a

range of public health responses, including a 9 p.m. watershed for these programs, so that children were less likely to see them, and compulsory nutrient labeling in cookbooks. What this curious example seems to demonstrate is the way some people are disinclined to see boundaries between what public health does and what other professionals do, even celebrity chefs. We mentioned public health's colonizing tendencies in the previous chapter and this eagerness to instruct other professionals on how they should do their work is a case in point. In fact, this example also demonstrates a determination to insert a public health mission into every corner of our personal pleasures and private pursuits. After all, why else would anyone call for nutrient labelling in celebrity cookbooks if not to discourage at least some people from following the recipes inside?

We suspect that this example also implies, if not a sixth definition for public health, then at least a dimension of Turnock's second definition that invites emphasis. That is, public health can also be understood as a collection of laws, rules, regulations, and even social mores. As a field of human endeavor, public health seeks to shape the behavior of groups and individuals and to classify particular behaviors as healthy and unhealthy. Further, an enterprise of this kind is nothing without sanctions, and these too can take different forms, from imprisonment and financial penalty to a loss of certain rights and social disapproval. In the case of tobacco, the full gamut of sanctions is employed in various jurisdictions around the world. The improper sale and importation of cigarettes are criminal matters in some countries, while in others the freedom to advertise and sponsor sporting teams and events is often denied to tobacco companies. Perhaps the most pervasive sanction against tobacco, at least in Western countries, can be seen in the efforts of public health to render smoking socially undesirable. In fact, almost all public health advertising and publicity campaigns are intended to influence the relative desirability of certain behaviors.

In summary then, we might say that public health can be thought of as a state—as in the general health of the public—as well as a collection of people, professions, knowledges, practices, experiences, and rules, both officially legal and unofficially sociocultural. Crucially, the nature, influence, and configuration of these components has varied across time and space, an observation that, in taking us beyond Turnock's definitions, suggests we are dealing with a process rather than a thing. In fact, perhaps what needs to be said is that public health is a kind of transhistorical social movement, with all the fuzziness and imprecision this statement implies.

Fuzziness notwithstanding, people who study it and people who do it have all had a stake in defining public health. Definitions have political dimensions, not least because they inevitably lead to questions of responsibility and power. Is public health primarily the business of govern-

ments? Do particular professional groups have a privileged position in deciding what is to be done? What is the role of individual citizens? Is public health something that is done to individuals or do they, by virtue of being citizens of states, have public health duties? If so, what is the nature of these duties? Is it economic, such that failure to be healthy can and should lead to some kind of financial penalty? Or are the health-related responsibilities of individuals simply matters of personal morality? And what about private enterprise? Is it possible or desirable to see public health as a commodity or service that can be bought and sold, or is profit and public health a contradiction in terms? After all, if profit relies on the existence of a particular health problem there may be commercial incentives in favor of perpetuating rather than eradicating the problem.

Inevitably, these complexities have led practitioners and scholars to very accommodating definitions of public health. While Berridge, Gorsky, and Mold[6] point to the way definitions are subject to politically motivated variation through time, in recent decades the broadly palatable idea of "collective action in the name of health" has emerged. For example, they quote the businessman and treasury adviser Derek Wanless, whose 2004 report to the British government, *Securing Good Health for the Whole Population*, defined public health as: "The science and art of preventing disease, prolonging life and promoting health through the organised efforts and informed choices of society, organisations, public and private, communities and individuals."[7] Notice here the explicit inclusion of the private sector and "choice" at a particularly pro-business moment in British political history.

Somewhat more succinctly, the historian Dorothy Porter has suggested we think of public health as "collective action in relation to the health of populations."[8] As reassuringly to the point a definition of this kind might seem, the danger is that it glosses public health in a veneer of common sense. For example, understood this way it becomes much easier to see schools as an axiomatic part of the general enterprise of public health, precisely the habit of mind this book seeks to undermine. Nonetheless, Porter's definition is a reasonable point from which to proceed because it invites us to think about the historical process of public health, and suggests specific questions about whose actions are important, to what ends and with what outcomes.

LEARNING FROM HISTORY

By attempting to tease out the different elements that contribute to present-day understandings of it, our discussion of the term "public health" has so far been of a mostly philosophical kind. Although not sufficient, this layered definition will be helpful when we come to think

about the extent to which schools can and should have a public health role.

By contrast, we now want to be more concrete, empirical, and historical. Our goal is to think about what public health "really is" or at least, what it has been. From the outset, we think it is reasonable to assume that authorities who are in a position to affect the health of a given population will do so for reasons that will vary, not always be obvious, and may even differ from what is publicly announced. On top of this, we would add that public health is closely linked with a range of momentous historical processes, including European imperialism, the Industrial Revolution, the formation of nation-states, and the evolution of democratic systems of government.[9] Putting these points together, we would make a further somewhat more controversial claim: It would be naïve to simply assume that the primary motivation for, or affect of, any public health measure is to improve people's health. To take a modern example, it seems likely that after certain thresholds are reached, further increases in tobacco taxes have the effect of raising government revenue without an appreciable impact on smoking rates.[10] Illicit drug policy presents an even starker case. While the criminalization of certain drugs is sometimes defended on public health grounds, many experts argue that criminalization merely reflects the moral sensibilities of a certain portion of the adult population while doing very little to reduce drug use.[11] Likewise, can we simply assume that school-based public health interventions are intended or are likely to have an effect on public health? Could they exist for some other reason?

For readers who are at least prepared to entertain these questions, the next step is to consider what our alternatives are. If public health measures aren't necessarily about health, why do they exist? Inevitably, parts of the following discussion will strike some readers as implausible or uncharitable as we explore the different ways in which scholars have analyzed public health and its connection to other historical events and social processes. It is important to say that this is not necessarily an exercise in looking for direct historical parallels, which is, after all, a highly subjective business. What we do suggest, though, is that all of the following examples are food for thought and resources for making sense of the present.

One place to start is with the foundational mid-twentieth century work of René Sand and his contemporary, George Rosen. Sand and Rosen were both members of an international circle of mostly European scholars, active in a period roughly bounded by the 1930s and 1960s, whose work centered on the relationships between medicine, the state, and the general public. Although a theoretically and politically heterogeneous group, they nonetheless shared an ambitious vision of the potential for medicine to be harnessed for the common, and not just private, good, an enterprise to which they gave a variety of names including

social medicine, social hygiene, state medicine, and sanitary engineering among others.[12] The basis for their optimism varied somewhat; some drew inspiration from post-Enlightenment European history, particularly Germany, while others openly favored the state-run medical system of Soviet Russia. There were also important differences in the epistemological nature of their respective projects. For example, some saw the new social program for public health being led by the medical community itself. Others strongly disagreed, pinning their hopes on a rigorously statistical approach and the formation of completely new scientific fields concerned with policy analysis and creation. The common thread in all of this work, however, was a determination to see medicine as a broad, modern, preventative (not just curative), and politically engaged social science.

Born in Brussels in 1877, René Sand was a pioneer in the fields of social work and "social medicine."[13] The focus of his career evolved from early studies in scientific medicine into a concern with the life conditions of poor families and youth in the cities of Europe and the United States. He was the driving force behind the creation of a number of international social work and social medicine societies, as well as a leading player in the international Red Cross movement and the formation of the World Health Organization. In 1944 he was arrested in Brussels by the Gestapo and imprisoned in Austria until the end of the Second World War. Shortly after, he published *Vers la Médicine Sociale*,[14] which appeared in English in 1952, not long before his death, as *The Advance to Social Medicine*.[15]

The aspirations of Sand and his contemporaries obviously need to be understood in the context of the twentieth century's political and ideological struggles over the role of governments in personal and economic affairs. This was particularly so in the immediate post-World War II period, and partly explains why Sand's work was embraced, if not revered, in American public health circles during this period, despite his preference for the term "social medicine."[16] In *The Advance to Social Medicine*, Sand imagined a future in which all arms of government would be involved in a coordinated approach to population health, a vision which explicitly sought to de-emphasize what he called "private health." As the Scottish professor of public and social medicine J. H. F. Brotherston wrote:

> For Sand, social medicine is not only an academic discipline, the medical study of man in his environment; it is not only a point of view which must permeate all medical thinking; it is above all a spur to action, it is medicine out in the public places determined to play a leading part in moulding the social environment in the interests of health and happiness.[17]

The historian Dorothy Porter describes Sand's outlook as Hegelian because he saw social medicine as the inevitable culmination and unification of medical knowledge under one absolute idea.[18] To this end he

mined the histories of ancient Rome, Greece, Babylon, and Egypt in search of the antecedents of his modern vision, thus glossing social medicine with a timeless and apolitical nobility. In fact, as both the optimistic title and the opening pages of *The Advance to Social Medicine* make clear, Sand was inclined to see almost any individual or collective health focused action as part of social medicine's long and deep history:

> In order to appreciate fully the immense scope of social medicine, it is necessary to study the elements which have given it birth. We shall describe successively, in their evolution from ancient times: medical practice; hospitals; personal hygiene, public health and social hygiene; industrial medicine and the medical services of public assistance and the friendly societies; and finally, the sciences concerning man himself. We shall then see the separate streams converging and intermingling to form the science of social medicine.[19]

With similarly wide-ranging erudition, George Rosen's (1910-1977) 1958 work *The History of Public Health* also invited readers into a panoramic narrative of inexorable human progress toward rational and socially just health systems.[20] Rosen was a native of New York City but was denied entry to American medical schools because of his Jewish heritage. Amazingly, he completed his medical training in Berlin in 1935 in the middle of Hitler's rise to power before returning to work in New York as a physician and health official.

Eventually making the transition to historian, Rosen assumed the editorship of the *American Journal of Public Health* in 1957 and held the position for sixteen years. During that time he was a prodigiously prolific writer and advocate for public health. In his retrospective of Rosen's editorials for the journal, Milton Terris records that at the time of his death in 1977 Rosen was acutely aware that the expansive vision for public health that he and others had argued for so tirelessly was in serious trouble.[21] On this and many other issues, Rosen's roots in the leftist social politics of the first half of the twentieth century were clear enough. For example, Rosen lamented rampant specialization in medicine and public health because of the way it encouraged narrow profit-seeking behavior at the expense of the common good. He also felt it led to a fragmentation of public health's objectives and knowledge base. Above all, Rosen argued that specialization exacerbated the constant danger of health's depoliticization. He believed that a fundamental concern of his field should be the workings of political power. In a 1959 editorial he wrote:

> mercantilist princes, Jacobin revolutionaries, Benthamite utilitarians, and New Deal liberals have all seen that the solution of community health problems involves not alone scientific and technical knowledge, but equally and perhaps even more important—political action. . . . In fact, throughout the development of public health the element of politi-

> cal action is so intimately intertwined with social organization and scientific knowledge that it is often difficult to consider the effects of each factor independently. . . No conception of the political process is adequate, however, that does not take into account the dynamic and power implications of class structure in the community. The informal power structure of the community and its significance must be as familiar to the public health worker as the formal organization of government and administrative bodies. . . . The political highway in the community is one that public health workers must learn to travel, despite its twistings, turnings, and ruts. Their skill in avoiding its dangers and in mastering its geography will no doubt be reflected in their ability to deal effectively with the health problems of the community.[22]

Like Sand, Rosen's work has been criticized for being too willing to see a transhistorical unity of purpose in the actions of individuals and institutions. In her warm and respectful 1979 obituary for the *American Journal of Public Health*, Barbara Rosenkrantz nonetheless commented that:

> As he wove these elements together, Rosen persistently emphasized the forces which made it possible to improve man's lot; dispassionate interpretation could never hide the underlying exhortation and the confidence in progress that led Rosen to single out "precursors" and heroes as individuals, leaving the forces of darkness and reaction clothed in anonymity.[23]

Writing more recently, Porter is rather more pointed, noting that Rosen wrote often about the need to attend to the clash and competition between ideas, institutions, and the self-interest of specific groups. And yet:

> In the 1930s, 1940s and 1950s, a group of historians produced analyses and contemporary accounts of social medicine, carrying the implicit polemical argument that it could be a panacea for the ills both of society and of medicine. Rosen was a key member of this group; yet, paradoxically, he ignored his own prescriptions for history-writing when he came to deal with social medicine itself, failing to examine the dialectical aspects of institutional struggles and clashing interests.[24]

Perhaps the most important clash which Porter thinks Rosen was inclined to overlook was the one between the medical profession itself and public health. As we will see, one interpretation of history, sharply at odds with Sand and Rosen's, is that the goals of the public health movement and modern medicine have regularly been anything but harmonious and might actually be better thought of as distinct and competing traditions. In fact, Porter's point is to question whether it makes sense to talk about a coherent and unified public health movement in the way that Sand and Rosen did.

This is obviously not the place to attempt to adjudicate on these matters. The achievements of Sand, Rosen, and their contemporaries remain a rich source of insight and historical comparison. At a basic level, they

invite us to reflect on the pros and cons of Western health systems that, from the 1950s onward, seemed to place an ever greater emphasis on curative, industrialized, scientific medicine instead of sociologically and epidemiologically minded preventative health. We might also wonder, as Rosen clearly did, whether the political and economic forces shaping modern health systems have led to better outcomes for the poor and disadvantaged.

A HAPPY MARRIAGE?

Whatever else is true, there is little to be gained by glibly siding with or against social medicine and its formidable, though now long dead, advocates. What matters for us here is how we decide to think about public health today and its role in schools. For example, from a social medicine point of view, we might be more likely to think school-based public health a good idea. After all, most children go to school and, if we can develop effective programs, there are probably few other ways to efficiently reach so many children, rich or poor. In a more philosophical vein, a social medicine outlook is far less inclined to draw hard and fast boundaries around the purposes of particular institutions. There would therefore be no obvious reason *not* to see schools as contributing to the general well-being of society—including its health—and as symbiotically joined with other instruments of the state in pursuit of good health for everyone. And if public health really is an enduring human tradition with ancient historical roots, as some in the social medicine circle thought, arguing against school-based public health becomes, if not impossible, at least much more difficult. We would surely require very good arguments indeed to disassociate schools from such an apparently obvious, enduring, and noble human enterprise.

On the other hand, thinking about Sand and Rosen's ideas might also prompt us to wonder about the nature of public health's role in schools; what kind of knowledge should we draw on in order to shape school-based interventions? For example, if we accept the general point that there is a limit to what schools can achieve, should we take a more medical view and focus on the causes of specific medical conditions? Among other things, this would tend to direct our attention toward the behavior and biological state of the individual. In other words, perhaps the best way to prosecute the goals of public health in schools is simply to provide students with information; to teach them about their physical body and the different things that can go wrong with it if is not properly cared for.

A less medical and more social outlook, on the other hand, might stress the role of education in lifting people out of poverty or educating students about the health inequalities that exist in society. In other words,

even if we agree that schools do have an important public health mission, this still leaves unanswered questions about what form this mission should take.

While harvesting ancient history to give public health a humanistic universality, Rosen also saw the remarkable advances in biological knowledge and laboratory-based experimentation throughout the late eighteenth and nineteenth centuries as the decisive turning point for modern public health. Here he was particularly thinking of the Parisian and Viennese laboratories of Louis Pasteur and Gerard van Swieten respectively, their pioneering discoveries in microbiology, and the invention of entirely new fields of medical research. For Rosen, these developments made it possible to see public health (or, in his words, social medicine) as the synthesis of mature but hitherto separate social and biological knowledge traditions; a triumph of scientific rationality in the service of the modern state and humanity.

There are probably many reasons why Rosen was inclined to interpret history in this way, not least of which was his own background in medical science. Without dismissing his point of view as misguided though, we can at least observe Rosen's determination to see public health—at least in its social medicine incarnation—as an essentially and simultaneously medical and humanitarian project. But from the perspective of the early twenty-first century, there are compelling grounds on which to question Rosen's harmonious account. For example, many public health scholars look back on the medicalization of public health in the twentieth century as a mixed blessing at best.[25] In this view, the flourishing of the sanitation movement in nineteenth-century Europe, and its more muted echo in the United States, was a nonmedical golden age in public health's evolution. In the absence of scientific understanding about what diseases were or how they spread, the nineteenth-century reformers thought and acted in pragmatic ways and sought to alleviate the health impacts of poverty and make material improvements to people's living conditions. As Fairchild and colleagues put it in an article for the *American Journal of Public Health*:

> In Chicago, social reformers . . . focused on living conditions as the reason for the declining health and well-being of workers, women, and children. In Boston, charity workers looked at the slums in which the Irish lived as the source of disease. In Philadelphia, New York, and Boston, reformers focused on housing as a cause of the city's physical, social, and moral decline. These efforts mirrored the work of reformers and social critics in Europe, who saw in the relationship between poverty and disease the foundation for a call for radical social change.[26]

Although it might be too strong to say that public health operated as a fully blown social science during the nineteenth century, it was a

thoroughly social enterprise. In fact, in the absence of robust biological knowledge it could scarcely have been anything else.

Despite Rosen's vision of a happy symbiosis, however, nineteenth and twentieth century advances in scientific medicine actually posed a direct challenge to the social view of public health that he and others championed. For one thing, from the beginning of the twentieth century some public health leaders argued that the new scientific discoveries rendered the social view obsolete and inefficient. Why, they asked, should we employ the scattergun of social reform—which may or may not work—when we now have the scientific knowledge that will allow us to target disease in far more precise and cost-effective ways?[27]

These arguments became particularly contentious in the United States, especially against the backdrop of a cultural bias against government intervention in daily life. In her comparative history of maternal and infant health policy in the United States and France between 1890 and 1920, Alisa Klaus offers the instructive example of the United States Children's Bureau, created in 1912 by President William Taft.[28] Unlike France, little public policy aimed specifically at promoting the health of mothers and babies existed in the United States at this time. As a result, the Bureau occupied a new and mostly unpopulated sphere of policy and benefited from the absence of national or state welfare and public health agencies through which they might otherwise have had to act. According to Klaus, this administrative freedom was exploited by the Bureau. Staffed by a group of socially progressive women, it argued for women's health as an important policy goal in its own right, thus implicitly rejecting the growing rhetorical dominance of health as a national economic and, following WWI, military asset. Its feminist leanings also meant that it was disinclined to take a moralistic stance toward the plight of the poor, emphasizing instead the economic and social conditions that families and, in particular, mothers found themselves in.

At first, the work of the Bureau went relatively unnoticed. It conducted research and advocated for services in relatively small American communities as well as a number of medium-sized cities. In turn, this research produced reports that described the economic and health challenges that poor American families faced. Almost immediately, though, the findings of the Bureau angered employers who, not unreasonably, assumed that high rates of infant mortality were being blamed on the low wages they paid workers. But the Bureau's consistent emphasis on the ills of industrial capitalism also brought it into conflict with the medical establishment and urban public health officials, a situation that was exacerbated after WWI when the federal government began to make major new financial allocations for maternal and child health, thus sparking competition for resources and professional prestige. For many in the medical community, mothers and babies were best served by banning the use of midwives, increasing funding for laboratory research, more hospi-

tals and more well-trained physicians educated in the latest scientific theories. Faced with such formidable opponents, the Bureau toned down its economically radical rhetoric. In its place it emphasized the role of maternal education and the provision of professional services for poor and rural mothers. Nonetheless, throughout its existence the Bureau's leaders argued against the medicalization of childbirth and for the efficacy of doctor-free births. For their part, physician groups were determined that the public understand childbirth as a pathological condition that demanded the presence of trained, male medical practitioners. It is also clear that they resented what they saw as the interference of the Bureau and other government services in a field they were beginning to claim as their own. As much as anything else, they saw free health care of any kind as impinging on the capacity of medical practitioners to generate private income.

The example of the United States Children's Bureau's skirmishes with the increasingly scientific and rapidly expanding medical profession was repeated throughout the progressive era and, in fact, the remainder of the twentieth century. Approaches to population health that put faith in the capacities of ordinary people to manage their own well-being so long as they were free of the consequences of poverty and had access to good quality information were attacked for lacking scientific sophistication and, just as important, for harboring socialist intent. Although never wholeheartedly embraced in the United States, the European model of social and sanitary reform would increasingly come to be seen as a relic of the nineteenth century. There would, in other words, be no happy marriage between social and medical approaches to the health of the public, a reminder that when we talk about public health in any context, including schools, this tension remains whether we acknowledge it or not. That is, what *kind* of public health do we imagine schools doing? Should it be an extension of medical science? Or should our goals and practices for school health be underpinned by other knowledge traditions? Should it be shaped by a concern with the effects of poverty or even try to alleviate the causes of poverty? And as we now go on to explore in the next section, does a consideration of poverty lead us to politics? That is, should public health in schools have a political dimension and, if so, what form should this politics take?

POLITICAL HEALTH

As we saw, George Rosen talked about the centrality of "politics" to public health. However, we could simply read this as the idea that the task of helping people live healthier lives in healthier contexts required political skills and had political effects. However, an alternative analysis is to see public health as, first and foremost, a form of politics, rather than

just an enterprise with political dimensions. Such a view becomes possible if we make the emergence of the modern nation-state, rather than medical science, as our starting point. That is, we might argue that the business of taking legal and bureaucratic actions for the purpose of influencing the health of entire populations is a characteristic of certain kinds of political formations and not others. To this end, a great deal of pre-nineteenth century evidence could be marshaled. Most obvious are the measures taken across Medieval Europe in response to epidemics of contagious disease and, particularly, the social upheaval they provoked.[29] Contagion has been a constant throughout human history, but it is only once epidemics threaten social stability and the power of ruling administrative elites that administrative solutions are sought. A host of historical examples exist, but an important and historically early case comes from Richard Palmer's work, which describes the importance of the Black Death in the emergence of the city states of Renaissance Italy.[30] In this case, we see the rehearsal of a story that, at least in the eyes of some scholars, has been repeated throughout history and is as true today as it ever was; the tendency of medical emergencies to increase and consolidate the power of central authorities. Of course, claiming and exerting power over populations inevitably means taking power from someone else. For contagious diseases in Medieval Europe, this meant restricting people's movement and, in some cases, detaining them. For a range of reasons, these measures impinged on both commercial and religious activity and provoked immediate opposition.[31]

However, we do not need to go so far back in history to see similar dynamics at work. The world's first national health insurance scheme was introduced by Chancellor Otto von Bismark in the newly unified German state in 1883.[32] This required manual workers to insure themselves against sickness and injury with some of the costs to be met by employers. While there is debate about the true motivations behind the introduction of the scheme, it seems clear that a concern with industrial efficiency and fear of the rise of left-wing agitation across Europe were important factors. In particular, the scheme applied only to workers in heavy industry, by then the mainstay of the German economy but also a hotbed of socialist sentiment.[33] Likewise, the story of the emergence of tropical medicine and its application around the world is tightly linked to nineteenth- and twentieth-century European colonialism.[34] In simple terms, tropical medicine was a response to the medical hazards associated with exploiting African, Asian, and Latin American colonies. As a field of study, it played a central role in maintaining the profitability of the imperial project through the exploitation of land and labor. More subtly though, there is ample historical evidence that techniques for protecting against and curing disease were used selectively and strategically. Sometimes this meant reserving treatment for expatriate Europeans only. At other times, decisions about how to control disease among Indigenous

laborers were made only when illness reached economically unsustainable levels. Throughout, though, treatment regimes were selected or rejected on the grounds of their perceived economic efficiency. In the case of the United States, Warwick Anderson's work demonstrates tropical medicine's central role in shaping colonial governance and race relations in the Philippine archipelago.[35]

Lest our point be misunderstood, we are not suggesting that these examples lead to any specifically sinister conclusions about public health in general. To point out that public health can be seen as a form of politics is not, in and of itself, a criticism. The proliferation of public health reform across nineteenth-century Europe, but particularly in England, was as much as anything else an expression of new forms of political power being used for explicitly humanitarian ends. There have been and will continue to be debates about the motivations of reformers and the overall impact of their work on urban poverty, but there can be no doubt that concern with the plight of others shaped the necessarily political dimensions of public health reform during this period.[36] In particular, we could point to Rudolph Virchow, the hugely influential nineteenth-century German polymath.[37] Although he died in 1902, Virchow's life work as, among other things, a physician, politician, and scientist laid much of the intellectual foundation for twentieth-century social medicine and the ideas of scholars like René Sand and George Rosen. He is also the source of the much-quoted aphorisms "Medicine is a social science, and politics is nothing else but medicine on a large scale"[38] and "The physicians are the natural attorneys of the poor, and social problems fall to a large extent within their jurisdiction."[39]

Nonetheless, the more one's focus pulls out from the actions of individuals and specific moments in time, the greater the scope for locating public health within broader shifts in the organization and management of human populations. Taking a lead from the French intellectual Michel Foucault, we could see public health, and its close relationship with scientific medicine, as instruments of what is often called bio-power; the tendency of Enlightenment cultures to generate new languages, knowledges, rationalities, and professional groups devoted to producing "disciplined" populations.[40] This is achieved, in part, through new forms of surveillance and the collection and manipulation of information but also via a shift in the way people think about themselves and their responsibilities to the state. Understood this way, rather than the heroic actions of individuals, the history of the health professions takes on a more repressive hue with varying professional groups vying for power, resources, and prestige; and individual citizens being instructed and coerced into ever-more elaborate and intimate practices of self-surveillance. Health and medicine, in other words, can be seen as instrumental in a centuries-long process of expanding and consolidating the power of the state and experts of various of kinds.

For obvious reasons, Foucauldian histories of the health professions tend to be directly at odds with more celebratory mainstream accounts. Nonetheless, even in the most reverential hands, the stories of both Western medicine and public health are rarely told without acknowledging the intense struggles among professionals and between professionals and nonprofessionals. The field of public health in America is a particularly interesting example in this regard. As we have alluded to already and will return to in the next chapter, the role of clinical and scientific medicine within public health has always been and remains a matter of some division. But putting these internal debates to one side, the ideas and actions of public health workers have consistently provoked the resistance of ordinary people. The vaccination controversies with which we began this book were merely one example. Throughout the nineteenth century government health officials attempted to regulate the way working-class urban Americans kept their domestic animals, particularly pigs and horses, and disposed of them when they died.[41] For many reasons, but particularly the costs of enforcement, this proved to be a constant and often unsuccessful battle. As much as anything else, though, many ordinary Americans just resented and openly rejected this kind of intrusion in their daily lives.

While many people would dismiss this resistance as simple ignorance, a Foucauldian perspective demands that we not forget that public health laws and regulations originate in a desire to manage and govern human populations efficiently. It is this power dimension that invites us to look critically at public health rhetoric. For example, easily the most studied subject in the history of public health literature are the social and sanitary reforms of nineteenth-century Britain. These reforms would act as the iconic public health ideal to which scholars would hark back for generations to come, partly because of the way they embodied a humanitarian philanthropic spirit. Nonetheless, one of the figures most closely associated with the period, Edwin Chadwick, was nothing if not a bureaucrat. Initially celebrated for his only partially successful efforts to reform Britain's Poor Laws during the 1830s, he went on to be the leading advocate for centralized regulation of public sanitation.[42] A devoted follower and one-time colleague of the utilitarian philosopher Jeremy Bentham, Chadwick's ideas mixed faith in free-market mechanisms with a belief in the superiority of strong central government oversight over piecemeal local action. In other words, he believed and argued openly that sanitary reform would save the state money and increase overall economic prosperity. It is worth pointing out also that Chadwick's ideas emerged long before the economic burden of national medical insurance in Britain and that, similar to thinking in other European countries, he saw improved sanitation playing an integral role in promoting overall economic efficiency.

One reason why the mixture of motivations of reformers like Edwin Chadwick is worth thinking about is that they help us to make sense of the specific forms public health has taken. For example, we might ask why nineteenth-century industrialization and huge growth in European urban populations coincided with such a concerted surge in public health activity. While the answer might seem somewhat obvious, we should remember that rural Europeans had for centuries faced catastrophic waves of disease and injury. What's more, the nineteenth-century sanitation movement was largely conceived and enacted without the detailed biological explanations for disease that medical science would later deliver. Rather than a medical matter, improving the health of the population in this context was an urban, engineering, administrative, logistical, and, above all, political exercise. It is true, of course, that sanitary and general public health activity happened unevenly across Europe and around the world and that there are dangers in focusing on the experience of a small number of European countries. Nonetheless, public health's broad nineteenth-century history demonstrates that it was seen not only as a means to save lives, but also to win votes, maintain social order, increase industrial efficiency and profitability, and exercise greater control over the actions of individual citizens.[43]

The extent to which modern public health has been an urban phenomenon is also significant in its own right. As we will see in the next chapter, in contrast with Western Europe, a broad, collectively minded public health movement failed to take hold in nineteenth-century America. However, what progress there was centered on the creation of municipal authorities and the administration of America's burgeoning urban centers. This pattern was repeated across the English-speaking settler societies. To take a particularly acute example, the health of rural and remote Indigenous peoples in Australia, New Zealand, Canada, and the United States went relatively unnoticed by public health advocates throughout the nineteenth and twentieth centuries.[44] And as recent history in Australia shows, many Indigenous communities continue to endure living conditions that would be considered intolerable in urban centers. That these kinds of injustices still exist should once again discourage us from imagining public health as standing innocently outside the workings of political power, the distribution of wealth, and the management of human populations. This is not to deny the historical point that at least some form of health-focused collective action has probably been present in all human communities, regardless of time or place. Nonetheless, as much as anything else, modern governmental public health, aimed at affecting the lives of large human populations, can be seen as both the product of, and a response to, the rise of the industrial city.

We could develop this point a little further by suggesting that it is possible to understand public health via the kinds of problems it has addressed itself to. The deprivations of the new industrial cities spawned

a huge and complex set of anxieties that ranged from the immediate living conditions of the poor to the long-term health of societies and even entire races. It was in this context that the worldview and science of eugenics emerged. While we certainly cannot do justice here to the origins, consequences, and different strains of this important intellectual movement, we can at least draw on it to show, once again, that neither the motivations nor practices of public health are always straightforwardly benign.[45]

Despite their differences, nineteenth- and early-twentieth-century eugenicists believed that the moral and physical decline they perceived around them could be addressed by intervening in the processes of human reproduction. Biologically minded advocates of so-called "negative" eugenics favored selective human breeding so that people seen as having the most desirable characteristics would be encouraged to reproduce with each other, while the reproductive rights of others would be restricted or removed altogether through, for example, immigration restriction, marriage bans, and forced sterilization.[46] Eugenicists with a more sociological perspective were inclined to believe in the potential for human improvement. In this more "positive" form, eugenics generated a wide variety of interventions, often of an educational kind such as those concerned with nutrition, domestic hygiene, and the child-rearing practices of mothers. "Positive" eugenics was actually the stimulus for some of the more general criticism of nineteenth-century public health reform. Any measure that improved the life prospects of those deemed genetically inferior, including immigrants and the poor, was liable to be condemned because it increased their opportunities to reproduce.

In exploring their connections, Pernick[47] argues that we should neither under- nor over-estimate the influence of eugenics on American public health in the early decades of the twentieth century. In some cases both the teleological theories and goals of eugenicists and public health advocates were identical. This was particularly true for positive eugenics. On the other hand, eugenics was by no means the only source of the racism and paternalism that public health interventions often exhibited. The point we cannot avoid, though, is that much of the twentieth-century public health activity in America in the years before WWII flowed from the rapid social and demographic change brought about by immigration and industrialization. In fact, a crisis of American identity, fueled by a worldwide preoccupation with the purity of the white race, shaped a great deal of American public policy in this period.

Our point here is not to equate school-based public health with eugenics although it is plainly the case that American schools have been one of the testing grounds for eugenic ideas. At the very least, however, the eugenics example should direct our attention to the motives and targets of school-based public health: Who is being targeted and why? What

theories, prejudices, and anxieties lie behind policies that, at least publically, are justified purely in the name of health?

DOES PUBLIC HEALTH WORK?

Finally, we turn to probably the most obvious question we could ask about public health: Does it work? After all, given that there are many different ways a society might choose to channel its resources in order to improve the health of its members, efficacy and value for money are unavoidably important matters. An obvious contemporary illustration of this is played out in discussion about the relative merits of preventative and curative medicine; do we spend too much money on treating the sick and not enough on preventing people from getting sick in the first place?

A variation of this debate was sparked by what become known in the field of public health history as "the McKeown thesis." In a series of publications beginning in the 1950s, the professor of social medicine Thomas McKeown proposed that improving life expectancy in nineteenth-century Britain could be explained by general improvements in living standards and, particularly, nutrition.[48] The implication of this argument was to cast doubt on the then conventional wisdom that tended to celebrate the impact of medical science and specifically targeted public health interventions. The McKeown thesis was, in other words, a myth-busting attack on public health's foundation stories. From the 1960s onward, McKeown's work was enthusiastically taken up by a wide cross-section of mostly leftist interest groups who shared a suspicion of science, industrial medicine, and masculine power structures. Needless to say, people who yearned for more economically equal societies were also particularly drawn to McKeown's ideas. In essence, the McKeown thesis was an extreme version of Sand and Rosen's social medicine; while agreeing that health was a broad, politico-economic, whole-of-society matter, McKeown appeared to throw the baby out with the bath water by leaving little room for health workers at all.[49]

Inevitably perhaps, McKeown's work was subjected to searching critique and, on the whole, found somewhat wanting, a point which has not diminished its popularity in some quarters. Leading the charge, the historian Simon Szreter has pointed out the many flaws in McKeown's thesis and attempted to rehabilitate public health as a field of rational and effective intervention.[50] While acknowledging the shortcomings of his research and the ideological motivations behind it, others have been a little more conciliatory, suggesting that McKeown raised some important questions about the impact of public health that have still not been satisfactorily answered.[51]

Taken together, one of the most important things these appraisals of McKeown show is that arguing for or against public health intervention,

no matter where it occurs, is a rather empty exercise without a precise understanding of the history and nature of the problem we are interested in addressing. Put another way, the tendencies to believe wholeheartedly in the justness or effectiveness of public health is likely to be just as misleading as an outright dismissal of it.

IN THE NAME OF PUBLIC HEALTH

Even the briefest sojourn in the history of public health literature should be enough to discourage any reader from simple or totalizing conclusions. This is partly because public health's story is a close companion to that of the rise of the nation-state itself and certainly the experience of Western industrial and postindustrial modernity. The same is true for the evolution of European capitalism, socialism, imperialism, and democracy. Wherever we look, attempts to control disease and ill health at the population level are there, sometimes facilitating, sometimes hindering, but always complicating the business of governing people.

A second hurdle to understanding public health as a social phenomenon is related to the first; its ubiquity leads to a shopping list of definitions and understandings. Precisely because the term "public health" has been used across time to describe a diverse set of actions, policies, professional groups, and scientific discoveries, we are left having to accept that we are not dealing with a single, stable entity. Like art, public health has a tendency to be whatever one says it is.

In the following chapter we begin to engage more directly with the histories of public schools and public health in America. It is for this reason that, despite the obvious complexity, we have used this chapter to seek a measure of conceptual precision about the meaning and nature of public health. We have tried to do this by surveying a variety of its incarnations while, inevitably, dwelling on specific examples that will need to speak for a much larger whole. The precision we have sought to achieve, however, has not been to try to nail down what public health is. Rather, we have tried to demonstrate the many different kinds of things that have been and continue to be done in the name of public health. We understand public health as a set of arguments, aspirations, and ideas that emerge, mutate, and reappear under different political and social conditions. This means that we cannot simply assume that "doing" public health anywhere, including schools, is a good or a bad thing or likely to have the impact that its advocates assume. In fact, we cannot even assume that public health policies and actions exist, primarily, to improve the health of the public. They may or they may not, but we must at least entertain the possibility that their origins and consequences are much murkier than, or just very different from, what we might first think.

NOTES

1. For a recent contribution see Ann Gibson Winfield, *Eugenics and Education in America* (New York: Peter Lang, 2007).
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3. K. Kumishiro and Bic Ngo, "Six Lenses for Anti-oppressive Education," (New York: Peter Lang, 2007).
4. Bernard J. Turnock, *Public Health: What Is It and How It Works* (Burlington, MA: Jones & Bartlett Learning, 2012), 8.
5. Simon Howard, Jean Adams, and Martin White, "Nutritional Content of Supermarket Ready Meals and Recipes by Television Chefs in the United Kingdom: Cross Sectional Study," *British Medical Journal* 345(e7607), (2012), accessed November 6, 2013, doi: 10.1136/bmj.e7607.
6. Virginia Berridge, Martin Gorsky, and Alex Mold, *Public Health in History* (Maidenhead: Open University Press, 2011), 24.
7. Quoted from Berridge, Gorsky, and Mold, *Public Health in History*, 25.
8. Dorothy Porter, "Changing Definitions of the History of Public Health," *Hygiea Internationalis* 1, no. 1 (2000): 9-21.
9. Berridge, Gorsky, and Mold, *Public Health in History*. Also see Dorothy Porter, ed., *The History of Public Health and the Modern State* (Amsterdam: Rodopi, 1994).
10. Kevin Callison and Robert Kaestner, "Do Higher Tobacco Taxes Reduce Adult Smoking? New Evidence of the Effect of Recent Cigarette Tax Increases on Adult Smoking," *Economic Inquiry* (2013): doi: 10.1111/ecin.12027.
11. For example Michael J. Reznicek, *Blowing Smoke: Rethinking the War on Drugs Without Prohibition and Rehab* (Lanham: Rowman & Littlefield, 2012); Dan Baum, *Smoke and Mirrors: The War on Drugs and the Politics of Failure* (New York: Little, Brown, 1996).
12. For a discussion of the divergent historical threads and political commitments that informed the thinking of these scholars, see chapter 4 of Dorothy Porter, *Health Citizenship: Essays in Social Medicine and Biomedical Politics* (Berkeley: University of California Medical Humanities Press, 2011).
13. For a brief account of Sand's career see Kerstin Eilers, "René Sand (1877-1953) and His Contribution to International Social Work, IASSW-President 1946–1953," *Social Work and Society* 5, no. 1 (2007): 102-109.
14. René Sand, *Vers la Médicine Sociale* (Paris: Bailliere et fils, 1948).
15. René Sand, *Advance to Social Medicine* (New York: Staples Press, 1952).
16. For examples of the reception and influence of Sand's work see a review of *Vers la Médicine* in: C. E. A. Winslow, "Vers la Médicine Social," *American Journal of Public Health and the Nation's Health* 38, no. 9 (1948): 1284-1285; and an Obituary in: Editorial, "René Sand," *American Journal of Public Health* 43, no. 11 (1953): 1476-1477.
17. Quoted from Cab Direct, accessed November 5, 2013. http://www.cabdirect.org/abstracts/19492700477.html;jsessionid=40C51EE8DEC0C9D2A6B0788A65F30CFD.
18. Dorothy Porter, "Transformations in Social Medicine," *The Lancet* 354 (1999): SIV57.
19. Sand, *Advance to Social Medicine*, 14.
20. George Rosen, *The History of Public Health* (New York: M.D. Publications, 1958).
21. Milton Terris, "George Rosen and the American Public Health Tradition," *American Journal of Public Health* 69, no. 2 (1979): 173-176.
22. Terris, "George Rosen and the American Public Health Tradition," 174.
23. Barbara G. Rosenkrantz, "George Rosen, Historian of the Field," *American Journal of Public Health* 69, no. 2 (1979): 165-168.
24. Porter, *Health Citizenship*, 84.
25. For examples see Jennie Popay and Gareth Williams, "Public Health Research and Lay Knowledge," *Social Science & Medicine* 42, no. 5 (1996): 759-768; Heather A. Cahill, "Male Appropriation and Medicalization of Childbirth: An Historical Analysis," *Journal of Advanced Nursing* 33, no. 3 (2001): 334-342; Graham Hart and Kaye

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28. Alisa Klaus, *Every Child a Lion: The Origins of Maternal and Infant Health Policy in the United States and France, 1890-1920* (Ithaca, NY: Cornell University Press, 1993).

29. Samuel Kline Cohn, *Lust for Liberty: The Politics of Social Revolt in Medieval Europe, 1200–1425* (Cambridge, MA: Harvard University Press, 2009).

30. Richard John Palmer, *The Control of Plague in Venice and Northern Italy 1348-1600* (PhD diss., University of Kent, 1978).

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32. Till Bärnighausen, and Rainer Sauerborn, "One Hundred and Eighteen Years of the German Health Insurance System: Are There Any Lessons for Middle and Low-income Countries?" *Social Science & Medicine* 54, no. 10 (2002): 1559.

33. Ulrich Bauriedl, "100 years of German Social Insurance: Looking Back on a Century of Self-managed Social Security," *International Social Security Review* 34, no. 4 (1981): 403-409.

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35. Warwick Anderson, "Immunities of Empire: Race, Disease, and the New Tropical Medicine, 1900-1920," *Bulletin of the History of Medicine* 70, no. 1 (1996): 94-118; Warwick Anderson, *Colonial Pathologies: American Tropical Medicine, Race, and Hygiene in the Philippines* (Durham, NC: Duke University Press, 2006).

36. For examples of this debate see David Roberts, "Tory Paternalism and Social Reform in Early Victorian England," *The American Historical Review* 63, no. 2 (1958): 323-337; Knut Ringen, "Edwin Chadwick, the Market Ideology, and Sanitary Reform: On the Nature of the 19th-Century Public Health Movement," *International Journal of Health Services* 9, no. 1 (1979): 107-120.

37. For a brief biographical account see Theodore M. Brown and Elizabeth Fee, "Rudolf Carl Virchow: Medical Scientist, Social Reformer, Role Model," *American Journal of Public Health* 96, no. 12 (2006): 2104-2105.

38. Rudolph L. K. Virchow, *Collected Essays on Public Health and Epidemiology*, ed. Lelland Joseph Rather (Cambridge: Science History Publications, 1985 [1848]), 33.

39. Martin McKee et al., "Austerity: A Failed Experiment on the People of Europe," *Clinical Medicine, Journal of the Royal College of Physicians* 12, no. 4 (2012): 349.

40. Robin Bunton and Alan Petersen, eds., *Foucault, Health and Medicine* (London: Routledge, 2002).

41. John Duffy, *The Sanitarians: A History of American Public Health* (Urbana: University of Illinois Press, 1992).

42. For an assessment of the centralizing dimensions of Chadwick's career see Anthony Brundage, *England's "Prussian Minister": Edwin Chadwick and the Politics of Government Growth, 1832-1854* (University Park, PA: Pennsylvania State University Press, 1988).

43. In the case of Germany and France post-1848, Ramsey and Weindling point out that the altruistic aspirations of revolutionaries were insufficient to bring about significant health reform. The impetus for far-reaching change in health citizenship would eventually come from those most committed to statecraft and political economy.

44. See the essays in Porter, *The History of Public Health and the Modern State*.

45. There is a huge history of eugenics literature, but interested readers might consult Diane B. Paul, *Controlling Human Heredity: 1865 to the Present* (New York: Humanity Books, 1995); Frank Dikötter, "Race Culture: Recent Perspectives on the History of

Eugenics," *The American Historical Review* 103, no. 2 (1998): 467-478; Alison Bashford and Philippa Levine, eds., *The Oxford Handbook of the History of Eugenics* (Oxford: Oxford University Press, 2010).

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47. Martin S. Pernick, "Eugenics and Public Health in American History," *American Journal of Public Health* 87, no. 11 (1997): 1767-1772.

48. McKeown's most significant work on this topic is probably Thomas McKeown, *The Modern Rise of Population* (London: Edward Arnold Publishers, 1976).

49. For an overview of this debate see James Colgrove, "The McKeown Thesis: A Historical Controversy and its Enduring Influence," *American Journal of Public Health* 92, no. 5 (2002): 725-729.

50. In particular, see Simon Szreter, "The Importance of Social Intervention in Britain's Mortality Decline c. 1850-1914: A Re-interpretation of the Role of Public Health," *Social History of Medicine* 1, no. 1 (1988): 1-38.

51. Amy L. Fairchild and Gerald M. Oppenheimer, "Public Health Nihilism vs Pragmatism: History, Politics, and the Control of Tuberculosis," *American Journal of Public Health* 88, no. 7 (1998): 1105-1117.

THREE

The Birth of the Miracle Factory

In the previous chapter we attempted to build a case for seeing public health from multiple perspectives without necessarily prioritizing any single viewpoint. Our goal was to move beyond complacent celebration toward a more skeptically open-minded orientation that might then be brought to a consideration of its role in schools. We argued that the ideas, things, and actions that constitute public health may exist for a wide variety of reasons and with both predictable and unpredictable consequences. Finally, we argued that it is intellectually unacceptable to automatically assume that things done in the name of public health are done for the reasons that are officially claimed on its behalf or that they will have the benefits that are predicted.

These strike us as relatively uncontentious propositions and ones that most readers would probably accept were we talking about more high profile and routinely controversial areas of social policy such as taxation or international relations. In the general field of education too, it is normal for the policy directions taken by authorities to be hotly contested and debated. Apart from a couple of exceptions though, most obviously education about sexuality and drug use, the public health role of schools seems to enjoy a peculiarly becalmed consensus.

Our approach in the previous chapter was also intentionally peripatetic, drawing anecdotally from public health scholarship to illustrate particular historical tendencies. Now, however, we turn to the specifics of American history and the contrasting fortunes of the fields of public health and public education. Specifically, we want to compare and contrast nineteenth- and early-twentieth-century public health with evolving ideas about the purpose of American public schooling. Inevitably, this means confronting what is usually called the Progressive Era in American education, a period whose beginning and end are matters of

debate but is generally seen as gathering pace in the years immediately following the American Civil War. This is not to deny earlier attempts to use schools for health purposes. However, on many levels the Progressive Era establishes the ground rules for later school-based health initiatives. Just as important though, it offers some instructive examples of apparent successes and failures.

While mindful that the lessons of history are not always obvious and never neatly analogous, we are inclined to draw deliberately and, perhaps, provocatively concrete conclusions about the historical relationship between public health and American public schooling. There seems little point traversing these overlapping histories only to then offer a mealy-mouthed summary. Above all, it is important to stress that our overriding interest in this and the following two historically focused chapters is a critical engagement with the *present*. So, while in purely historical terms we present conventional narratives, what we hope will strike readers as less familiar are the uses to which we think these narratives might be put. In terms of the relationship between schools and public health, we think their histories offer both important pre-echoes of, and instructive contrasts with, the present.

DISEASE, POVERTY, AND THE FAILURE OF PUBLIC HEALTH IN PRE-TWENTIETH-CENTURY AMERICA[1]

Prerevolutionary America will seem to some readers like an unnecessarily distant point from which to begin, not least because compulsory public schooling was still several decades away when war with the British broke out. However, a few relatively obvious although important features of the early republic are fundamental to the shape American public health would subsequently take. To begin with, America's first white settlers both encountered and constructed their new home. They wrote about their small rural communities idealistically, drawing sharp contrasts with the crowded towns and cities they had left behind. As well as the moral and religious freedoms they sought, they interpreted the new world's open spaces as altogether more conducive to good physical health, and there is evidence to suggest that there was some truth to this view.[2]

But as with the other colonial and settler adventures of the age, there was also no escaping the threat of starvation and malnutrition nor the smorgasbord of diseases, both familiar and new, that would roam the country essentially unchecked for well over two hundred years. Among the most feared were smallpox, malaria, yellow fever, scarlet fever, diphtheria, and the full range of respiratory diseases and other conditions associated with inadequate sanitation. And although relative isolation provided communities with a measure of protection, it also meant that immunity was low when contagion struck, as it regularly did. As else-

where, the settlers also brought diseases with them that would devastate the Indigenous population.

While feared, pestilence quickly became a normal and familiar part of settler life, much as it was in Europe. Lacking the knowledge or the tools to fight back, little by way of organized or systematic action was possible, leaving prayer and forbearance as most settlers' only response. Disease or its absence was widely assumed to be an expression of God's judgment on people's moral conduct, and seventeenth- and eighteenth-century civic leaders periodically resorted to days of community-wide religious observance in order to ward off future epidemics. In short, throughout the colonial period, health in the United States emerged as a largely private and local matter. To the extent that people intervened to improve the health of others, this was mostly voluntary and underpinned by religious motivations. In larger communities like New York, the church was one of the very few places where the sick poor could seek refuge and care.

Between 1700 and 1770, the population of the colony grew from approximately 300,000 to just under 2.5 million. This meant more crowded living conditions in population centers and, therefore, more disease. It also increased the amount of trade coming in by sea, and this too simply added to the means by which disease could be imported and spread. In most communities, leaders introduced basic quarantine and sanitation regulations, while authorities in New England and New York attempted to regulate the onboard conditions of ships docking in its harbors. Perhaps more than anything else, though, the management of human and animal waste presented civic leaders with their most acute health challenges. These would go mostly unsolved, literally, for centuries.[3] Where and how domestic animals could be kept, slaughtered, and disposed of proved a similarly enduring challenge.

Overwhelmingly, the responsibility for maintaining public hygiene and sanitation was assumed to be the individual citizen's. However, the pressure of increasing population during the eighteenth century made it impossible to completely ignore the need for collective action. Civic leaders gradually began to dig public wells, build rudimentary drinking water systems, and fund the construction alms-houses for caring for the sick. But public infrastructure on the one hand, and sanitation and quarantine regulations on the other, were only as effective as the resources devoted to maintaining and enforcing them. Historians of the colonial period repeatedly describe how attempts to regulate daily life in the name of combating disease and maintaining health were constantly revised, repealed, relaxed, and always difficult to enforce. Sanitation laws, for example, often sought to stipulate where and how certain forms of commerce, such as those involving the slaughter of animals, could be done, and these provoked ongoing resistance. The fact that it was the poorer members of society who lived closest to the more noxious industries also meant that calls to remedy the situation were more likely to be ignored. Time and

again, measures taken by civic leaders in the lead up to, or the immediate aftermath of, outbreaks of disease were simply forgotten or ignored once the apparent danger had passed. In the case of quarantine measures, these were sometimes only intended to be temporary. Requests to state assemblies for funds to build hospitals or quarantine stations or employ local health officials were rarely successful.

The spread of disease was fanned by the outbreak of revolutionary war, in part by displacing civilians and by bringing relatively large numbers of soldiers, usually with little or no knowledge about the hygienic treatment of food, injuries, or human waste, into close proximity with each other. The war also had the effect of stalling and even reversing the already slow and spasmodic developments in public health law and infrastructure. As a result, and with new state and federal governments only gradually taking shape in the years immediately following the war, eastern and Gulf Coast communities once again found themselves severely ill-equipped to deal with the catastrophic yellow fever outbreaks of the 1790s and early 1800s. In essence, each community was left to fend for itself. In most cases health committees of various kinds were formed to deal with the emergency. And although these would prove to be the forerunners to the city and state health boards that would eventually proliferate in the nineteenth century, they were generally seen as a necessary evil that could be dispensed with once the danger had cleared.

Elizabeth Fee[4] has argued that the United States of the seventeenth and eighteenth centuries developed into three relatively distinct political and economic entities: an increasingly commercial northeast, a more free-wheeling and entrepreneurial West, and what she describes as a semi-feudal South. As a result, generalizations about public health provision in the United States as a whole during this period are not without risk. It is important to remember also that the majority of historical scholarship in this field has focused, not surprisingly, on eastern and Gulf Coast communities; this is, after all, where the largest populations emerged in the first three centuries of white settlement, and if history teaches us anything about public health it is that it has predominantly been an urban enterprise with far less interest in or relevance for people living in smaller, more remote settlements. If anything, public health historians have concluded, not unreasonably, that while public health reform in America's colonial towns and cities lagged behind Western Europe, the situation was even worse in the south and the west of the country. The risks of glib generalizations notwithstanding then, the conclusion that coordinated public health reform was essentially nonexistent in large parts of the country until the revolutionary war seems justified. In fact, until the early decades of the nineteenth century, very few health-focused public institutions existed anywhere. By the end of the eighteenth century both federal and state authorities played almost no direct role in the day-to-day health of Americans. In short, while expanding and interventionist central

governments in Europe were making significant strides in public health—most obviously Britain—a very different American policy trajectory was taking shape.

The reasons for this difference have occupied historians for some time, and we will not assume to join this debate here. However, scholars tend to begin by pointing to a peculiarly American brand of rugged individualism born out of the country's founding suspicion of centralized power structures. As formulaic as this explanation sometimes feels, there is undoubtedly a great deal of evidence that a strident discourse of personal responsibility shaped attitudes toward health, at least among those with the power to speak and be heard on these matters. At the outbreak of the revolutionary war, for example, although America consisted of colonies with very different social and economic conditions, the wealthy gentlemen who were instrumental in the revolution had little interest in radical economic or social reform and subscribed to an ideal of rule by a virtuous and disinterested elite. In fact, the revolution had little or no effect on the class differences that had preceded it. Following the war the nation's founders took for the federal government a limited set of powers but, to the extent that they thought about it at all, public health was a matter for individual states. In addition, the sheer geographical size of the United States, and the large distances between population centers, probably made it much harder for a strong and credible central state to emerge and play an active role in day-to-day life.

The state of scientific knowledge about the causes of disease seems also to have played a significant role in shaping American public health throughout the colonial period and beyond. While lagging behind the centers of European medical learning and investigation, by the end of the eighteenth century a small number of American experts had begun to challenge classical humoral ideas about sickness.[5] Although something of a shorthand, at this time disease theory was increasingly seen in one of two ways: either contagiously spread from person to person or miasmatically, the result of decaying and putrefying matter fouling the air that people breathed. The important point, though, is that in the absence of compelling scientific consensus decisive public policy was unlikely to emerge and probably even more difficult to impose on a skeptical population. It is instructive to note, for example, that it was very rare for medical practitioners to be included in the temporary municipal committees formed to respond to health emergencies in the eighteenth and early-nineteenth centuries. The explanation for this appears to be that the physicians were seen as too divided to offer decisive or reliable advice. It is certainly true that advocates for both contagionist and miasmatic theories could be found and that debate between them was often acrimonious. In short, while it was an era which saw the formation of the first medical societies[6] and the nascent stirrings of a more assertive medical voice in public affairs, the late-eighteenth and early-nineteenth century was a

time when the rise of scientific medicine to a position of cultural authority was still decades away.

The various municipal health committees[7] that sprang up in the early nineteenth century tended to be populated by civic leaders and laymen with considerable business interests and a disinclination to jeopardize profits on the basis of, at best, contested medical knowledge. As elsewhere, American business and civic leaders tended to choose and deploy theories of disease that suited their own interests. For example, traders who relied on the free flow of people and goods through American ports were inclined to reject contagionism in favor of the miasmatic view and oppose what they saw as onerous quarantine regulations. Likewise, the leaders of businesses that made things had a vested interest in seeing disease as originating outside the community rather than in the wastes their operations created locally. Civic leaders, too, were reluctant to accept miasmatic theories which, if accepted, implied far greater responsibility, and therefore expense, for sanitary infrastructure. In other words, no matter who you were, there were always apparently scientific reasons that one could fall back on in order to resist public health regulation and expenditure. According to Duffy, it would take until middle decades of the nineteenth century for the miasmatic thesis to be widely accepted and thus pave the way for increased sanitary activity.[8]

The flurry of public health activity that began the nineteenth century had been in response to a medical crisis. Thereafter, the gradually receding yellow fever threat lulled civic leaders into a new and extended period of complacency. Health boards were disbanded and defunded, and sanitation and quarantine laws were repealed or just ignored. In the absence of an immediate crisis, public health measures seemed less necessary even though diseases like malaria, typhoid, diphtheria, and tuberculosis remained essentially incurable and continued to kill thousands of Americans every year. It is true that the yellow fever emergency had the effect of both extending the reach and consolidating the centrality of municipal authority in the organization of daily life. However, on balance, it seems safe to say that civic leaders during this time were far more interested in fostering the commercial life of their communities than expending significant amounts of money on preventing diseases whose origins remained, at best, controversial. As a result, with the exception of Boston, all of the health boards and committees created from the 1790s through to 1830 were temporary and none had statewide authority, a situation that would prevail until the Civil War. In New Orleans, for example, a board of health was created in 1804 to deal with yellow fever and smallpox outbreaks. It was disbanded shortly after, and repeated attempts to revive it over the following few years failed. A new board was eventually formed in 1821 but the city's business interests, supported by anti-contagionist doctors, objected so strongly to its proposed quarantine measures that it was abolished in 1825. It would be another sixteen

years before a new city health board was formed, but it too lasted only a few months.

At the end of the eighteenth century America was a mostly rural society with only thirty-three towns with more than 2,500 people. However, social historians of the nineteenth century paint a picture of rapid growth in the size of America's towns and cities and an increasing economic and geographic distance between rich and poor.[9] The size of communities and the social disparities that emerged meant that the role of neighborly voluntarism, while not extinguished, would inevitably play a diminishing role in American life. With the rich living further away from the poor, and new forms of biblically literal evangelicalism stressing the salvation of individual souls, the stage was set for a more morally judgmental social climate. As Duffy argues, rather than unfortunate individuals deserving charity, the poor were now more easily thought of as an abstracted faceless mass who could be blamed and demonized for the deprivations, injuries, and illnesses they suffered.[10] Conversely, in a sharp break with America's religiously austere origins, economic prosperity, both collective and individual, came to be celebrated as signifying moral superiority.

This is not to deny that some significant public health gains were made in the first half of the nineteenth century. Civic leaders had learned from past epidemic experiences, and sanitation and quarantine measures, when implemented, became more numerous, organized, and sophisticated. For example, considerable progress was made in the provision of water systems although they tended to be built in the absence of sewers or adequate drainage. As a result, water systems tended to become *de facto* sewers, thus setting the scene for the next wave of disease, that of Asiatic cholera, during the 1830s. Although progress was painfully slow and the quality of the work variable, municipal authorities also gradually assumed greater responsibility for street cleaning, in some cases employing their own sweepers and scavengers, contracting the work to the private sector in others.

On balance, though, because it could be funded by the fees charged on visiting ships, quarantine regulations received far more consistent attention from civic leaders than sanitary reform, which was seen by many as an expensive extravagance and unwelcome intrusion in commercial affairs. In any case, even if the apparent disappearance of yellow fever had not reduced the impetus for public health action of all kinds, the profound health consequences of rapidly swelling urban populations during the early nineteenth century would probably have swamped whatever the achievements of the past may have been. Meanwhile, the health prospects of rural Americans were only slightly better. Westward expansion saw the inexorable spread of smallpox, diphtheria, measles, and scarlet fever. Malaria, in particular, became endemic in large parts of the country especially as more land was cleared. And as new towns and cities grew in

size and population, the diseases of overcrowding and poor sanitation soon followed.

Despite news of its pandemic progress across Europe beginning in the late 1820s, American politicians and civic leaders were disinclined to take seriously the warnings of the medical profession about Asiatic cholera. Charles Rosenberg, for example, describes how the New York Medical Society's suggestions for preemptive quarantine and sanitation measures were ridiculed by business leaders for unnecessarily alarming the population and criticized for their apparent disregard for the economic life of the city.[11] In fact, it even appears that New York physicians who reported the presence of infectious disease were likely to be publicly abused and even threatened with physical injury. When action was finally taken, it tended to focus on the behavior of poor New Yorkers, warning them about the dangers of intemperate eating and drinking, failing to wash, and working in the heat of the day. Whether well intentioned or not, this was neither scientific nor particularly useful advice for people living in cramped, overcrowded, and unsanitary conditions, with limited access to clean water and little freedom to refuse whatever work was available. As with previous epidemics, when cholera did reach North America virtually nothing was known about its causes or cures. As well as misery and death, it spread panic and provoked a torrent of claim and counterclaim about the moral and medical meanings of the epidemic and, by extension, the lessons that should be learned. For many Americans, the Asiatic cholera epidemic simply reinforced their belief that poor Americans, whose living conditions ensured they suffered disproportionately, brought the disease upon themselves. Worse still, their imprudence and immorality were seen as endangering the rest of the population.

Nonetheless, by the first decades of the 1800s the squalid living conditions of America's urban poor would have been obvious enough to anyone who cared to look. Aware of the advances made by the sanitary movement in Europe, the nascent American medical profession led the call for sanitary reform. In this increasingly unsympathetic cultural climate, however, attempts to raise taxation to improve the living conditions of poor Americans or to expand the public health reach of federal or state governments were generally aggressively opposed. In 1813 President James Madison created the position of federal vaccine officer. However, the position was abolished in 1822 because of concerns it overstepped the role of government. In a pre-echo of health care policy debates in the United States in the twentieth and twenty-first centuries, public health reform was consistently opposed on the grounds that it infringed on the rights of the individual.

The social infrastructure of American cities and towns came under even greater population pressure with the inflows of European immigrants, particularly Irish, during the 1840s and 1850s. Once again, a complex history must be treated expeditiously here, but we can reasonably

say that as the size, location, and makeup of the population began to alter more rapidly, new questions about what it meant to be American and the ways in which citizens should be produced and managed began to emerge. As we have already mentioned, one consequence of these social and cultural changes was to harden attitudes toward the poor. Gambling, prostitution, public drunkenness, juvenile delinquency, and petty crime all came increasingly to be seen as threats to idealized visions of American life and a sign that particular sections of the population needed to be "cured" or controlled. Moreover, while many Americans were inclined to believe in the inherent healthiness of life in the United States compared with Europe, the country now faced the uncomfortable truth of its own urban slums. Perversely, while many civic leaders were inclined to exaggerate the cleanliness and healthy life afforded by their city in an effort to attract business investment, for poor urban Americans the chances of leading a long and relatively disease-free life were low and declining.

While few doubted that poverty was, at least in part, the result of personal moral failings, by the middle of the nineteenth century the first signs of an organized and coherent sanitary movement were evident. Taking its lead from Europe, the medical profession increasingly voiced its concerns about the ghastly living and working conditions that were a feature of the quickly industrializing and urbanizing American landscape. Spurred on by the reappearance of yellow fever in the East and the South, and bolstered by the increasing tendency for state and city authorities to keep more detailed population statistics, a string of reports, similar to those that had appeared in Europe, described the plight of the urban poor and the human cost of extreme poverty. John H. Griscom's *The Sanitary condition of the laboring population of New York* (1845), Lemuel Shattuck's *Report of the sanitary commission of Massachusetts* (1850), and Edwin Miller Snow's *Statistics and causes of Asiatic cholera as it prevailed in Providence in the summer of 1854* (1855) are examples of the gathering momentum of the sanitary movement during this period, which would later be expressed in a series of conventions in the late 1850s.

The emerging consensus of the sanitarian movement was strongly anti-contagionist and, therefore, anti-quarantine. Instead, its leaders made wide-ranging regulatory and infrastructural recommendations, most of which, if implemented, would have been costly and unpopular. Under the lingering influence of Jacksonian small-government thinking, there was simply very little appetite for increasing taxes and wresting significant administrative oversight of city life away from local authorities. The movement was also noticeably northeastern in its makeup, hardly surprising given the intense opposition to central government that had fermented in the South and which would soon be an important ingredient in the slide to civil war. It is worth remembering also that local politics was notoriously corrupt at this time and that, as much as any-

thing else, the aspirations of the sanitarians faced opposition from entrenched vested interests, regardless of geography. Not surprisingly, with civil war brewing, very little by way of concrete reform actually happened, and the public health challenges facing America were allowed to worsen.

EVERYTHING TO EVERYBODY

We turn now to the early years of American public schooling, a particularly complex and intensely contested area of academic study. On one level, our interest here is to chart some of the shifting and sometimes contradictory political, economic, ideological, and social goals with which schools have been linked. Our ultimate goal, though, is to draw comparisons with the previous historical narrative about American public health and the roles schools were expected to play during overlapping periods of history. While there has never been a national consensus on *the* purposes or aims of public education—and there is often a gulf between rhetoric and reality—we think there is value in examining the hopes that various stakeholders have had for American schools, particularly given opposition to reform in the area of public health. In what follows we describe important historical moments when schools have been called on to accomplish certain ends and solve particular social problems. What strikes us most of all is the scope of ambition that has always attached itself to schools and the relative success of its most prominent educational reformers in creating a new and costly arm of government: American public education.

THE COLONIAL ERA AND EARLY NATIONAL PERIOD

The New England colonies were arguably the most successful in advocating for and developing formalized systems of education. Guided largely by a strong Puritan ideology, colonists advocated for church-run schools focused on teaching obedience and adherence to biblical principles. Early schools stressed the values of punctuality, honesty, submission to authority, and hard work.[12] The 1647 "Old Deluder Satan Act" perhaps best exemplifies these moralistic impulses. The "Old Deluder" law required towns comprised of fifty or more families to make formal provisions for instruction in reading and writing. Towns of more than a hundred households were also required to establish grammar schools to prepare boys for college entry. Selectmen were authorized to issue fines to communities that were not in compliance with the law. "Old Deluder's" goal was to "outwit Satan," who, the Puritans believed, deceived ignorant and illiterate people into sinning.[13] The law applied to both girls and boys since the souls of both genders were assumed to be at stake.[14]

The Act reveals some of the early religious aims of education: a growing faith in the potential of education as a key weapon in the fight against ignorance and immorality. In Puritan society education was not for the advancement of a child's personal interests, but rather functioned to protect and enhance the state. Puritans believed that an "educated populace was as much a moral issue as a civic necessity"[15] and a necessity "too important to leave in the hands of delinquent parents."[16] Despite the penalties of the law, "most towns responded with a variety of strategies, ranging from outright noncompliance to meeting the letter of the law but compromising on its spirit."[17] Ten years following its passage, all eight Massachusetts towns comprised of "100 or more families established grammar schools but only a third of the towns with fifty or so families complied with the reading-and-writing school requirement."[18] Even though compliance and enforcement were uneven, by 1700 literacy rates in New England were superior to those in England.[19]

The success of the American Revolution ended British rule over the thirteen colonies in 1781 and established the United States as a sovereign nation. Early leaders with aspirations for the country believed education needed to play a central role in configuring the new government. And although the United States Constitution remains silent on the provision of education, prominent figures such as Benjamin Rush, Noah Webster, and Thomas Jefferson all spoke in support of creating state systems of universal education. They wanted schools to emphasize "republican values" and "virtue," qualities defined as "the willingness to set aside purely selfish motives and work for the good of the larger society."[20]

Formal systems of education, then, were largely advocated for on the grounds that they would be critical to the advancement and progress of the country. They promised to create a more enlightened citizenry, help train and identify future leaders, instill nationalism and patriotism, and serve as a balance between liberty and order. Kaestle claims that the balance of liberty and order was a critical aspect of the project: "Political theorists and policy makers were therefore concerned with not only protecting liberty, for which the Revolution had been fought, but also with maintaining order, without which all might be lost."[21] According to Jefferson, "if a nation expects to be ignorant and free, in a state of civilization, it expects what never was and never will be."[22] Mass schooling, then, would serve as a kind of political safeguard. Jefferson's ideas on the role of education in a free society were echoed by a number of early leaders. Benjamin Rush claimed that schools would operate as a central unifying force, a means of protecting and ensuring the republic's continued success: "We have changed our form of government" he wrote, "but it remains to effect a revolution of our principles, opinions, and manners, so as to accommodate them to the forms of government we have adopted."[23]

While there was relatively broad consensus on the potential benefits of schooling, advocates often disagreed on what to emphasize. Rush, for example, stressed virtue and republican values.[24] In particular, he believed that the best way to ensure universal education was to allow each religious sect to educate their own children in the manner they saw fit. As such, he advocated for the development of comprehensive systems of state schools and colleges run by both private and public interests.[25] Private interest groups, namely churches, should be given the opportunity to raise money and, in combination with state funding, be permitted to oversee the development, organization, and administration of schools. Rush also advocated for a focus on the Bible and emphasis on reason and scientific progress for the purpose of "understanding the perfection of God's design."[26] Sectarian education would not only develop a student's moral faculties but secure their commitment to republican values. Rush's ideas contributed to changing ideas about the role of children, families, schools, and government and, specifically, for the priority of state (read school) interests over the family.[27] "Let our pupils be taught that he does not belong to himself," Rush wrote, "but that he is public property. Let him be taught to love his family, but let him be taught at the same time that he must forsake and even forget them when the welfare of his country requires it."[28]

In contrast, Jefferson held somewhat different ideas on the role of private interests in schools. Jefferson thought that government support of church-related schools threatened religious liberties and limited free inquiry. His ideas were rooted in his belief that students already possessed moral and rational senses, and that the role of the school was to cultivate these characteristics, not establish them.[29] Jefferson trusted "the guiding power of natural reason to lead the citizen to correct political decisions."[30] Sent to school for literacy and armed with newspapers, citizens would learn how to become self-governing through the development of their political or religious preferences in the "marketplace of ideas."[31]

Jefferson's educational philosophies are reflected in his Bill for the More General Diffusion of Knowledge, introduced in the Virginia State Legislature in 1779. The bill provided three years of free, state-supported education to all non-slave children. These free elementary schools would focus on reading, writing, and mathematics. Those (boys) who excelled at the elementary level would be selected to attend secondary schools (grammar schools) where they would study Latin, Greek, English, geography, and mathematics. This competitive selection process would ensure that the best and brightest were "raked from the rubbish . . . and instructed, at public expense."[32] Even though the bill was eventually defeated, Jefferson's ideas offered new ways of thinking about the role and purpose of public schooling, embodying both democratic and meritocratic principles.[33] His belief that schooling was the best means for iden-

tifying democratic leadership has become ingrained in American social thought.[34]

Noah Webster approached the goal of creating an educated citizenry from a slightly different perspective. Webster, known as the "Schoolmaster of the Republic," was an educator and lexicographer and one of the nation's leading cultural nationalists.[35] He was described as a "staunch patriot whose proposals sometimes bordered on the fanatic (e.g., the proposal that the first word a child learned should be Washington)," and has been credited for his role in shaping a distinctive American idiom, pronunciation, and style.[36] Webster stressed the need for cultural independence from England and the school's role in developing a monolithic American cultural identity by emphasizing patriotism, Protestant morals, and an American lexicon. Webster wrote a number of textbooks emphasizing American identity and achievements, including his famous *American Dictionary of English Language.* Webster also advocated for schools to train "quiet Christians, citizens educated to be humble, devout, and submissive to legitimate authority," a belief that grew out of his concern that the new republic may provide citizens too much freedom and, as a result, fall victim to anarchy.[37]

THE COMMON SCHOOL ERA

The period between 1830 and 1865 has been described as the age of the common school movement. In many ways the period witnessed a crusade to secure public support and state financing for public schools. It was also during this era that the legislative and bureaucratic arrangements that had applied to seventeenth- and eighteenth-century schools were replaced with something more akin to the contemporary U.S. school system.[38]

The movement was a product of a number of complex and profound shifts in the society's economic and political environment and the social anxieties these changes generated. Historians have attributed four key phenomena to the development of common schools: industrialization and urbanization, pressures for the state to take responsibility for the provision of schooling, the growing preference for "institutionalization" as a solution for social problems, and the redefinition of family.[39] Common school reformers believed that while "cities and factories were necessary and good" they also brought social and familial disintegration and "produced the most frightening kinds of social and moral decay."[40] Schools, it was believed, would help re-create the social unity of preindustrial society; foster community civilization, halt the collapse of the family and parental apathy, train skilled workers, and curb moral vices. In other words, reformers looked to schools to "help build industrial cities permeated by the values and features of idealized rural life."[41]

Lack of progress in public health notwithstanding, the early nineteenth century was a period in which support for state involvement in social welfare was gaining momentum, although still far from universally accepted. As with the field of health, up to this point philanthropic and charitable organizations had played a dominant welfare role. In many ways, philanthropic activity grew out of the absence of any state-sponsored mechanisms to respond to the increasingly dismal circumstances in many urban areas. They also "reflected the belief that social distress represented a temporary, if recurring, problem which charitable activity could alleviate."[42] As a result, the task of school reformers was partly to convince a somewhat hesitant citizenry that social problems were more "widespread and intractable than they had believed," and their solution required the development of a formalized, state-run school system.[43] And although state educational reformers had been successful in establishing the legal foundations for state school systems, they had, until this point, remained relatively unsuccessful in building administrative structures.[44]

The common school movement represented the emergence of at least three principles that have since become entrenched in public school philosophy.[45] First, the movement called for the education of all children in a common place—the schoolhouse. It should include children of all social classes and teach a common curriculum. Second, it embraced the idea of using schools as instruments of government policy.[46] Reformers argued that common schools were the solution to a range of social anxieties: they would preserve the republic; prevent class differentiation; reduce crime, poverty, and distress; and increase economic production.[47] Third, the movement was guided by the notion that the development of a state-sponsored bureaucratic apparatus was the best approach to governance of local schools. Reformers asked citizens and legislators to think of mass schooling as a kind of capital investment that needed centralized bureaucratic support.[48] This kind of state-sponsored infrastructure, they claimed, would revitalize local, community schools and reorganize them into an effective system of public schooling.[49]

Horace Mann, the "Father of the Common School," is the era's most celebrated public school advocate and social reformer. His life and work perhaps best represent the essence and impulses behind the common school movement.[50] A successful lawyer and skillful orator, Mann was attracted to politics early in his career. In 1827 he was elected to the Massachusetts General Court in the state's house of representatives where he served a four-year term.[51] Drawing on his Whig ideology of responsible republicanism and his belief that all citizens stood to benefit from state-sponsored intervention, Mann argued for improved systems of transportation, communication, and social services. He advocated for a variety of other tax-supported internal improvements including the development of railroads, turnpikes, canals, and roads.[52] He was also in-

volved in a myriad of social reforms including the temperance movement, penal reform, the abolition of slavery, improvements in care for the mentally ill, women's rights, and schools for the blind.[53] However, somewhat frustrated with politics, in 1837 he decided his skills would be better used in the newly created position of secretary of the Massachusetts Board of Education.[54]

During his twelve-year tenure as secretary, Mann gave lectures, visited schools, and served as editor of the *Common School Journal*. He used all of these activities to build a support base, both in Massachusetts and abroad, for common school reform. Impressed by the accomplishments of Prussia's education methodology and centralized school system, he also made several trips to Europe. Here he studied the work of Johann Heinrich Pestalozzi, a leading theorist who advocated for a more child-centered approach to schooling.[55] These European experiences influenced his educational philosophy, as well as the changes he sought to emulate in Massachusetts. Crucially, Mann built his case for reform by producing meticulous summaries of the teaching practices and school conditions he had witnessed. Each year he submitted these findings and recommendations in the form of *Annual Reports* to the legislature for their consideration.

His arguments for common schools ranged from the ideological to the highly practical.[56] Philosophically, Mann believed that education was the right of every citizen and that it was the state's responsibility to provide it. He thought common schools should contribute to the development of a shared "public philosophy" that would strengthen the entire community.[57] They would also promote social harmony by training an intelligent and moral citizenry and provide children the kind of intellectual and moral instruction that would free society from crime, immoral behavior, class divisions, and political revolution.[58] Finally, and as the advocates of government-sponsored schooling had done in the past, Mann believed common schools were a national unifying agent and stabilizing force.

Mann tended to favor justifications for public schools rooted in what he saw as collective moral principles and national economic virtues. Still, his crusade often required him to appeal to the self-interest of his audience.[59] Wealthy businessmen and industrialists, many of whom already sent their children to private schools, were told by Mann that supporting common schools was a rational economic decision. Schools would inculcate future workers with the modern habits of punctuality, orderliness, docility, and the postponement of gratification.[60] To these elite groups, Mann revealed the conservative nature of his argument by highlighting schooling's potential to *secure* and *protect* middle- and upper-class positions, not to disturb them. Summarizing Mann's thinking, Urban and Wagoner write:

> Schooled workers were not an ignorant rabble, but rather men and women infused with respect for property, for the work ethic and for the wisdom of property owners. This respect and docility were equated with morality, implying that those workers who acted in opposition to owners of capital and property were immoral. Strikes and other crimes could be avoided if common schools flourished.[61]

Mann's appeal to the working class, however, took on a somewhat different tone. To them, he stressed education's ability to transcend class boundaries. Common schools would teach an enriched curriculum consisting of reading, writing, spelling, arithmetic, history, geography, health, music, and art. This kind of curriculum, he said, would better all children—even those with the humblest of origins—with "the skills and subjects needed by practical businessmen, skilled workers and competent citizens."[62] Common schools, he said, would be the great equalizer and provide the children of the working class new opportunities for upward mobility. "Beyond all other devices of human origin," Mann maintained, education "is the great equalizer of the conditions of men—the balance wheel of the social machinery. . . . For the creation of wealth, then,—for the existence of a wealthy people and a wealthy nation—intelligence is the grand condition."[63]

In addition to these plainly ideological arguments for schooling, Mann's annual reports also contained a number of practical recommendations. Concerned with the health implications of the many dilapidated and unsanitary school buildings he visited, Mann advocated for:

> Ceiling vents for better ventilation, more windows for better lighting, and more efficient wood-burning stoves for better heating. He urged the instillation of desks with backs to replace the crude backless benches. He wanted schools plans to include space for playgrounds.[64]

Plagued by ill health himself, Mann ardently advocated for schools to teach children the benefits of maintaining good physical health and hygiene. In many respects he can be credited for stimulating the development of the first formalized health education programs, not only in Massachusetts but in schools across the country.[65] Health instruction, he believed, was a natural responsibility of the school: "I see no way in which this knowledge can ever be universally or even very extensively diffused over the land, except through the medium of the Common School."[66]

Claiming that a great number of young people were ignorant of the most basic laws of physicality, Mann articulated a vision of public schools as the arbiters of the fundamentals of physiology, health, and hygiene. It was largely through Mann's efforts that the state of Massachusetts became the first state to require a compulsory course in physiology and hygiene in 1850.[67] That same year, a course to better prepare future teachers to instruct on matters of health was added to their normal school requirements. For, according to Mann, "no person is qualified to have the

care of children, for even a single day, who is ignorant of the leading principles of physiology."[68]

In addition to teaching children the fundamentals of health and hygiene, Mann also believed that it was essential for schools to implement health-promoting practices. Physical education, in particular, became a key focus for Mann, for he believed that "until the subject of physical education is understood, any general reformation is hopeless."[69] He advocated for teachers to allow students regular and frequent opportunities to be physically active during the school day. Children in most schools, Mann claimed, were often "victims of an overactive brain," a solution to which he advocated outdoor recess breaks. Dedicating an entire section to issues of health and physical education in his *Sixth Annual Report*, Mann argued that

> in nine-tenths of the schools in the State, composed of children below seven or eight years of age, the practice still prevails of allowing but one recess in the customary session of three hours; although every physiologist and physician knows, that, for every forty-five or fifty minutes' confinement in the schoolroom, all children under those ages should have at least the remaining fifteen or ten minutes of the hour for exercises in the open air.[70]

Mann was also interested in issues of nutrition. "How little is the diet, especially of young children, regulated in accordance of the principles of physiology!" he wrote.[71] Children, he claimed, often came to school without the adequate nourishment to help them successfully attend to their academic responsibilities. But it was not only nutritional deficiencies for which Mann was concerned. Schools were also to address the vice of excess, particularly with regard to consumption. Without learning how to self-regulate their eating, children develop "selfish" tendencies and "physical disturbances . . . and morbid appetites are generated, which, before the close of life grow into tyrannical desires, involving character and happiness, or subject the sufferer to agonizing struggles and mortifications before they can be subdued."[72]

Mann's reports also called for radical changes in curriculum and instruction. He criticized the lack of attention to teacher training and effective pedagogy. He believed teachers relied too heavily on corporal punishment as a form of motivation and used anachronistic instructional techniques like recitation and memorization.[73] He recommended the establishment of state-run normal schools where teachers could acquire expert knowledge of the skills and subjects they teach. According to Urban and Wagoner, Mann's involvement in normal school development and pedagogical reforms was highly controversial, particularly among the Boston schoolmasters.[74] In 1844, a group of thirty-one schoolmasters publicly challenged Mann, contending that his more child-centered pedagogical approach would lead to widespread anarchy.[75] Conservative Cal-

vinists also opposed his nondenominational vision of public schools because they felt that Mann's harsh criticism of current teaching methods, "especially recitation and corporal punishment was directed at them."[76] In addition to these groups Jacksonian Democrats argued against the centralizing reforms called for in Mann's reforms, particularly the creation of state school boards and the establishment of normal schools for teacher training. Orestes Brownson, a leading Democrat, argued that the new systems Mann proposed would lead to the political indoctrination of students and future teachers. At the heart of the Democrats' opposition was their commitment to "democratic localism," or the belief that authority for governance of schools should be vested at the local level.[77]

Despite these objections, Mann emerged as the "apparent but not uncontested victor."[78] He secured state funding for public schools in Massachusetts, and by 1852 the state had passed the nation's first compulsory elementary school attendance law. By 1900, thirty-two states had passed similar legislation. He also succeeded in the establishment of three normal schools, the first of such teacher training institutes in America. And even though the authority of the new school boards was often limited to a perfunctory supervisory role, by the early 1860s, twenty-eight of the thirty-four states had established state boards of education and appointed chief state school officers to oversee them.[79] As the primary architect of the general outlines of public school philosophy, funding, and organization, Mann's common school movement has been credited with influencing the development of the nation's bureaucratic, formalized, state-supported system of schooling that was "purposefully articulated, age graded, hierarchically structured, generally free and often compulsory, administered by full-time experts and . . . taught by specially trained staff."[80]

A TALE OF TWO SOCIAL MOVEMENTS

Prior to the Civil War, the trajectory of nineteenth-century public policy in the United States had developed a number of different threads and tensions. One of the most obvious of these tensions relates to the role of government in caring for its citizens. Broadly speaking, by the middle decades of the century American political discourse was strongly flavored by Jacksonian notions of a robust and resourceful American citizenry, operating within a free market economic system with only limited need for an intervening state. Jackson himself, president from 1829 till 1837, had presided over a number of reforms that reduced federal power including the dismantling of the National Bank established by James Madison twenty years earlier.

At the same time, as with much of Europe, the seismic demographic, industrial, and economic changes of the age were forcing officials and

intellectuals to confront the growing pains of modernity. Previous ways of living and organizing social life were increasingly out of step with a nation gearing itself toward industrial efficiency and, at least for some, the maximization of economic reward. Compared with the past, social problems were now of a different kind, scale, and complexity. The inevitable diversity and frailty of human minds and bodies presented particularly intractable challenges; what was to be done with those who could not or would not be bent to the demands of new ways of living? Framed more positively, how might the country go about producing and nurturing the kind of citizens it needed?

Despite these broad trends, there were important qualitative and quantitative differences in the way the antebellum American polity approached the various problems it perceived. For example, Duffy claims that, to a large extent, the abolition movement tended to consume the energy of reformers and that this limited progress on other fronts, although he does concede that social movements such as Christian temperance and women's rights (and we would add those concerned with the treatment of children, criminals, and the mentally ill) were also gaining momentum.[81] Whatever the merits of this argument, very little systematic public health reform occurred through the middle of the nineteenth century. Federal and state governments consistently refused to act, leaving municipal authorities in the major cities to fight a mostly losing battle. So, while the abject material poverty, disease, and hardship endured by many Americans went largely unaddressed and probably deteriorated, other domains of social policy reform appear to have gained more traction.

As many scholars have noted, the creation of a compulsory mass education system can, as much as anything else, be seen as a response to the opportunities and social dislocations produced by industrial modernity. Some of the arguments recruited to argue for mass public schooling referenced the alleviation of poverty, quelling potential social unrest, and educating poor Americans to accept their position in the social hierarchy. It was never completely clear how schools would achieve these aims and yet, despite widespread and in some cases virulent opposition, advocates like Horace Mann were able to build coalitions around his nation-building dreams for mass education. In particular, Mann was able to present schooling as both an answer to many of the country's social and economic anxieties and good for industry.

Meanwhile, attempts to formalize, regulate, and improve quarantine and sanitary infrastructure foundered because they were seen as expensive, intrusive, and a constraint on legitimate commerce. It is also worth keeping in mind that public health reform was often resisted because medical explanations of disease causation were seen as unreliable. But we could hardly say that the educational reformers of the late-eighteenth and early-nineteenth centuries were in possession of revolutionary new

knowledge. What they did have was a new set of dreams, theories and, above all, promises. Right from the beginning of mass schooling in the United States, then, we see the birth of the idea of the school as a kind of miracle factory; a place where the capacities and dispositions of entire generations of children could be remade and where, in a few short years, they could be immunized against the depravations, illnesses, and injuries of life.

In attempting to draw broad conclusions, there is always the risk of oversimplification and caricature. Resistance to centralized social policy, for example, drew from a range of concerns including suspicion of north-eastern hegemony. In other words, it was not simply a mean-spirited conspiracy of business interests that prevented anything remotely resembling a federal health bureaucracy taking shape in nineteenth-century America. Likewise, in the fields of both public health and education there were passionate advocates for and opponents of stronger federal and state government intervention. Above all, in attempting to draw out specific historical differences we are not suggesting that the histories of public health and education represent polar opposite tendencies or endpoints.

Instead, our argument is that we should see them as linked to a broader public policy context and intellectual environment. The overriding point, though, is that enough people in sufficiently influential positions were prepared to be convinced that a system of state-run schools was a good idea. The idea of the school meant that people could imagine a huge and complex range of social problems being addressed via the creation of a single institution. Importantly, the idea of educating these problems away sat comfortably with the assumption that individuals were responsible for their own welfare. Although a state imposition, mass schooling was still a form of policy making which assumed that social problems would be solved an individual at a time rather than through sweeping structural change.

It is also striking that while the primacy of local particularity in social policy was often used to resist social reform on many fronts, the idea of inculcating a unified, coherent, and, apparently, monolithic American culture could be entertained when it came to the country's schools. In fact, the beauty of the idea of a common school system was that it could be made to mean almost anything to almost anybody. The sheer elasticity of this idea is not the reason why so little progress in public health was made during the nineteenth century, but it does remind us that this lack of progress did not stem from a lack of awareness that health challenges existed. Instead, what the two histories described in this chapter suggest, we think, is that the idea of mass schooling was both the product of, and a vehicle for, simplistic, depoliticized, and individualistic ways of thinking about social disparity and the multiplying forms of deprivation and hardship that it spawned.

NOTES

1. Except where stated, the following historical analyses have been used in this section: John Duffy, *A History of Public Health in New York City, 1625-1866* (New York: Russell Sage Foundation, 1968); John Duffy, *The Sanitarians: A History of American Public Health* (Urbana: University of Illinois Press, 1992); Elizabeth Fee, "Public Health and the State: the United States," in *The History of Public Health and the Modern State*, ed. Dorothy Porter (Amsterdam: Rodopi, 1994), 224-275; Dorothy Porter, *Health, Civilization and the State: A History of Public Health from Ancient to Modern Times* (London: Routledge, 1999); Virginia Berridge, Martin Gorsky, and Alex Mold, *Public Health in History* (Maidenhead: Open University Press, 2011).
2. Mary J. Dobson, "Mortality Gradients and Disease Exchanges: Comparisons from Old England and Colonial America," *Social History of Medicine* 2, no. 3 (1989): 259-297.
3. In particular see Duffy, *The Sanitarians*, 12-13.
4. Fee, "Public Health and the State," 224.
5. The Harvard University medical school was created in 1782 and immediately its leading figures, including John Warren, a founder of the *New England Journal of Medicine*, assumed a leading role in medical debate and discussion in the United States. For more detail see Henry K. Beecher and Mark B. Altschule, *Medicine at Harvard: The First 300 Years* (Hanover, NH: University Press of New England, 1977).
6. Most prominent among these, the Massachusetts Medical Society was formed in 1781 and the New York County Medical Society in 1806.
7. Not to be confused with the professional medical societies mentioned above.
8. Duffy, *The Sanitarians*, 67-68.
9. For detailed historical accounts see Herbert G. Gutman, *Work, Culture, and Society in Industrializing America: Essays in American Working-Class and Social History* (New York: Vintage Books, 1977); Michael B. Katz, *In the Shadow of the Poorhouse: A Social History of Welfare in America* (New York: Basic Books, 1996), 19-20.
10. Duffy, *The Sanitarians*, 53.
11. Charles E. Rosenberg, *The Cholera Years: The United States in 1832, 1849, and 1866* (Chicago: University of Chicago Press, 1988).
12. Edward B. McClellan, *Moral Education in America: Schools and the Shaping of Character from Colonial Times to the Present* (Williston, VT: Teachers College Press, 1999); Gerald L. Gutek, *Historical and Philosophical Foundations of Education: A Biographical Introduction*, 5th ed. (Upper Saddle River, NJ: Pearson, 2011).
13. Allen C. Ornstein and Daniel U. Levine, *Foundations of Education*, 10th ed. (Boston, MA: Houghton Mifflin Company, 2008).
14. Leslie S. Kaplan and William A. Owings, *American Education: Building a Common Foundation* (Belmont, CA: Wadsworth Cengage Learning).
15. Ibid., 94.
16. McClellan, *Moral Education*, 5.
17. Kaplan and Owings, *American Education*, 94.
18. Wayne J. Urban and Jennings L. Wagoner Jr., *American Education: A History*, 2nd ed. (New York: Routledge, 2000), 43.
19. Sol Cohen, *A History of Colonial Education, 1607–1776* (New York: Wiley and Sons, 1974).
20. McClellan, *Moral Education*, 13.
21. Carl F. Kaestle, *Pillars of the Republic: Common Schools and American Society, 1780-1860* (New York: Hill & Wang, 1983), 5.
22. Thomas Jefferson as cited in Urban and Wagoner, *American Education*, 70.
23. Lawrence Arthur Cremin, *American Education: The National Experience, 1783-1876* (New York: Harper & Row, 1983), 1.
24. Urban and Wagoner, *American Education.*
25. Hyman Kuritz, "Benjamin Rush: His Theory of Republican Education," *History of Education Quarterly* (1967): 435.

26. Ibid., 436.
27. Joel H. Spring, *The American School, 1642-1990*, 2nd ed. (New York: Longman, 1990), 37.
28. Benjamin Rush as cited in Spring, *The American School, 37.*
29. Joseph W. Newman, *America's Teachers: An Introduction to Education* (Boston: Allyn and Bacon, 2002).
30. Joel H. Spring, *American Education,* 15th ed. (New York: McGraw Hill, 2012), 9.
31. Ibid., 9.
32. Thomas Jefferson as cited in Spring, *American Education,* 9.
33. Urban and Wagoner, *American Education.*
34. Spring, *American Education.*
35. Harlow Giles Unger, *Noah Webster: The Life and Times of an American Patriot* (New York: Wiley, 1998).
36. L. Dean Webb, Arlene Metha, and K. Forbis Jordan, *Foundations of American Education,* 5th ed. (Upper Saddle River, NJ: Pearson, 2007), 133.
37. Urban and Wagoner, *American Education,* 81.
38. Michael B. Katz, "The Origins of Public Education: A Reassessment," *History of Education Quarterly* 16, no. 4 (1976): 383.
39. Katz, "The Origins of Public Education," 384; Urban and Wagoner, *American Education.*
40. Michael B. Katz, *The Irony of Early School Reform: Educational Innovation in Mid-Nineteenth Century Massachusetts*, (New York: Teachers College Press, 2001), 40, 49.
41. Ibid., 49-50.
42. Katz, "The Origins of Public Education," 385.
43. Ibid.
44. Thomas B. Timar, "The Institutional Role of State Education Departments: A Historical Perspective," *American Journal of Education* (1997): 232.
45. Spring, *The American School,* 74.
46. Ibid.
47. Urban and Wagoner, *American Education.*
48. Spring, *The American School,* 91.
49. Gutek, *Historical and Philosophical Foundations,* 236.
50. Urban and Wagoner, *American Education.*
51. Gutek, *Historical and Philosophical Foundations,* 236.
52. Urban and Wagoner, *American Education.*
53. Maris A. Vinovskis, "Horace Mann on the Economic Productivity of Education." *The New England Quarterly* 43, no. 4 (1970): 556; Gutek, *Historical and Philosophical Foundations.*
54. Urban and Wagoner, *American Education.*
55. Ibid.
56. Gutek, *Historical and Philosophical Foundations,* 236.
57. Kaplan and Owings, *American Education,* 118.
58. Webb, Metha, and Jordan, *Foundations of American Education;* Spring, *American Education.*
59. Vinovskis, "Horace Mann on the Economic Productivity," 552.
60. Katz, "The Origins of Public Education," 375. According to historian Michael Katz, "it is no accident that the mass production of clocks and watches began at about the same time as the mass production of public schools."
61. Urban and Wagoner, *American Education,* 103.
62. Gutek, *Historical and Philosophical Foundations,* 236.
63. "Horace Mann on Education and National Welfare," Tennessee Criminal Law, accessed November 17, 2013, http://www.tncrimlaw.com/civil_bible/horace_mann.htm.
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66. NEW FOOTNOTE INFO.
67. Ibid., 373.
68. Ibid.
69. Horace Mann, *Life and Works of Horace Mann, Volume III* (Boston: Lee and Shepard, 1891), 142.
70. Ibid., 139-140.
71. Ibid., 141.
72. Ibid., 142.
73. Gutek, *Historical and Philosophical Foundations,*, 241.
74. Urban and Wagoner, *American Education*, 110.
75. Gutek, *Historical and Philosophical Foundations.*
76. Steven E. Tozer, Paul C. Violas, and Guy Senese, *School and Society Historical and Contemporary Perspectives*, 4th ed. (New York: McGraw-Hill), 71.
77. Ibid.
78. Gutek, *Historical and Philosophical Foundations*, 241.
79. Webb, Metha, and Jordan, *Foundations of American Education*, 135.
80. Katz, "The Origins of Public Education," 383.
81. Duffy, *The Sanitarians*.

FOUR
A Dazzling Variety

In both its origins and popularization, the idea of the American public school was rhetorically elastic. It could, as we saw in the previous chapter, be put to all kinds of ideological and political uses. Reducing poverty, ensuring a compliant workforce, promoting social stability, making Americans more American, and producing physically robust generations of young people were just a few of the not easily reconcilable projects with which the new common school system was entrusted. What matters for us here, however, was not so much the consistency or otherwise of this vision, but the sheer scale and diversity of the aspirations that were contained within it.

The ongoing scale and diversity of these aspirations is the focus of this chapter. Beginning in the years immediately following the Civil War, the so-called Progressive Era, we describe some of the reform and counter-reform movements that shaped the idea of the American public school through the late-nineteenth and twentieth centuries. While a comprehensive narrative is beyond the scope of this chapter, what we hope to show is that, right up until the recent past, grand new agendas for American public schools have come and gone. While these agendas have not always explicitly been health related, our argument here is that school's public health role needs to be understood within this transhistorical sociopolitical narrative. We would also want to argue that through all of the rhetorical and political twisting and turning, a general concern with the well-being of young people has always at least been implied. Above all, our purpose is to help readers to see both historical and contemporary examples of school health activity, at least in part, as an outgrowth of their rhetorical and political milieu.

In the first half of this chapter, then, our discussion of broad shifts in educational policy rolls forward as far as the 1980s. After that, for the

remainder of this and the entirety of the following chapter, we retrace our historical steps more slowly by offering a series of concrete examples of school-based public health activity. Readers will notice that the forms of school-based intervention we describe spring from a variety of sources and are not, for example, always purely analogous expressions of the contemporaneous state of party politics or intellectual fashion. In any historical moment, actors act out of a variety of motivations. Equally, though, these examples are all products of the assumption that it is possible, simply by force of will, to mobilize the entire American public school system to address any social or health-related problem, regardless of its causes, scale, or complexity.

A DAZZLING VARIETY

If anything, the changes in American life that we described in the previous chapter accelerated during the decades immediately after the Civil War. Perhaps not surprisingly, the confusion wrought by social upheaval nurtured a culture now seething with evangelists of every kind: religious, spiritual, educational, medical, psychological, nutritional, artistic, and many others. Advice on virtually any subject, no matter how personal, was increasingly easy to come by.

The Progressive Era is often summarized as a time when scientific rationality became the dominant paradigm for thinking about educational knowledge and its application. However, as Reese's[1] analysis suggests, Progressivism in education had its roots in a somewhat haphazard mixture of science, culture, politics, Romanticism, and folk wisdom. He writes:

> In its American phase, child-centered progressivism was part of a larger humanitarian movement led by particular men and women of the northern middle classes in the antebellum and postbellum periods. This was made possible by changes in family size, in new gender roles within bourgeois culture, and in the softening of religious orthodoxy within Protestantism. Progressivism was also part and parcel of wider reform movements in the Western world that sought the alleviation of pain and suffering and the promotion of moral and intellectual advancement. Like all reform movements, it sought both social stability and social uplift. In addition, child-centered ideas gained currency as activists drew very selectively upon particular romantic traditions emanating from Europe. A trans-Atlantic crossing of ideas from the Swiss Alps, German forests, and English lake district thus played its curious role in the shaping of early progressivism.[2]

The relevance of Progressive Era thinking to this book should not be difficult to see. Above all, this is a period in history when faith in a rational, expert-led approach to education flourished, at least initially.

While the Common School movement had clearly imagined them as much more than just a place to teach children to read and write, and Horace Mann wrote a great deal about school's health role, Progressivism hugely expanded the social mission of schools. For many of its leading thinkers, there seemed no reason to limit the rational ends to which education might be put. After all, in their different ways they argued for a radical departure from the teaching techniques of the past. As with all revolutions, actual and imagined, this was a not a time for modest claims.

According to historian Joseph Newman, reformers like Mann, while certainly no stranger to social change himself, "could hardly have anticipated the pace and scale of industrial development after the Civil War."[3] Population growth, urbanization and industrialization all prompted a variety of social reforms, many of which found expression in schools.[4] However, despite the wide array of reform trajectories, historians have attempted to characterize most, if not all of them, as "part of a movement to organize twentieth-century American society into an efficiently functioning unit that would be in harmony with the needs of a modern industrial society."[5]

Between 1880 and 1920 the population of the United States grew at a staggering rate, from a country of fifty million to more than 106 million people. This happened despite declining fertility rates which were offset by improvements in medicine and a reduction in rates of infant mortality. The most significant factor in the country's population growth, however, was immigration. The era saw the arrival of 26 million new residents, the largest mass movement of people in history.[6] Aside from sheer volume, there was also a notable shift in immigration patterns after 1890. Prior to this date, the majority of immigrants (more than 85 percent) originated from northern and western European countries. These immigrants tended to share a similar cultural and religious heritage with most Americans (white, Christian, English speaking). In the early twentieth century, however, more than half of new immigrants came from central, eastern, and southern Europe.[7] These "new" immigrants represented a much more heterogeneous group, bringing "with them a host of differences in language, religion, food, work habits and cultural traits."[8] By 1920, one-third of all residents were either foreign born or children of foreign-born parents, and more than half of all Americans lived in urban settings.[9] While cities were attractive for those in search of employment and amenities, urban population growth often outpaced the development of local infrastructure. In many cities there was "virtually little or no planning to accommodate the increasing population."[10] Overcrowding, inadequate housing and sanitation, and high poverty exacerbated the plight of many new urban residents, problems many reformers considered to be in a state of crisis.[11]

The sweeping social and cultural changes also presented new challenges for schools. Most obviously, schools were forced to accommodate

a greater number of children. Between 1890 and 1920 the school-age population increased 49 percent and school enrollments by 70 percent. Apart from this, the changing cultural mix of urban schools meant they were also responsible for educating more students whose histories were unfamiliar, whose languages were foreign, and whose habits were often odd and alarming.[12] Into this scene of rapidly shifting school demographics stepped Ellwood Cubberley, committed assimilationist, educator, administrator, and future dean of the School of Education at Stanford University.[13]

Cubberley advocated for programs in schools to Americanize immigrants. A sense of the urgency of the problem he saw is captured in his description of America's new citizens whom he characterized as "largely illiterate, docile, often lacking initiative, and almost wholly without the Anglo-Saxon conception of righteousness, liberty, law, order, public decency and government, [and] their coming has served to dilute tremendously our national stock and to weaken and corrupt our political life" making the task of education "everywhere . . . more difficult."[14]

Administrative progressive educators like Cubberley believed that public schools were the country's greatest Americanizing force. Schools, he thought, could teach American notions of law and government so that immigrants would "come to act in harmony with the spirit and purpose of American ideals."[15] To this end, he insisted that teachers should discourage children from speaking their native language, having an accent, and observing traditional customs and holidays. School cafeterias were also introduced to reform the immigrant eating habits in the hope that they would "persuade children to abandon the diet of their parents for a new American cuisine."[16]

As well as assimilating immigrants, Cubberley also believed schools needed to address the social problems caused by urbanization, technological advances, and industrial expansion. Claiming that the influence of the home and church had been seriously eroded as a result of these forces, Cubberley argued for schools to focus on teaching children traditional values of courtesy, respect, honesty, and obedience. In his book *Public Education in the United States: A Study and Interpretation of American Educational History,* first published in 1913, he claimed:

> As modern city-life conditions have come more and more to surround both boys and girls, depriving them of the training and education which earlier farm and village life once gave, the school has been called to take upon itself the task of giving formal training in those industrial experiences and social activities which once formed so important a part of the education of American youths.[17]

Most educators and school administrators agreed with Cubberley's conservative approach, and support for his proposals far outnumbered the voices of a few liberal dissenters.[18] Two reformers, however, social work-

er Jane Addams and philosopher John Dewey, did voice opposition to Cubberley's assimilation strategies that were increasingly being implemented in schools in the early twentieth century. Rather than attempting to "cure" America's growing cultural diversity, Addams and Dewey advocated a pedagogical approach that sought to embrace it. They believed that cultural diversity created new possibilities for schools, not problems, as Cubberley claimed. Further, they understood the era's debates about curriculum and school practices as symptomatic of broader struggles over how schools would contribute to social progress and, perhaps more importantly, who had the authority to define what "progress" meant.[19]

Aiming to chart something of a middle course between ethnic separatism and total assimilation, Addams argued that assimilation policies and practices were not simply unwise, but were detrimental: "driving a wedge between immigrants and their children, depriving the immigrants as well as other Americans of a valuable cultural heritage."[20] Writing for the National Educational Association in 1908, she argued that schools should do more to connect "children with the best things of the past, to make them realize something of the beauty and charm of the language, the history, and the traditions which their parents represent."[21]

While Dewey shared Addams's pluralistic ideals, his critique of school practices and purposes was more wide-ranging. For Dewey, "the school itself was a social institution, a part of society, and needed to be continuously organized as such."[22] He spoke out against forms of schooling that were based on a traditional, rigid, and subject-centered curriculum and instead urged schools to attend to the needs and interests of the individual child. Schools needed to be experiential and child-centered, encourage cooperation, problem solving, and decision-making skills. He emphasized "student interests, student activity, group work and cooperation—methods premised on the idea that the school had to serve a new function in a world of increasing urban life and large corporations."[23] For Dewey, the primary purpose of schooling should be tied to children's preparation for participation in democratic life. "Given a world in which change is the central feature," Dewey claimed, the role of education must be to "help people adapt."[24]

Importantly, Progressive Era debates over the social role of schooling were fundamental to the evolution and organization of the American high school. Throughout the Progressive Era, high schools (typically grades nine through twelve and also referred to as secondary schools) grew in number and popularity. Between 1890 and 1930 secondary school enrollment virtually doubled each decade, preparing increasing numbers of middle-class students for work and college.[25] Recognizing the trend, in 1918 the National Education Association asked the Commission on the Reorganization of Secondary Education (CRSE) to review and revise the secondary school curriculum and establish common objectives. Comprised of elementary and secondary school educators, the CRSE is-

sued its seven *Cardinal Principles of Secondary Education*. These seven principles advocated for high schools to realign their curriculum and focus on "health, command of fundamental processes, worthy home membership, vocational citizenship, worthy use of leisure and ethical character."[26]

The *Cardinal Principles*, informed by the logic of social efficiency, sought to organize schools, particularly at the secondary level, for maximum cost effectiveness and saw them as institutions whose function was to prepare young people for their future economic and vocational station. Schools were charged with producing individuals who were, on the one hand, trained for an independent and customized societal role and, on the other, willing and competent to work cooperatively with others. According to Spring[27] the doctrine of social efficiency was to have a lasting effect on educational practice and administration. Right from the outset, however, it shaped the way the school curriculum was reorganized; school activities were structured to teach cooperation, and the curriculum was differentiated with students' assumed future vocational destinations in mind. Educators were expected to identify the strengths and weaknesses of students and to help them fit into appropriate social and vocational roles.[28] While all students were to take general education courses to promote common knowledge and shared values, schools increasingly offered guidance and career counseling and implemented intelligence and achievement tests to determine possible future academic or vocational placements. In this way, Progressive Era school reformers cemented a strong link between schooling and employment. According to Newman "if nineteenth century educators had felt some pressure to make schools relevant to work . . . early twentieth century educators became job brokers."[29]

While social efficiency was the central rationale reformers used to justify myriad proposals aimed at revamping the academic curriculum, this logic was also used to justify efforts to broaden the mission of schools to include a greater focus on their social functions. According to historians Urban and Wagoner, social efficiency reformers "sought to provide students, parents and community members with a variety of extracurricular activities aimed at increasing both the survival skills and the social cohesion of America's increasingly diverse population."[30] In this way reformers increasingly advocated that schools were necessary agents for the socialization of youth through activities such as athletics, student government, clubs, and school dances.[31] While most high schools already sponsored extracurricular activities, during the 1920s reformers tried to use these programs to prepare youth for the needs of modern corporate society.[32]

Reflecting a growing concern for and recognition of G. Stanely Hall's idea of the "adolescent," reformers stressed the duty of schools to instruct youth on citizenship education, physical activity, personal hygiene, sex instruction, and "wholesome boy-girl relationships."[33] According to a

1921 article by Mary Sheehan published in the *High School Journal*, "A school's service to the future makers of America does not end with preparing them for working hours which occupy only a third of the day. It must also provide specifically for the worthy use of leisure."[34] For historian Jeffrey Moran this curricular expansion reflected a generalized encroachment of state authority on the lives of individuals, but particularly for youth. Indeed, Moran argues that Progressive Era "bureaucratic innovations" were also "embodied in juvenile courts, immunization campaigns, mental health crusades, and state institutions for 'defectives' to name only a few."[35]

The Progressive Era has been credited with stimulating a "dazzling variety" of educational reforms designed to influence the nature and form of educational practices and purposes.[36] The business of schools also became of interest to business leaders and industrialists who wanted them to prepare students for factory work. Elsewhere, municipal reformers sought to use schools to promote hygiene, while settlement workers wanted schools to provide urbanites and immigrants instruction in domestic science, manual arts, and child care. Assimilationist educators, like Cubberley, aimed to inculcate patriotism and teach children how to become better Americans, agrarians compelled schools to stress a love for rural life in order to halt urbanization, and liberal progressives like Dewey and Addams argued that schools should aim to foster democratic sensibilities through a child-centered approach.[37] Schools also became a focus of educational psychologists and social behaviorists like Lewis Terman and Edward Thorndike, who championed the measurement movement—a movement that has also become a permanent feature of American education.

So, despite this "dazzling" array, each aim shared a common animating logic: a belief that, "the family, neighborhood, and workshop were no longer fulfilling their time-honored educational function. Schools had inherited the educational role from other social institutions that could no longer do what they had always done because the modern world was too complex and too large."[38] Taken together, Progressive Era reforms significantly expanded the social function of schools and attempted to change the way educational goals should be approached. In other words, while schools had long been tasked with achieving various social ends—such as reducing poverty and instilling morality—these goals were primarily achieved via instruction. By the early twentieth century, however, Progressive Era reforms reimagined schools as multifaceted policy instruments with which a new society could be engineered.[39]

SCHOOLS AND GLOBAL COMPETITION

The social roles of schools continued to interest post-progressive reformers. In the 1930s the more radical social reconstructionists, like George Counts, argued that the Progressive Era's child-centered approach was not only ineffective but potentially harmful. For Counts, "child-centered progressives were naïve in believing that their complete attention to the child bespoke no social position."[40] As a result of this failing, schools were complicit in perpetuating the country's problematic existing social arrangements. Deeply concerned about declining socioeconomic conditions and the negative effects of capitalism, Counts argued that schools should build a "new social order," one that could counter capitalism's inhumanity and individualism. To accomplish this, teachers needed to play a more active role in developing and promoting, and not avoiding, democratic traditions. Although it was obviously unlikely that schools would or could ever assume the radical social leadership role that Counts envisioned, he did contribute to an image of liberal and progressive educators that widened "the gap between the community of professional educators and the business community."[41]

Debates about the curricular priorities of schools continued in the 1940s and 1950s. For example, claiming that schools were not meeting the needs of young people, life adjustment educators sought to revamp the curriculum once again. Like reformers before them, at the heart of their agenda was a desire to structure education to prepare adolescents for their future life experiences; schools should produce students who were "well adjusted and prepared to live effectively in modern society."[42] Life adjustment advocates claimed that curriculum should be flexible and relevant, and offer students guidance in hygiene, family and peer relations, and even driver education. Inevitably, though, the movement had its critics. Most notably, historian and educational essentialist Arthur Bestor argued that the new nonacademic focus that life educators advocated contributed to a growing anti-intellectualism in society and, more specifically, within schools. For Bestor, life adjustment courses were interfering with schools' primary function: to produce intelligent citizens capable of rational thought. Writing in the *Bulletin of the American Association of University Professors*, Bestor argued:

> American public schools have the responsibility of raising up a nation of men and women highly literate, accurately informed, and rigorously trained in the processes of rational and critical thought. If the schools fail in this, then we may expect to see the collapse or defeat of democratic self-government through the sheer inability of its electorate to grapple intelligently with the complex problems in science, economics, politics, and international relations that constantly come up for public decision.[43]

Later in the article, he went on to argue that life adjustment curriculum represented "an attempt to define education exclusively in terms of the needs of youth, without reference to the capabilities of the school."[44] It was an attempt that, for Bestor, ended in "*reductio ad absurdum.*" It could not be the job of the school to meet the specific individual needs of youth, he claimed, because if it were then schools should attend to needs that are even more basic than proper life adjustment: food, clothing, and shelter.[45]

Aside from Bestor's concerns, critics also argued that promising successful "life adjustment" via curricular reforms was both unrealistic and problematic. In a 1946 article titled "Reflections on Sex Education in the High School" published in the *Marriage and Family Living Journal*, educators John F. Cuber and Mark Ray remarked:

> One of the characteristics of American education seems to be the frontal attack method of attaining purposes. If one wants better health, then introduce (and require, by all means) a course conspicuously labeled "health"; if one wants to attain temperance, then add a chapter (or unit) called "temperance." The trend may culminate some day in a course in "How to use a telephone on a party line"—who knows, there may now be such a course.[46]

Cuber and Ray were not suggesting that schools abandon sex education *per se*, but rather that life adjustment reforms were often bound up with other kinds of social agendas that were not necessarily explicit. Sex education, they argued, often functioned "as a sort of bait with which to entice the student into doing or being something which someone else wanted him to do or be."[47]

From the 1940s through the 1960s schools were also subject to important shifts in their governance structures. According to Spring, the cold war "created a framework for massive federal intervention," positioning the federal government as a key authority on matters of educational policy.[48] The 1957 launch of the Soviet Union's Sputnik satellite escalated this anxiety, further stimulating federal activity and influence. Perhaps the most obvious manifestation of this anxiety came in the shape of the National Defense Education Act (NDEA) of 1958 which appropriated aid to expand school instruction in science, mathematics, and modern foreign languages. In so doing, it helped establish the new federal role of providing categorical aid for issues deemed of national import. In the years following the NDEA, the federal government passed legislation with similar kinds of categorical aid provisions: the Vocational Education Act of 1963, the Manpower Development and Training Act of 1962, the Elementary and Secondary Education Act (ESEA) of 1965, and the International Education Act 1966 are just a few examples of this increasing trend.

School desegregation also had a centralizing effect on educational governance. In 1954 the Supreme Court issued their decision in the *Brown v. Board of Education* case, a ruling that determined that segregated

schools were "inherently unequal" and thereby deprived children of equal protection of the law. The ruling affirmed that education is "the most important of state and local governments' functions to ensure a democratic society, good citizenship, awaken children to cultural values and prepare them for later professional training."[49] Many local and state authorities vehemently resisted integration, particularly in the South, which ultimately necessitated federal intervention.

Alongside federal initiatives to address civil rights legislation were attempts to use schools to eliminate socioeconomic disparities. In particular, President Lyndon Johnson's War on Poverty explicitly addressed perceived problems with unemployed and delinquent youth, equality of educational opportunity, and economic poverty. As Spring puts it: "By the 1960s, it was commonly believed that discrimination and poverty were the two basic problems preventing the use of the schools as a means of discovery and classifying talent for service to the national economy and national defense."[50] In this context, Congress passed the Economic Opportunity Act of 1964, a bill designed to equip youth with basic literacy for employment; and the ESEA, which provided significant funding for schools to expand programs and resources for children of low-income families.

The 1970s and 1980s brought a further wave of federally inspired reform amid an increasingly conservative political environment for education. Much of this agenda "stemmed from the fact that many conservatives blamed schools for the social unrest of the early 1970s and 1980s and for many of the social problems that were seen as undermining the very moral fabric of the country."[51] Concerns about national economic competitiveness and academic standards prompted calls for higher standards, greater accountability, school choice, increased parental support, and a greater role for the business community in school policy. The mood of the moment was captured in The National Commission on Excellence in Education's 1983 report, *A Nation at Risk*, that warned of schools' mediocre performance; a situation that threatened the United States' global commercial, scientific, and industrial eminence. According to its authors, American students lacked critical thinking, math and science skills, scored poorly on international comparisons, and, as a result, placed the entire nation at risk.

Responses to the report varied; some criticized its seemingly simplistic "cause-and-effect relationship between public schooling and market dominance or industrial productivity" while others raised broader questions about "whether schools could either cause or cure America's social, economic, and political dilemmas."[52] Despite these criticisms, the report's allegations were taken seriously by most policy makers, and their responses worked to "reinforce existing trends in the distribution of power" in favor of state and federal agencies.[53]

A Nation at Risk[54] has been described as a "bombshell" for educational policy, and its central ideas continue to shape and inform education—from President Bush's 2001 No Child Left Behind legislation to President Obama's 2010 Race to the Top initiative.[55] Each of these policies calls for the establishment of challenging academic standards and comprehensive assessment systems. They also articulate a belief that top-down interventions aimed at increasing achievement and accountability will better prepare students for participation in an increasingly global society. Indeed, one of the driving forces over the last thirty years has been a concern about the achievement of American students when compared to students of other industrialized countries.

SCHOOLS AND ALCOHOL EDUCATION

Although a rather obvious observation, it is interesting how often the idea of a "nation at risk" has framed the way reformers and leaders of various kinds have talked about the mission of schools. There are no doubt many reasons for this, but the idea of immanent crisis is clearly an important weapon for anyone with an ideological agenda; doom, therefore, awaits anyone who refuses to heed the ideologue's warnings. This is probably true in all areas of public policy, but given that almost all children go to school, the nation's classrooms have proved irresistible to crusaders of every stripe. Returning now to the post-Civil War Progressive Era, however, there is perhaps no better example of a school-based crusade for the health of America's children than the Woman's Christian Temperance Union's war on alcohol.

As a large historical literature attests, concerns about the level and effect of America's alcohol consumption had exercised religious and secular thinkers for many decades. Prior to the Civil War, activist organisations such as the American Temperance Society, formed in 1826,[56] as well as informal coalitions had demanded and in some cases succeeded in having drinking establishments closed or the sale of alcohol restricted. In general, though, their successes were sporadic and short-lived, and the forces arranged against them formidable. In particular, the alcohol industry grew steadily in size and influence throughout the nineteenth century, and the reluctance of state and federal governments to collect income tax meant that public finances relied heavily on alcohol duties. In fact, the Civil War effort of both sides was significantly underpinned by alcohol-related taxes. Nonetheless, by the 1880s, support for the prohibitionist cause was substantial and growing. Votes for the Prohibitionist Party jumped dramatically at the 1884 presidential election[57] leaving political leaders in the delicate situation of needing to appease a vocal and increasingly well-organized prohibitionist constituency without endangering the financial lifeblood that alcohol represented.

Formed in the early 1870s, the Woman's Christian Temperance Union (WCTU) emerged out of the earlier spontaneous activism of groups of concerned women and began advocating for temperance instruction in American schools in 1878.[58] From this point onward, temperance instruction would become the single most influential force in American school-based alcohol education and remain so well into the twentieth century. It did this in part because it arrived at a time when political leaders were looking for an alternative to the outright prohibition of the sale of alcohol.

As Jonathan Zimmerman's book *Distilling Democracy: Alcohol Education in America's Public Schools*[59] shows, the WCTU's campaign to educate American children about the evils of liquor was led by the former school teacher and devout Puritan Mary Hanchett Hunt. Despite sharp divisions within the WCTU concerning the best way to discourage young people from drinking, Hunt's leadership and activism were remarkably effective. On the back of an apparently continuous program of travel, speech giving, letter writing, lobbying, networking, and coalition building, Hunt and her supporters succeeded in having their preferred approach to alcohol education, "scientific temperance instruction" (STI), written into legislation in every state.[60] They also went to great lengths to ensure that publishers only produce and schools only use textbooks they approved of. Among other things, this meant seeking out and endorsing experts who shared their views, attacking those who did not, and generally making it as difficult as possible for American children to read anything that strayed from their fiercely abstinence-only position.

While Zimmerman's historical account is surprising on many levels, it is particularly instructive in the way it cautions against a simplistic caricature of Hunt and the WCTU's educational activism. For example, Zimmerman makes the argument that, far from ignoring science, Hunt was firmly committed to the idea that scientific truth and "cold logic"[61] should guide school instruction. Unlike many of her more spiritually charismatic colleagues within the WCTU, Hunt was adamant that the best way to discourage drinking was to present students with the facts about alcohol's effect on human physiology and psychology. The important point here, of course, is that she simply dismissed as flawed or biased any scientific finding that contradicted her views, particularly any suggestion that alcohol was not a poison or that there was a safe level at which it could be assumed. Zimmerman's conclusion is that Hunt's selectivity in what counted as "the facts" is a tendency that all advocates share, whether religiously inspired or not. In the context of the arguments we have made and will make about school health in this book, we would add that this is probably particularly true where school-based intervention is concerned. After all, any social movement that claims that its ideas are so unimpeachably truthful and urgently important that every American school child needs to hear about them must, almost by definition, ignore contradictory ideas. In other words, religious zealotry

is by no means the only wellspring from which dogmatically held ideas about the mission of schools come.

Hunt and the WCTU's most impressive achievement was probably in America's state legislatures. Initially, they had directed their efforts toward pressuring local educational officials into adopting STI methods and using STI friendly textbooks.[62] During 1879 and 1880 they met with some success, albeit partly because some officials probably agreed merely to gain some respite from the relentless Mrs. Hunt and her disciples. More broadly though, they met with outright resistance to their message, a fact Hunt attributed to the pro-drinking culture she was determined to dismantle. Faced with this opposition, Hunt determined that the focus should turn to the country's state lawmakers, precipitating an even more intensive, widespread, and extended program of lobbying.

At this point in his history, Zimmermann makes the telling observation that this change in tactics amounted to a rather sharp about-face in Hunt's thinking. Rejecting the parades, flag waving, chanting, and pledge making favored by her less cerebrally inclined rivals within the WCTU, Hunt had originally insisted that people would embrace teetotalism of their own free will so long as they were presented calmly and rationally with the scientific facts about alcohol. However, the rejection of STI by many local educators represented a stumble at the very first hurdle. At this point, Hunt decided that if they could not be bent to her will voluntarily, they should be made to do so. Zimmerman writes:

> Mary Hunt's legislative strategy was conceived in the belief that some boards could *never* be convinced. In this sense, Scientific Temperance Instruction bridged two mainstreams of nineteenth century temperance—indeed of nineteenth century reform. Simultaneously coercive and persuasive, STI laws would use legal suasion of adults to institutionalize moral suasion of the young.[63] (emphasis in original)

Throughout the remainder of the 1880s Hunt and her supporters around the country succeeded in having compulsory STI legislation passed in a number of states, and by 1901 every state of the union had STI legislation of some kind.[64] They collected petitions, wrote letters, held rallies, and encouraged local citizens to agitate for STI with their parliamentary representatives. Hunt even spent time personally coaching members of her network in the words they should use and the arguments they should make when lobbying officials with the power to effect change.

After a rebuff in Connecticut, Vermont became the first state to legislate for STI instruction in its schools in 1882. By this stage Hunt's strategy had expanded to include insisting and, remarkably, in a number of cases being allowed to address state legislatures. Other states quickly followed suit, even those considered "wet." In fact, what is most interesting about her legislative success is that even staunchly anti-prohibition politicians who ridiculed Mary Hunt and the WCTU voted for STI in considerable

numbers. The reason, as we have seen, is that STI scratched a political itch; it allowed political leaders to claim to be committed to doing something about alcohol while keeping the liquor producers onside. Best of all, as an educational solution, STI could at least be presented as a rejection of heavy-handed central government interference, thus neatly sidestepping the question of an outright ban. Who could object to children receiving some education about alcohol?

In truth, STI faced attack on multiple fronts, and as the number of states that passed STI legislation grew, so too did opposition to it. Despite what appeared to be runaway success, STI still had to contend with a long list of obstacles that have dogged the aspirations of educational reformers throughout history. To begin with, the various state-based STI bills that were passed differed enormously in their wording and requirements. From Hunt's point of view, they suffered from vague definitions, unclear stipulations about how much STI instruction should be given to which age of children, and a host of other loopholes. And as she began to realize that it was one thing to pass a law but quite another to change the practices of an entire profession, Hunt identified an even more serious shortcoming: the absence of penalties for schools and teachers that did not comply. As a result, she also agitated for a string of amendments and follow-up legislation. She called for noncomplying teachers to be sacked and in some cases had lists of such teachers published in local newspapers. But this simply created more confusion and resentment. In states where penalties applied it was often unclear whether teachers could be sacked or were liable for fines, or how a decision about noncompliance would be arrived at or executed.

Undaunted, Hunt insisted on, and in some cases was granted access to school classrooms for the purpose of monitoring teacher instruction. For this purpose she devised template reports called "blanks" which she distributed among her supporters so that they could record what they saw. Needless to say, this was not popular among teachers, many of whom either resented teaching a point of view with which they disagreed or felt they lacked sufficient scientific knowledge to teach STI. Some teachers complained about the imposition of a whole new area of study in what they saw as an already crowded curriculum. Others said that students found STI boring while still others claimed that STI was counterproductive because it sparked young people's interest in alcohol.[65] For their part, school administrators also resented the extra costs associated with complying with STI legislation. In short, in resorting to state legislation as their primary line of attack, Mary Hunt and the WCTU failed to factor in the American tradition of local control over social policy and the inevitable complexities of curriculum development and implementation.

STI particularly provoked anger and resistance among some immigrant parents for whom alcohol consumption was not the pressing moral issue it had become in America. Understandably, they disliked their chil-

dren being told that their parents routinely consumed something that was a poison and morally evil.

Despite Mary Hunt's repeated claims that it was based on the most up-to-date scientific knowledge, STI was criticized by a diverse set of professional groups. The vast majority of the medical and scientific community, for example, were unimpressed with STI's scientific credentials, and a number of prominent scientists went to great lengths to communicate their misgivings with educational authorities and the general public. In the field of education, Progressive Era educators saw STI as out of step with their new child-centered theories. Not only did they dislike its reliance on memorizing and reciting the contents of textbooks, some also thought STI's focus on anatomy, physiology and the allegedly fatal consequences of alcohol would be too gruesome and disturbing for children. The recent popularization of developmental thinking also caused some educational thinkers to claim that STI was simply too advanced for most children. The concerns of educators were not dissimilar to those of some Protestant leaders who saw STI as an echo of the old fashioned Puritan scare tactics approach to religion that they were trying to move beyond.

Hunt died in 1906. By this time, years of fighting for classroom time as well as fending off critics had taken a heavy toll on her, her network, and even the WCTU's support for STI itself. Some WCTU leaders were openly arguing that STI needed to be abandoned or modified so that it was more aligned with Progressive educational thought. A few even suggested softening STI's zero tolerance approach in order to bring it closer to mainstream science. Rumors that Hunt had for years been collecting royalties from the sale of STI-friendly textbooks did not help matters. Until her death, though, Hunt, refused to compromise and admitted to few errors of judgment throughout nearly three decades of campaigning for STI.

Not all the details of Mary Hanchett Hunt's crusade for a religiously based and yet scientifically informed approach to alcohol education are directly relevant to the purpose of this book. And yet, we would discourage readers from dismissing STI as an isolated example of religious fanaticism. As Zimmerman shows, the WCTU was nothing if not a grassroots movement. Its views on alcohol were shared by a sizable portion of the American population, and the rapid spread of STI legislation and classroom instruction would not have occurred were this not the case. Despite their differences and bitter antipathy toward each other, Hunt's crusade for STI also had a great deal in common with more highbrow Progressive Era concerns. Both saw schools as a place in which a wide range of social and health problems could be addressed. As we will see shortly, by the late-nineteenth century reformers of various kinds had identified schools as an ideal site for intervention and the application of new medical and public health knowledge. Hunt and the WCTU were merely one player among many others.

We would also want to reiterate Zimmerman's earlier point that Hunt's idiosyncratic mixture of moral conviction and science is not so very different from all school-based health interventions, particularly those that see themselves with a mission to reach all or at least most children. As with all of the school health activities that we will discuss in the remainder of this book, our point is that advocates for school-based public health *always* pick and choose the scientific and nonscientific arguments that best suit their agenda. In this respect, Hunt was exactly like many school health advocates in that she presented the current situation as a crisis which could only be solved by the application of the knowledge and expertise that she possessed.

Hunt's vision for STI faltered for many reasons but, above all, it failed at the level of the school. Not only did teachers find a range of reasons not to teach STI, it also rested on the assumption that knowledge would lead to healthy behavior. Whether or not one is inclined to sympathize with Hunt's goals, there is precious little evidence that STI actually worked even where faithfully enacted using the methods that Hunt endorsed. Americans' alcohol consumption may actually have gone up during the Progressive Era,[66] and while it is obviously impossible to be certain about these matters, there are other lines of analysis which might inform more concrete conclusions about the effectiveness of STI or any other form of alcohol education.

Despite steadily declining popularity, STI continued to be taught well into the 1930s. Once established in state legislation, it took some time to disappear completely from the educational landscape. Nonetheless, its influence persisted. Writing in a 1947 edition of the *American Journal of Public Health and the Nations Health*, Joseph Hirsh lamented what he saw as the plainly partisan nature of the content of most textbooks used by schools for alcohol education.[67] In particular, he argued that most textbooks included gross scientific inaccuracies and, as a result, children continued to be exposed to WCTU propaganda. He also noted:

> As an aside, it is both interesting and important to note that in eight states the Woman's Christian Temperance Union workers are specifically authorized to lecture in public schools on this subject. They are also active in the schools of a number of other states. This alone is a challenge to health educators.[68]

Hirsh conceded that "the framework for intelligent education of emerging citizens on this important social and public health problem exists in the law in all states."[69] But despite there being no legislative impediment, Hirsh's conclusion was that the poor quality of educational materials and the inadequate training teachers received severely mitigated against the effectiveness of alcohol education. In fact, his assessment was that the current situation

> perpetuates errors and falsehoods, delays an intelligent solution of the problem, prolongs halfhearted social action and results in the waste of incalculable thousands of dollars of public funds presently being appropriated for medical and educational programs in this field.[70]

It is difficult to detect much change ten years later in the results of a survey of alcohol education provision in American schools published in a 1957 edition of the *Journal of School Health*.[71] Under the title "What is Being Done about Alcohol Education," the paper's author, Arthur V. Linden, paints a dismally pessimistic picture. A litany of problems are described including a lack of teacher training, the small amount of teaching time allocated to alcohol education, widespread confusion about when and how it should be taught, and the failure of schools to employ anybody with appropriate subject matter knowledge. Linden observes, "the assertion can be made that there are few really organized programs of alcohol education in the schools of this country."[72] He goes on: ". . . the content now being used for instruction in alcohol education is a hopeless hodge-podge of inaccuracies, outdated misinformation, and in many cases outright untruthful material."[73]

In 1976, G. G. Milgram's brief historical summary of alcohol education in American schools describes provision in the 1940s as "weak and chaotic," little better in the 1950s, and "ineffective" in the 1960s. While conceding that educators were now more likely to accept that many young people consumed alcohol and that most did so without causing themselves harm, she argues that alcohol education materials directed at young people were "almost non-existent and of poor quality." Alcohol education was, in other words, decontextualized and irrelevant. "To date," she writes, "alcohol education in the schools in the 70s can be characterized as inadequate, ambivalent, and vague."[74] She concludes by listing the perennial problems of teacher's bias, lack of knowledge, and discomfort with teaching material that is perceived as complex and controversial.[75] In an article for the *Journal of School Health* Milgram argues that while "objective alcohol education is espoused by all who comment in the literature, it is not a reality in practice."[76] She observes:

> The problems of alcohol education exist in varying proportions throughout the United States. While these problems exist we cannot consider alcohol education a reality or evaluate its success in terms of prevention. Alcohol education requires prepared teachers, community guidelines and policy, clear and specific goals designed to meet the needs and interests of students at various age levels, adequate time periods, and objective and scientific materials.[77]

Jumping forward another ten years to 1986, Marcus Grant's comparative analysis of alcohol education in Europe and North America for the *Annals of the New York Academy of Sciences* is titled "Elusive Goals and Illusory Targets." As is common in the field of health education generally,

Grant found that while the research literature dealing with alcohol education was large, very few studies were well designed and even fewer used robust forms for evaluation. But even in cases where a credible effort to evaluate program effectiveness had been made, his conclusions are uniformly scathing. Overall, he argues,

> alcohol education is directed towards a target audience that simply melts away out of sheer boredom, inertia, and lack of footholds in the substance of what is being taught. Similarly, while the goal of knowledge increase appears relatively easily attainable, it is difficult to know how important it is in the face of the increasingly ambiguous results that are achieved, the closer an evaluation comes to actual day-to-day drinking behavior.[78]

In summing up, Grant muses about the continuing popularity of school- and university-based alcohol education:

> Alcohol education programs are all too often like firing quivers full of arrows into the night. Some of them, indeed, will hit home. Others may hit targets for which they were never intended. Most will be lost forever in the dense undergrowth and unmown grass of the school system. As it stands, this is a spectacularly wasteful enterprise. Yet, like many such enterprises, it remains popular with international organizations, governments, trade associations, and miscellaneous researchers.[79]

Whether anything has changed in more recent times is a matter to which we will return briefly in chapter 7. For now, our point here is historical; surely what is most striking about the story of alcohol education in American schools is its apparent indestructibility as an idea in the face of constant failure. It is important to point out also that, regardless of which historical period one cares to look at, advocates for one form of alcohol education or another are never in shortage. But, as a research study published in the *Journal of Studies on Alcohol and Drugs* in 1988 found, perhaps it is mistake to look for strengths or weaknesses in particular types of alcohol education.[80] While measuring and allowing for a range of variables, the researchers found that even drawing on the best available knowledge and the latest intervention techniques may not be enough. They write:

> It is concluded that contemporary alcohol education programs do address variables that, when considered alone, appear to be related to drinking. However, these same variables make such a small independent contribution to drinking behavior that it is unlikely even a highly successful classroom intervention directed at these variables would do much to prevent alcohol use or abuse by youth.[81]

In other words, perhaps the things that matter most when it comes to the health decisions young people make are simply beyond the reach of educative intervention.

THE AGE OF INSPECTION

Readers will recall that in chapter 3 we left the history of American public health on the eve of the Civil War. At this point, an embryonic movement was taking shape, led mostly by medical men, many of whom had seen firsthand and written about the plight of America's growing urban poor population. By the end of the nineteenth century a more mature and cohesive public health profession had emerged. The American Public Health Association was formed in 1872, and the work of applying revolutionary new scientific discoveries about the origins of disease was under way. This is not to say the material health of most Americans had improved; far from it. Significant outbreaks of disease such as cholera and diphtheria were still occurring as late as the 1890s, and the formation of federal and state health bureaucracies had progressed only slowly by the end of the century. Much remained to be done.

From the outset, the English public health reformers of the 1830s, 1840s, and 1850s had largely been people of a bureaucratic or philanthropic ilk. This was in contrast to the medical leaders who dominated American public health a generation later. The reasons for the difference are complex but are in part due to the gradual shifts in medical knowledge during this period. By the 1870s, knowledge about the microbial causes of disease had substantially advanced, giving medical professionals a far more compelling set of reasons to involve themselves in the reform of sanitary conditions in American cities and towns. In fact, the period between the end of the Civil War and the beginning of the First World War has been described as something of a golden age for public health because of the way medicine worked in concert with engineers, town planners, and other professionals in the pursuit of social reform. As we discussed in chapter 2, this is often contrasted with the middle and late twentieth century in which the medical profession is seen as having largely evacuated the field of public health for the more lucrative pastures of private medicine.

During the Progressive Era, however, American public health was both medically led *and* explicitly focused on ameliorating the social conditions that produced disease, a philosophical orientation it shared with educational progressives. In fact, among Mary Hanchett Hunt's many critics were educational progressives who described STI as both educationally old-fashioned but also guilty of ignoring the social causes of disease, antisocial behavior, and low academic achievement.

In turning their gazes to schools, Progressive Era public health reformers saw an ideal site for intervention. As well as improving the safety and hygiene of school buildings, as we saw in chapter 1, children could be inspected for signs of disease and vaccinated *en masse*. School inspections for disease had actually been occurring in the larger northeastern cities since the late 1890s, and a small number of school vaccination programs had occurred as early as the 1850s.[82] However, with the influence of STI on the wane following Hunt's death in 1906, initiatives such as the promotion of physical education and instruction in nutrition proliferated. The American School Hygiene Association was formed in 1906 and immediately advocated for the improvement of school buildings, health instruction, physical training, and school inspections. As the practice of inspection spread, its remit expanded to include dental inspections and the search for "abnormalities" such as impaired sight and hearing. In the following decades, hundreds of other organizations representing a rainbow of religious, historical, nationalistic, militaristic, and social causes lobbied for curriculum space in schools.[83]

There can be little question that many children benefited from the school health reforms of the Progressive Era, despite the long list of contemporary criticisms leveled against them and then later by social historians. It needs constantly to be kept in mind that at the beginning of the twentieth century thousands of American children still lived, worked, and went to school in dangerous and grossly unhygienic circumstances. As Markel writes:

> Many urban schools at the turn of the century conducted classes in poorly lit, underventilated basements, corridors, and temporary wooden structures called "portables." Inadequate plumbing and sewage systems meant that these "halls of learning" were often filled with the stench of poorly working toilets or overfilled outhouses. Improving public school facilities and sanitary and health conditions for students became a matter of great concern. Between 1908 and 1909 alone, more than 500 articles on school hygiene appeared in popular periodicals and the medical literature.[84]

As the field of public health expanded, more health professionals began to look specifically at the plight of children, a point reflected in the emergence of pediatric medicine and the broader child health movement.[85] In fact, school inspections were just one example of a wave of reforms and programs designed to improve child health; public health and hygiene education programs, home nursing visits to poor communities, the Sheppard-Towner Child Welfare Act of 1921, new child labor laws, and the establishment of the United States Children's Bureau are just a few examples. In the particular case of schools, the Progressive Era saw a huge amount of school building refurbishment activity, the funding of thousands of school nurse positions, and the expansion of explicit health in-

struction. Teacher training and classroom instruction in the workings and care for the body, or what became known as "hygiene," received widespread support. Writing in the *American Journal of Public Hygiene* in 1910, Adrian De Garay offers a particularly evocative rendering of the subject:

> Hygiene gives us a knowledge of the rules which have to be observed for preserving and perfecting our health; that is to say, its object is the prolongation of human life and the enjoyment of perfect health during life, together with sufficient physical and intellectual vigor to be able to enjoy that life and all the pleasures which it furnishes. We are therefore all interested in obtaining a knowledge of hygiene, because we first require to live and afterwards arrange our method of life. Without life there are no honors, no pleasures and no wealth. The most civilized nations are unquestionably those whose mortality is lowest and longevity highest. It is therefore necessary to give the best possible instruction on hygiene, to children, the working and professional classes, soldiers, prisoners, and in fact, to all the world.[86]

However, despite the Progressive Era's achievements in school health, school inspection and vaccination programs, in particular, could be hugely unpopular and were resisted by immigrant groups, concerned parents, and religious leaders among many others.[87] Immigrant communities regularly accused inspection authorities with unfairly targeting their children and, as a number of scholars have shown, the practice was clearly informed by class prejudice, eugenics, and flagrantly racist thinking.[88]

By the 1930s, a number of experts were starting to doubt the effectiveness of school inspections. Writing in a 1930 issue of the *American Journal of Public Health*, Jean Downes concluded:

> The adequacy of the school medical examination, even in its more highly developed form, as a means of keeping tab on the school child's health, is properly being called into question. The principal ground for skepticism is the obvious fact that the periodic health examination takes into account only a few conditions at intervals of 2 or 3 years; it cannot promptly bring to light any conditions as they arise in the interim. Furthermore, the health examination does not and cannot, unless it is made far more searching than it is now, bring to light other impairments and defects, and it cannot conform to a fundamental postulate for accurate diagnosis, namely the opportunity for continuous observation.[89]

Ten years later, Frank L. Kelly made essentially the same criticisms in a 1940 issue of the *Annals of the American Academy of Political and Social Science*.[90] Pointing out that there seemed to have been little improvement in general childhood health during the 1930s, Kelly went further, arguing: "The school medical examination has become so routine a health procedure in the public school system that any challenge of its efficacy almost smacks of heresy."[91]

Of course, by the 1940s medical science had advanced a great deal, as had the reach of private medicine. Although school health inspections lingered on in a number of states for years, the grounds for their existence were gradually eroding. Outbreaks of infectious disease were far less common and less devastating and the living conditions of most Americans had improved markedly. Continued population growth and mass immigration also meant that the resources devoted to inspections were stretched ever thinner.

A GOLDEN AGE?[92]

Few subjects in American educational history have attracted as much scholarship and debate as the reforms of the Progressive Era. We have been careful in this chapter not to enter the fray and, instead, limit our conclusions to the relatively obvious.

First, a great deal changed during the Progressive Era. While using schools for health purposes was not new, it exploded to include a vast array of social and health concerns, only a small number of which we have touched on here. For example, health and educational reformers did not limit themselves to the state of school buildings, contagious diseases, and physical "abnormalities." To name only two, some readers will be aware that sexuality and psychology were also burgeoning areas of study, and schools were seen as a legitimate place to try to turn young people into what reformers saw as sexually and mentally well-adjusted subjects. In other words, it is during this period that experts, intellectuals, fanatics, dreamers, and ideologues of every stripe decided that their ideas could and should be used in schools to mold children in their own image.

And what of the relationship between public health and public schools? As Howard M. Leichter argues, although Progressive Era public health advocates were intent on changing the physical environment in which people lived, most of them were still, to varying degrees, inclined to blame poor people for their social position and health status.[93] In fact, the widespread enthusiasm for hygiene instruction, especially for poor, immigrant, and minority children, is testament to this. The rainbow of concerns that reformers charged schools with addressing speaks directly to the idea that informs almost all school health interventions: that children can be educated out of poverty and ill health. Returning to Progressive Era scholar William Reese, with whom we began the chapter, the dreams of educational reformers crashed hard against the day-to-day realities of American schools.[94] While educational philosophy would never be the same, the practices of teachers and the material resources of schools proved much less elastic.

On the other hand, perhaps the most important point to take away from the Progressive Era is that there *are* health-related things that can be

done in schools. Schools can be made safer, cleaner, and more pleasant places to be. As far as vaccination and inspections are concerned, while we might have misgivings about some of the motives behind them and the techniques that were used, they are nonetheless examples of schools being used to solve a problem for which they are well suited. Schools were a godsend for public health reformers because they solved the problem of access to a large number of children as quickly as possible. By contrast, if we are interested in changing the way young people use alcohol or conduct themselves sexually or manage their own mental lives, the problem is not access; the problem is how to have the effect that educators want to have. And in all the areas of complex human behavior that we can think of, educators are no closer to the answers to this problem than they were at the beginning of the twentieth century.

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FIVE
Sex, Drugs, and School Food

We continue our exploration of the twentieth century by considering three areas of school health activity; drug use, school food, and sexual behavior. While we have stressed that a single volume could never comprehensively assess the full range of health matters American schools have been asked to address, these three examples are powerfully emblematic of a central concern of this book: the ways in which school health has been and continues to be used. As we alluded to in chapter 2, our argument here will be that sometimes school health policies and interventions exist for reasons that are, at best, tangential to the immediate material health of young people. This does not mean that they are entirely cynical exercises, but we do invite readers to consider them in their full complexity. Above all, we want to stress that public schools are part of the apparatus of government and therefore, among other things, both a political instrument and battleground.

It also needs to be stressed that the kinds of school health policies and interventions that we describe in this chapter could only exist against a background of preexisting belief about the ability of schools to solve the perceived problems of the wider society. In this vein, two points strike us as central. First, continuing a line of argument begun in the previous chapter, each of these three areas of public policy concern complex areas of human behavior and yet there is little sense that policy makers ever stop to wonder about the capacity of schools to shape these behaviors. Put another way, there often appears to have been little intellectual or rhetorical space between the articulation of a problem and the assumption that schools are the place to address it. The second and related point is that it is noticeable how little attention is paid to questions of efficacy. In fact, it seems remarkable to us how straightforward an undertaking school health has regularly been assumed to be. As a result, what would

seem intellectually crude and unproven interventions have been proposed with a matter-of-fact air of certainty. In the particular case of school lunch programs, the health of students seems to have been strategically tacked onto policies that had already been decided upon in order to give them a "feel-good" veneer. But in all cases a startling, almost childlike optimism also seems to have played its part.

ECONOMIC POLITICS: SCHOOL FOOD

We turn first to a very specific area of school-based social policy: school food. While the idea of providing children food in schools has historically received widespread support from politicians and the public alike, the American system of school food service is the result of a complex interplay of economic, political, nutritional, and social welfare agendas. Prior to the 1946 passage of the National School Lunch Act, school meals were prepared primarily by volunteers from a variety of charitable organizations. Many of these early programs were associated with Progressive Era reforms concerned with urban renewal and the effects of poverty.[1] Progressive reformers were later joined by professionals from the emerging fields of home economics and nutrition science that believed that school meals could inspire "a culture of nutrition" across the country.[2] Advocates argued that lunches would transform American eating habits and help to solve two pressing social problems. On the one hand, lunches would protect children from malnutrition, the most obvious indicator of inequality and poverty. On the other, school lunches would Americanize the nation's newly arriving immigrant families by teaching children the values of nutrition science and health and stimulating an appetite for a distinctly American cuisine.[3]

When the U.S. economy collapsed in the early 1930s, a new concern—the growing surplus of farm commodities—entered the politics of school lunch provision. While obviously designed to rebuild the country's economic infrastructure, President Roosevelt's New Deal legislation also implicated school food in at least two ways. First, it allocated direct federal aid for meal programs. Second, the Work Progress Administration (WPA) arm of the New Deal paid farmers for agricultural surpluses and hired unemployed individuals (mostly women) to prepare and deliver meals.[4] Despite this, the legislation had a limited impact on the delivery of school meals. In many instances, funding was not sufficient or did not make its way into schools and, in cases where it did, long-term funding was not guaranteed. Lacking this assurance, many schools were unwilling to invest local funds into the construction of facilities necessary to run a viable lunch program.[5] Recognizing the gaps in the federal program, a number of state governments passed laws directing local school boards to establish meal programs. These state-mandated meal programs were

run as collaborative endeavors, with state school lunch administrators working with civic groups, parent teacher organizations, nutritionists, and charitable organizations.

As a result of these federal and state mandates, it is estimated that by 1940 as many as 64,000 individuals were employed by school meal programs across the country.[6] However, progress on this policy area was interrupted by World War II as many of the previously unemployed WPA workers involved in preparation and delivery of school meals secured more lucrative jobs in defense-related industries. In 1943 Congress disbanded the WPA, deeming the program no longer necessary. Along with the concurrent wartime shortage of agricultural surplus foods, this resulted in diminished federal funding for school meals.[7] The elimination of federal resources forced local schools to accommodate for the fiscal shortfall, a financial commitment few were willing or able to make. Thus, according to Susan Levine, "while almost six million children ate government subsidized school lunches by the time the United States entered World War II, few of those lunches were served free and few of the children served were poor."[8]

By the end of the war the school lunch lobby once again gained a measure of political traction, and this time reformers seized on wartime concerns around national defense to promote their cause. The security of the nation, advocates argued, made the provision of school meals more important than ever before. In 1945 the House Committee on Agriculture echoed this sentiment. Drawing on a recent Surgeon General's report that detailed the high number of unhealthy young men rejected for military service, the committee claimed that school meals were a national priority. School meals would help solve a range of social problems originating from the "increase of working mothers, consolidation of schools, greater travel time to school, and rising scale of food costs."[9] The committee's recommendations were also justified on the basis of the broader economic interests of the country. "The federal government has always had an active interest in providing markets for agricultural production and for maintaining agricultural production at a high level," they wrote, and "any measure that will expand the domestic consumption of agricultural production, both immediately and in the future, and assure a large share of the national income to farmers, should receive support."[10] Surplus agricultural commodities were also described as "price-destroying," and a national school lunch program was proposed as a way to dispose of these food items.[11] Importantly, the committee's views aligned with the those of both southern Democrats and northern New Deal Liberals who favored increased federal postwar investment in infrastructure and industry, particularly in agriculture. In short, a formidable strategic alliance between the U.S. Department of Agriculture (USDA), farmers, and schools emerged in support of a national lunch program, the primary

purpose of which was to ensure a ready-made market during times of agricultural surplus.[12]

President Truman embraced these recommendations and in June 1946 signed the Richard B. Russell National School Lunch Act (P.L. 79–396). Echoing the committee's justifications, the Act was established as

> a measure of national security, to safeguard the health and well-being of the Nation's children and to encourage the domestic consumption of nutritious agricultural commodities and other food, by assisting the States, through grants-in-aid and other means, in providing an adequate supply of foods and other facilities for the establishment, maintenance, and expansion of nonprofit school-lunch programs.[13]

At the signing, Truman praised the Act, stating that "nothing is more important in our national life than the welfare of our children, and proper nourishment comes first in attaining this welfare."[14] Many others agreed, and the legislation received widespread support from farm, labor, educational, philanthropic, and women's organizations. As per the committee's suggestions, Congress tied the Act to surplus agricultural items by designating these as the primary food commodity for school lunches, thereby cementing the relationship between schools and various agricultural and industrial sectors.

Susan Levine's book, *School Lunch Politics*, explores these early justifications for school lunches and places them against the broader political and economic context on which the merits of the program were debated. Levine's analysis underscores the influence of political ideology, special interest groups, race, and corporate lobbying on the development and ratification of the 1946 National School Lunch Program (NSLP). In particular, Levine suggests that the commitment to offer food in schools did not emanate from a unified and/or enthusiastic concern for children's health, as it is often celebrated. Rather, the policy brought together a somewhat unlikely and not always stable coalition of stakeholders with a disparate set of aspirations, ranging from the alleviation of social dilemmas to naked self-interest. In the process, debates and discussions about the creation of the NSLP touched on a variety of postwar anxieties about youth, families, American identity, national security, the economy, and the government's social policy responsibilities.[15]

Levine's analysis directly challenges the notion that interventions aimed at addressing social problems through schools are straightforward, transparent, or apolitical. In the case of school lunches, for example, rarely were the political maneuverings, logistical complexities, and fiscal implications of the program's design and delivery adequately addressed. And while the decision to tie agricultural surplus items was politically very popular, it was highly problematic for a number of schools. Lunchrooms quickly became a kind of dumping grounds for surplus food items, irrespective of their nutritional value. More than this,

the process of designating a food item as a "commodity item" became highly politicized. As Levine puts it, "food industry groups—and their congressional representatives—were not shy about claiming their commodities to be 'in surplus' if market prices were low."[16] For low-income schools, those most heavily dependent on surplus items, this sometimes meant olives for lunch one week and apricots the next. At the same time, USDA officials were clearly convinced that the NSLP was a means to an economic end, a kind of government-sponsored "insurance policy."[17]

Levine's work draws attention to the motives of political leaders who mandate social policies without providing adequate funding or administrative capacity. Indeed, claims that the NSLP would improve children's health may have only served to obscure the political and economic opportunism that facilitated the passing of the Act. Once passed, at least three practical issues hindered widespread adoption of the legislation. First, because Congress did not administer regulatory oversight, the legislative mandate to feed poor children for free was often ignored, despite need or schools' capacity to do so. Second, the legislation's funding formula required states and districts to match federal contributions. This resulted in low participation rates among districts that could not secure the necessary monetary provisions. Finally, many schools still lacked kitchen facilities necessary to prepare meals. These last two obstacles, more prevalent in lower-income neighborhoods, meant that those children who stood to benefit most from the program were precluded from participation. As Levine writes, "For the first fifteen years of existence the NSLP enjoyed widespread support but fed relatively few children."[18]

The NSLP has been amended numerous times following its 1946 passage. In the 1960s the legislation was expanded, making free and reduced lunches available to all children from low-income households. In 1966 President Lyndon B. Johnson introduced the Child Nutrition Act (P.L. 89-642), an Act that established the School Breakfast Program (SBP). Modeled on the NSLP, the SBP provided free or reduced-cost breakfasts to children in schools and was one component of Johnson's "War on Poverty," a series of legislative measures that also included the provision of food stamps and the development of the Head Start, Medicare, and Medicaid programs. Johnson's dramatic expansion of the social safety net, however, was short-lived. Inflation during the 1970s followed by President Ronald Reagan's promise to eliminate "wasteful" government programs resulted in massive funding reductions for many of these social welfare programs. For school lunches, this meant a $400 million cut in federal funds to the program's $4.6 billion budget.[19] Budget cuts continued through the 1980s so that by 1990 funding for the NSLP was only 58 percent of its initial 1946 level.[20] As a result, local school food authorities (SFA) and school administrators soon began to seek out alternative revenues to operate food services, prompting the development of school-industry partnerships.

THE BUSINESS OF SCHOOL FOOD

Although federal meal programs are considered a public program, in practice, they operate as a joint venture between government and industry. Administratively, meal programs are the responsibility of the USDA's Food and Nutrition Service's (FNS) Child Nutrition Division. This agency establishes nutrition standards, provides oversight and technical assistance to state agencies. Their authority, however, is never guaranteed and has been subject to the ever-shifting political leanings of legislators. Various state agencies are responsible for managing the fiscal elements of the program and monitoring local compliance with USDA standards. At the local level, it is the SFA that oversees the provision and sale of food in schools. However, because many SFAs lack the facilities, finances, or personnel to operate meal programs they often turn to food service management companies (FSMC) like Aramark, Marriott, Sodexo, and Chartwells to run them. These for-profit companies then take over the operation of school meal programs, including facilities maintenance, staffing, accounting, and state and federal reporting.[21]

While federal law dictates that a school food service must be a nonprofit enterprise, schools and companies can employ various strategies to increase their bottom line. One strategy involves the selling of popular *à la carte* items in cafeterias, vending machines, and school canteens. These *à la carte* items generate profits in food sales independent of federal food programs (i.e., NSLP and SBP) and are therefore deemed allowable. This, combined with years of diminishing federal contributions to the food program, has made *à la carte* items critical to the profitability of school food. Unsurprisingly, any legislative change that increases the costs associated with a school's food program or places greater restrictions on the sale of *à la carte* products has been fiercely contested by various factions of the food industry and, in many cases, schools themselves.

In addition to contracting food services to FSMCs, many schools also partner with soft drink and snack food companies. A number of these partnership arrangements—especially in the case of beverage sales—provide a company with exclusive rights to sell and advertise their products on school grounds. In many cases, school boards, administrators, parents, and students alike have endorsed the fiscal benefits of these partnerships, arguing they enable schools to purchase additional services, staff, and equipment. But schools are obviously not the sole beneficiary of these arrangements; manufacturers of food and beverage products have much to gain as well. Schools bring in direct profits via food and beverage sales and have come to be seen by food and beverage companies as important vehicles for building long-term brand loyalty among young consumers.

The economic dimensions of food in American public schools have also had a profound effect on the regulatory framework in which it occurs. In fact, despite long-standing and often repeated rhetoric about

schools' mission to promote healthy food behaviors, the largely unimpeded forty-year history of the sale of high-fat and high-sugar "competitive foods"—those foods sold in competition with the NSLP (i.e., *à la carte* items)—suggests otherwise. For example, representatives of the soft drink industry have been among the most vocal, organized, and effective industry school food lobbyists. Since the creation of the first soft drink contracts in the 1960s, the industry has actively—and in many cases successfully—blocked any legislation that would place limits on their ability to sell their products in schools.[22] In 1970, for example, congressional legislation authorized the USDA to establish nutrition standards that would have regulated the sale of competitive foods. Fearing that more stringent standards would reduce profits, many food companies and schools banded together to protest the decision. In 1972, Congress capitulated to pressure and amended the legislation to allow schools to sell competitive foods on the condition that any profits would support school organizations. At the same time, Congress referred the matter for judgment by state and local agencies, a decision that effectively removed the USDA's jurisdiction. A 1977 congressional ruling, however, restored the USDA's authority. With its reinstated authority the USDA announced a restriction on the sale of foods with minimal nutritional value, a restriction that was to be enforced from the beginning of the school day until the end of the last lunch period.[23] In response, the National Soft Drink Association (NSDA) filed several lawsuits against the agency in an attempt to reverse the new regulation.[24] On November 15, 1983, the U.S. Court of Appeals sided with the NSDA, finding that the USDA had gone beyond congressional intent in establishing time and place restrictions on school foods. For almost twenty years this ruling has effectively prevented the USDA from regulating the sale of many foods sold in schools.[25]

The NSDA has certainly not acted independently in its quest to influence school food legislation in its favor. Before what has been called the "1990 Pizza Hut exemption," federal law mandated that all meat products were subject to strict laws regarding their handling and inspection. Because these regulations made it more difficult and costly to serve Pizza Hut products in schools, the company successfully lobbied to have their meat toppings excused from these regulations. Essentially the company claimed that its meat toppings should not be considered meat, and therefore not subjected to inspections. The bill was pushed through Congress by company ally Democratic Representative Dan Glickman.[26]

This sort of legislative activity has had a number of ramifications for school food programs. To begin with, the lack of federal governance and lax state and local regulations contributed to dramatic increases in the availability of competitive foods on school campuses. A 1996 General Accounting Office (GAO) study wrote that 82 percent of school lunch providers noted an increase in sales of competitive foods in cafeterias and vending machines.[27] Over the next decade, the increase in vending ma-

chine sales contributed to an overall reduction in school lunch participation, a reduction that has diverted funds that would normally have supported the program.[28] Since volume is key to the program's fiscal viability, the introduction of private vendors and competitive foods put schools in the precarious position of competing with their own school meal program for revenue. More than this, however, the kind of lobbying characterized by the school lunch debate undermines the authority of agencies like the USDA to oversee a program that was, at least rhetorically, born of a desire to provide children with nutritious foods. The result, according to Fried and Simon, is that the USDA "finds itself in the diminished role of information clearinghouse, rather than enforcer of school meal regulations."[29] This contributed to a watered-down regulatory environment where authority was given to local governing bodies that had a clear economic conflict of interest.

The provision of food in American public schools over the last one hundred years is a dauntingly convoluted story that is open to multiple interpretations. In recounting some of its most intriguing subplots here, our purpose has not been to pass judgment, attribute blame, or suggest ways it might have been done better. Instead, we think a far simpler and uncontroversial moral emerges. The example of school food demonstrates how well-meaning aspirations to promote health through schools are likely to be no match for the internecine political struggles and complicated administrative contexts in which schools operate. To the extent that some of the players in this story believed that school food programs would make an appreciable difference to the health of American children, there is little by way of vindicating evidence and, instead, grounds for wondering whether, on balance, they have had the opposite effect. But this should not be surprising since it is not even clear that the promotion of health has ever been a primary goal of school food programs. What *is* clear, however, is that policy makers and other stakeholders regularly used the rhetoric of health to camouflage school-based policies that served another purpose altogether.

IDEOLOGICAL POLITICS: THE "WAR ON DRUGS"

> Drugs are menacing our society. They are threatening our values and undercutting our institutions. They are killing our children. . . . My generation will remember how America swung into action when we were attacked in WWII. . . . Well, now, we're in another war for our freedom, and it's time for all of us to pull together again. . . . Drug abuse is a repudiation of everything America is. The destructiveness and human wreckage mock our heritage. Think for a moment how special it is to be an American. Can we doubt that only a divine providence placed this land, this island of freedom, as a refuge for all those peoples in the world who yearn to be free? . . . As we mobilize for this

> national crusade, I'm mindful that drugs are a constant temptation for millions. Please remember this when your courage is tested: You are Americans. You're the product of the freest society mankind has ever known.[30]
> —President Ronald Reagan, September 14, 1986

> I've always thought of September as a special month, a time when we bundle our children off to school, to the warmth of an environment in which they could fulfill the promise and hope in those restless minds. But so much has happened over these last years, so much to shake the foundations of all that we know and all that we believe in. Today, there's a drug and alcohol abuse epidemic in this country, and no one is safe from it—not you, not me, and certainly not our children, because this epidemic has their names written on it. . . . And finally, to young people watching or listening, I have a very special personal message for you: There's a big, wonderful world out there for you. It belongs to you. It's exciting and stimulating and rewarding. Don't cheat yourselves out of this promise. Our country needs you. But it needs you to be clear eyed and clear minded. . . . Say yes to your life and when it comes to drugs and alcohol, just say no.[31]—Nancy Reagan, September 14, 1986

Having already announced a "war on drugs" in 1982, the Reagans' September 14, 1986, nationally televised address helped to further galvanize political and media attention on drugs, a situation that would endure for the next two decades.[32] During the speech, President Reagan proposed $900 million in new spending on drug prevention strategies.[33] Later that year he signed the Anti-Drug Abuse Act (P.L. 99-570), an omnibus bill providing $1.7 billion to fight the "war on drugs" by building new prisons, providing drug education, and expanding treatment facilities. It was the most far-reaching anti-drug act ever passed by Congress and, importantly, formally launched the Drug-Free Schools and Communities program, the purpose of which was to fund and establish drug and violence education programs as "essential components of a comprehensive strategy to promote school safety and reduce the demand for and use of drugs."[34] By the early 1990s the "war on drugs" had been "extended and systematized" by President Bush's "National Drug Control Strategy."[35] In total, between the years 1985 and 1993 the federal government's annual contribution for drug treatment, law enforcement, and education rose from $2.5 billion to $13 billion.[36]

According to Amos Kieve, "presidents are image makers. As such, they seek the opportunity to define situations and construct the reality they want the public to accept."[37] In the case of the "war on drugs," the Reagan administration's conceptualization and articulation of drugs as a threat to all Americans had a profound influence on the ways the public understood the "drug problem" and the kinds of policies that were enacted and seen as solutions.[38] Thus, while the "war on drugs" was driven by a variety of complex political concerns, President Reagan's description

of a national crisis of epidemic proportions garnered virtually unanimous bipartisan and public support for extensive and costly anti-drug interventions.

William Elwood claims that the Reagan administration's drug war was, in part, a series of "rhetorical, multifaceted public relations campaigns designed to enhance the images of specific political figures" and exploit public sentiment.[39] By launching a "crusade" against the drug "epidemic" the administration sought to garner electoral support during an era when anti-drug sentiment was high, relatively easy to exploit, and there was no substantial pro-drug opposition.[40] Mrs. Reagan's involvement in the "Just Say No" (JSN) campaign is also a clear illustration of Elwood's claims about the symbolic value of the "war on drugs." As a number of scholars have argued, Mrs. Reagan's involvement in and support for the JSN campaign partially concealed more complex political motivations.[41] According to Benze, the JSN campaign appears to have sprung, in part, out of White House concerns about Mrs. Reagan's negative public image and its effect on President Reagan's 1984 reelection chances.[42] In response to these worries, the White House embarked on an aggressive campaign to improve Mrs. Reagan's public appeal by highlighting her anti-drug stance.[43]

Mrs. Reagan's "just say no" catch-cry was as simplistic as it was popular. The message appealed to a moral conservative base concerned about the rise of permissive liberal humanism as well as various parent groups increasingly worried about drug use in schools.[44] Throughout the 1980s Mrs. Reagan made dozens of media appearances and anti-drug speeches across the country. What's more, the White House's strategy seems to have worked;[45] the press became more sympathetic towards her and in a 1985 cover story *Time* magazine concluded that "in the last two years [Mrs. Reagan] has probably become an outright political plus, winning friends and influencing people."[46] In addition to bolstering her public image, Mrs. Reagan's message reached more than 25 million youth, resulting in the formation of more than 12,000 JSN Youth Clubs across the globe and, over the next ten years, helped justify the allocation of millions of dollars in federal grants to schools for adopting the JSN approach to drug prevention.[47]

Aside from the symbolic value of anti-drug policies in generating political and public support, the discursive effects of the JSN campaign were enduring. Consistent with the JSN approach, drug policies advocated during this era offered largely reductionistic solutions that made no "acknowledgment of the economic, social, education, and political injustices that may breed the problem or raise the issue in the first place."[48] The campaign helped absolve the government of responsibility to address the complex structural issues associated with drug addiction and trade, even as they "claimed responsibility for resolving the drug problem by declaring war and proposing policies to ameliorate the situa-

tion."[49] At the same time, the rhetorical focus on the individual fitted neatly into the broader political program of scaling back the direct role of the government and urging youth to take personal responsibility for their behaviors. In significant ways, JSN "shifted the responsibility for social problems from the arenas of politics and medicine to morality."[50] Blaming the "hedonism and permissiveness" of individuals in the 1960s and 1970s, people who displayed a "flippant and irresponsible attitude toward drug use" also made it easier for the Reagans to frame problems and solutions in terms of self-will and restraint.[51] According to President Reagan, "law enforcement alone, [can]not significantly reduce drug abuse." Instead, he claimed solving the drug problem necessitated a "national crusade" directed at education.[52] Statements like this served to justify a variety of interventions intended to change individual attitudes, norms, and behaviors around drugs and drug use, of which school-based prevention programs became a central feature.[53]

Speculating on the complex contextual factors that gave rise to the rapid expansion of drug policies at the local, state, and federal levels described above may, in part, explain the rhetorical appeal of the JSN approach to drug prevention or why it made its way into schools. It does not, however, completely explain the widespread and long-standing optimism across the political spectrum about the effectiveness of school-based drug prevention. In the case of JSN, for example, support for the program had little to do with the actually efficacy of the approach in reducing risky youth behavior. Indeed, research pointing to the ineffectiveness of the JSN approach was often ignored.[54] Instead, advocates of JSN suggested that in the absence of the intervention, drug use would be even more rampant among youth.[55] In reality, perhaps the only thing JSN accomplished was to reassure some parents "that the schools [were] at least trying to control substance abuse among students."[56]

DRUG ABUSE RESISTANCE EDUCATION (DARE)

Reflecting the message and philosophy of JSN, the DARE program became one of the most widely utilized drug education curricula of the twentieth century.[57] Developed in 1983 by a partnership between the Los Angeles Police Department and the Los Angeles Unified School District, DARE operates through the nonprofit organization DARE America. Over the years the program has been funded by a variety of sources, including corporate sponsors such as McDonald's and Kentucky Fried Chicken, as well as through public funds from federal, state, and local entities. The curriculum consists of standardized, copyrighted anti-drug messages delivered to students by uniformed police officers who have undergone eighty hours of specialized training.[58] It targets fifth and sixth graders

and consists of seventeen weekly lessons lasting approximately forty-five to sixty minutes each.[59]

DARE is based on two related assumptions: 1) early intervention will maximize anti-drug effects; and 2) anti-drug messages can be effectively transmitted in a standardized, uniform manner.[60] According to the U.S. Department of Justice, the purpose of the program "is to prevent substance abuse among school children" by teaching students "the skills for recognizing and resisting social pressures to experiment with tobacco, alcohol and drugs."[61] Students are also taught life-enhancing skills such as self-esteem, decision making, coping, assertiveness, and communication. At various times the program has also asked students to sign a pledge indicating that they will avoid drug use.[62]

A number of factors have contributed to DARE's widespread popularity. First, the 1986 Drug Free Schools and Community Act (DFSCA), which tied federal funds to drug abuse prevention programs, led to the proliferation of anti-drug curricular materials. By 1990, there were more than one hundred drug education programs marketed to schools.[63] However, owing in part to specific congressional and legislative endorsements, DARE quickly became the prevention program of choice. It was, for example, the only school-based drug prevention program specifically identified in the DFSCA as a "model" approach.[64] Second, in 1990 $15 million of the federal Drug Free Schools fund was targeted for DARE, and in 1992 $50 million was proposed to increase its operational funding.[65] Federal funding of the program continued throughout the late 1990s and early 2000s. In 2000, the federal government provided approximately $2 million to DARE to support the training of new police officers. That same year the Department of Education provided more than $439 million to schools and communities under the Safe and Drug-Free Schools and Communities Act (SDFSCA) of 1994.[66]

Since its inception, DARE's stakeholders have established key partnerships with various political representatives, a strategy that has further contributed to its popularity.[67] Materially, these associations have aligned DARE with federal, state, and local government agencies that allocate funding. Discursively, these relations nourish the belief that the program is effective, comprehensive, and legitimate. In 1991, for example, the U.S. Justice Department argued that the DARE program represented a "long-term solution" to the nation's drug problem.[68] In 1992 President George Bush passed Senate Joint Resolution 295 designating September 10th National DARE Day. In his resolution Bush remarked that DARE has been responsible for keeping "millions of young Americans . . . off drugs, out of gangs and in schools." These students, he went on to claim, "are living testimony" to the program's effectiveness.[69] In 2000, President Clinton issued a similar statement. "Programs like DARE" he argued, work to "ensure that America's children have the skills, self-esteem, and guidance they need to reject substance abuse and

violence and to create for themselves a bright and healthy future."[70] These sentiments were echoed by President George W. Bush the following year: "Research has shown that ongoing reinforcement of drug prevention skills at home and at school play a critical role in decreasing the likelihood of drug use by our youth."[71] Owing in part to presidential endorsements like these, by the early 2000s the DARE program was being used in more than 80 percent of school districts across the country.[72]

Political popularity notwithstanding, DARE has been the subject of a number of evaluation studies that have called into question the program's efficacy. The preponderance of both short- and long-term studies have found minimal, if any, effect on future drug use and/or a change in attitudes about drug use.[73] Empirical findings have even suggested that DARE might have some outcomes that are contrary to its goals. An article published in the *Journal of Consulting and Clinical Psychology*, for example, revealed that DARE participation had an adverse effect on self-esteem when compared to nonparticipants. The authors conclude, "DARE status in the sixth grade was negatively related to self-esteem at age twenty, indicating that individuals who were exposed to DARE in the sixth grade had lower levels of self-esteem ten years later."[74] Another study, this one conducted by researchers at the University of Illinois, found that, among urban and rural youth, DARE's effects wore off by the senior year of high school. However, suburban youth who participated in the program were more likely to use drugs when compared to nonparticipants.[75]

Findings such as these prompted a Surgeon General's investigation, following which Surgeon General David Satcher concluded that DARE had a negligible effect on discouraging drug use; children who participated in the program were as likely to use drugs as those who did not participate. While Satcher acknowledged that DARE was the most widely implemented youth drug-prevention program in the United States and popular among educators, parents, and law enforcement officials, he voiced significant concerns about the program, pointing to a number of "well-designed evaluations and meta-analyses that consistently show little or no deterrent effects on substance use."[76] Specifically, Satcher criticized the program "for its limited use of social skills training and for being developmentally inappropriate." He further argued that the program was "implemented too early in child development: It is hard to teach children who have not gone through puberty how to deal with the peer pressure to use drugs that they will encounter in middle school."[77] As a result, Satcher removed DARE from the list of "effective" drug-prevention programs. Rosenbaum's review of thirty DARE evaluation studies found similar results. He writes:

> The results were very disappointing despite high expectations for the program. Across more than thirty studies, the collective evidence from evaluations with reasonably good scientific validity suggests that the

> core DARE program does not prevent drug use in the short term, nor does it prevent drug use when students are ready to enter high school or college. Students who receive DARE are indistinguishable from students who do not participate in the program.[78]

In 2003 a General Accounting Office report also documented significant concerns about the program.[79] Their results revealed no statistically significant differences in drug use between students who received DARE lessons and those who did not. Shortly thereafter, the Department of Education, a major DARE funder, issued a new rule regarding the use of federal funds. According to the new regulations, schools could only use federal funds for drug-prevention programs appearing on their list of evidence-based curricula, a list which did not include DARE. Despite the lack of federal funds to operate the program, DARE remained a popular program for many schools.[80] The shortfall in state or federal funding was often made up from other sources, including local police departments, local school districts, or city, town, or county budgets.

Advocates of DARE have consistently dismissed criticism about the program's efficacy and approach. In 1993 DARE's executive director Glenn Levant told the press that most of the studies that conclude DARE has no real effect are methodologically flawed and not comprehensive. "Scientists will tell you bumble bees can't fly," he claimed, "but we know they can."[81] Levant also claimed that critics were jealous of DARE's success. "We're like apple pie," he told reporters, "but I guess you can always find someone who doesn't like apple pie."[82] In 1997 DARE spokesman Ralph Lochridge also dismissed critics "as either failing to understand the program or as advocates of drug legalization."[83] At the same time as DARE has defended its approach, representatives have also claimed that the program has been revised to address critics' concerns. Researchers examining these modifications, however, are not convinced. Lynam and colleagues claim DARE's changes have not been significant enough: "any changes in DARE have been more cosmetic than substantive." Wysong and Wright concur, and suggest that despite the curricular alterations made throughout the 1990s, the approach and focus, by and large, has remained relatively stable.[84]

DARE's track record of inefficacy alongside the zeal with which many schools have clung to a narrative about its worth is perplexing and raises questions about the role and influence of evaluation research on policy. It also draws our attention to the role that policy rhetoric assumes in the midst of a moral panic, as with President Reagan's "war on drugs." A group of Harvard researchers recently considered the roles of evidence, efficacy, and ideology in school officials' decision to offer DARE even after the Department of Education cut funding for the program.[85] While their reasons varied, three dominant beliefs informed the decision to retain DARE. First, school officials indicated that they never expected

DARE to prevent drug use in the first place. Second, school officials believed program evaluators had "missed the boat" by focusing solely on drug use and not on the other social goals of the program they believed were equally, if not more, important (i.e., self-esteem, resisting peer pressure, etc.). Because of this, they were not deterred by evaluations suggesting the program did not reduce drug use. Finally, and related to the previous point, school officials did not believe the evaluation findings applied to *their* community because they felt DARE was indeed effective in their district. Taken together, the researchers concluded that school officials made decisions about the continuation of DARE based on their own affective response while denying the relevance of the empirical research evaluations. These results reinforce the important symbolic dimensions of school-based social programs like DARE in generating and sustaining political and public support. As other scholars have put it:

> The reassurance value of such programs can be viewed as linked to the extent to which they are grounded in widely respected and legitimate institutions and cultural traditions. Thus, ameliorative programs which are imbued with these potent symbolic qualities (like DARE's links to schools and police) are virtually assured widespread public acceptance (regardless of actual effectiveness).[86]

According to Kallis and Hahn, the popularity of DARE is simple to explain. The program remains persuasive, they write, because it asks "so little and promises so much. They do not ask for action, which requires effort; rather, they request effortless inaction."[87] DARE provides schools a one-size-fits-all approach to drug prevention that does not make any distinction between students.[88] It simply repeats a strict zero-tolerance message while avoiding the complexity of drug use behavior and refusing to grapple with the structural factors associated with the etiology of drug use, all issues that are probably impossible to adequately address in seventeen one-hour lessons.[89]

Likewise, Gorman believes that DARE remained popular for so long because of its promise and appeal: the "public tends to accept the existence of drug prevention in schools as a given and any suggestion that funding of such activities cease, elicits opposition."[90] But, he argues, if policy makers and school officials were to seriously consider the evaluation findings, the decision to pursue drug prevention programs like DARE would be, by no means, obvious. A 2004 *New York Times* article on DARE exemplifies Gorman's point. When asked about his continued enthusiasm and sponsorship of DARE in light of doubts about its efficacy, Marc Meyer, acting principal of Hampton Bays Elementary School, responded that while he had indeed heard about the potentially problematic evaluations, he had not read them because he believed the program was valuable. "It's [DARE's] a really good deal for the district," he told the reporter, Julia Mead, "I have to admit my view is skewed because I

love the program."[91] Educators and law enforcement officials in Chicago also defended DARE as a worthwhile effort: "I think if you asked our kids if the DARE program was worthwhile, they'd certainly say yes," said Howard Crouse, assistant superintendent of schools in Naperville and Aurora, Illinois. "Whether it actually works is practically unknowable."[92]

MORAL POLITICS: SEX EDUCATION

Our last example is a brief examination of the rise to dominance of abstinence sex education in American public schools during the 1980s and 1900s. With its connotative links to sexuality, morality, religion, and the authority of the family, sex education has been and continues to be a politically divisive issue. As the leading sex education historian Dennis Carlson puts it, sex education has also played a long-standing role in a "moral crusade" to advocate abstinence where purity becomes secularized through scientific discourses around issues of pregnancy and disease.[93]

In more recent years, however, debates about sex education have focused less on *whether* schools should teach these courses and more on *how* educators should go about it.[94] At the center of the debate are two competing approaches: abstinence and comprehensive sex education. While we accept that all educational endeavors have ideological dimensions, the ways in which supporters of the abstinence approach—most notably the religious right and social conservatives—have successfully mobilized political and financial resources to embed their moral agenda in schools and other areas of social policy are particularly striking. And precisely because of these maneuverings, we are able to describe some of the problems that arise when intractable ideological positions are supported by large sums of federal money in an attempt to use schools to impose a particular vision of how young people should live. To take an obvious example, the financial backing that a specific form of sex education has received means that schools, especially those experiencing budgetary pressures, are effectively coerced into adopting educational programs that may not suit the needs of their students or be consistent with the pedagogical values of its teachers. More than this, however, and as we saw with the DARE program, these funding incentives distract attention away from robust consideration of program effectiveness.

The most basic goals of sex education—that is, to reduce sexually transmitted infections, HIV/AIDS, and unintended pregnancy among young people—are relatively undisputed. Despite this, there remains a great deal of controversy about the methods to be used (i.e., what teaching techniques lead to the best outcomes) and the ideological intentions of its advocates (e.g., teaching particular moral values, or encouraging

autonomous decision making).[95] The central difference between abstinence and comprehensive sex education is that the former primarily frames sexuality as a moralistic enterprise, while the latter is driven by a belief that the dissemination of information and the development of critical decision-making skills will lead to responsible behavior.[96]

The abstinence approach holds that sexual relationships are only appropriate within the context of a heterosexual marriage. Contraceptive information is limited and "may even emphasize condom failure, the threat of death or serious illness (such as breast cancer or mental breakdown) from abortion and homosexuality, and the potential reversibility of homosexuality through religious faith and commitment."[97] Discussion of sexuality is framed as a means to identify personal values and build character. On the other hand, comprehensive programs assume that there are multiple approaches to teaching adolescents about sexual behavior. These programs emphasize access to information and knowledge. They also generally rest on the assumption that students should be prepared in advance to deal with the risks of pregnancy and disease transmission.[98] They seek to do this by providing opportunities for young people to discuss their own and society's attitudes toward different kinds of relationships, gain knowledge about their body, and develop skills to help them use contraception or resist social and peer pressure to have unwanted sex.[99]

Historically the federal government has not taken an active role in school-based sex education policy, leaving decision making to state and local governments.[100] While federal law cannot require schools to adopt a particular curriculum, it can use financial incentives to pressure and bait compliance. However, the federal government's laissez-faire approach with regard to sex education curricula shifted significantly in the 1980s and 1990s with the passage of three key pieces of legislation: 1) the Adolescent Family Life Act (AFLA); 2) Section 510 of the Temporary Assistance for Needy Families Act (TANF); and 3) the Special Projects of Regional and National Significance—Community-Based Abstinence Education (SPRANS-CBAE) grant program. These initatives, designed to promote a strictly abstinence-based approach to sex education, can be attributed to the growing political influence of social conservatives and the religious right as well as heightened concerns about the erosion of the country's moral foundation.[101] Using these anxieties as the leverage to bolster their position, conservative critics like William Bennett argued for schools to become a "conscious agent of community morality" by teaching about the value of chastity, conventional marriage, and traditional sex roles.[102]

In 1981 Congress passed the AFLA legislation, commonly referred to as the Chastity Act. This relatively small program awarded funds to public and nonprofit organizations to "promote self-discipline and other prudent approaches to the problem of adolescent premarital sexual relations,

including adolescent pregnancy," and "to promote adoption as an alternative for adolescent parents."[103] The bill was included in the Omnibus Budget Reconciliation Act and was passed without hearings or discussion. For social conservatives, the Act provided a mechanism to counteract existing federal programs that allowed for the distribution of contraceptives from agencies receiving federal funds. More important, however, "AFLA channeled funding away from organizations such as Planned Parenthood that provided a broad array of reproductive services, including abortion."[104]

AFLA was followed by the passage of Title V Section 510b of the 1996 Temporary Assistance for Needy Families Act (TANF). Signed into law by President Clinton, the Act was designed to overhaul the welfare system by reducing the number of welfare recipients, particularly unwed mothers. Like AFLA, it was signed into law with very little public scrutiny or debate. Indeed, "fifty million dollars' worth of funding for abstinence education was inserted in the bill during the final hours of negotiation, in a last-ditch attempt to reconcile the House and Senate versions."[105] Title V created an automatic annual appropriation for states to implement abstinence education programs in an effort to "promote the notion that out-of wedlock pregnancies were wrong for everyone, not just teens."[106] The legislation framed sex education as a "problem" of family values and called for the reestablishment of a "household headed by a breadwinner husband and father."[107] It mandated states to match every four dollars of federal funding with a three-dollar contribution of their own. California was the only state that did not accept the federal funds. The legislation also articulated a clear and definitive eight-point definition of abstinence education.[108] According to the federal definition of abstinence, a qualifying program must:

a. have as its exclusive purpose, teaching the social, psychological, and health gains to be realized by abstaining from sexual activity;
b. teach abstinence from sexual activity outside marriage as the expected standard for all school-age children;
c. teach that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems;
d. teach that a mutually faithful monogamous relationship in the context of marriage is the expected standard of human sexual activity;
e. teach that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects;
f. teach that bearing children out of wedlock is likely to have harmful consequences for the child, the child's parents, and society;
g. teach young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances;

h. teach the importance of attaining self-sufficiency before engaging in sexual activity.[109]

While it was expected that all programs would abide by this definition, they were given permission to emphasize some of the eight components over others.

In 2000 Congress approved the Special Projects of Regional and National Significance—Community-Based Abstinence Education (SPRANS-CBAE) grant program. This program provided block grants for community agencies and schools to implement abstinence-based education programs but this time did not ask states to match federal contributions. Similar to the welfare legislation, SPRANS-CBAE funds must conform to the eight-point federal definition of abstinence education, but now programs were also required to emphasize all eight points equally. Because of this requirement SPRANS-CBAE is considered by far the most restrictive of the federal government's funding mechanisms for abstinence education. In addition, the SPRANS-CBAE allows community agencies to completely bypass state governments as grants are awarded directly to the agency applying for the funds.[110]

These three initiatives have contributed to the development of a massive reserve of funds to promote abstinence programs in schools. In 2002, the federal contribution to the cause reached $102 million: "$12 million through AFLA ($10 million is earmarked for abstinence programs while $2 million is earmarked for abstinence-based programs), $50 million through the welfare reform legislation and $40 million through SPRANS-CBAE."[111] By 2007 nearly $1 billion had been dedicated to abstinence education.[112]

Critical to the successful passage of these three pieces of legislation has been the appointment of influential social conservatives to key policy positions. And, since congressional approval is not necessary for these midlevel positions, appointees were not required to publicly state their views on sex education.[113] Their influence and success in securing funding for abstinence programs has had a significant impact on state and local decisions to adopt abstinence education. Political appointees also played a variety of roles in national campaigns—organized by groups such as the Heritage Foundation, Focus on the Family, Concerned Women for America, Moral Majority, and the Eagle Forum—to discredit comprehensive education. The success of these campaigns has been quite astounding. In 1988, more than 93 percent of schools were teaching comprehensive sex education.[114] Less than thirteen years later, however, this figure would be completely turned around. A 2001 survey of school superintendents revealed that 86 percent of school districts had in place policies to support and require promotion of abstinence.[115]

Because abstinence education was ushered into schools lacking objective empirical endorsements it was not surprising—particularly for liber-

al advocates of comprehensive sex education—when results of evaluation studies revealed some disturbing findings about the efficacy of the approach.[116] In fact, studies revealed that abstinence programs did not affect teen sexual behavior, or reduce pregnancies or sexually transmitted diseases. They also found that abstinence curricula fostered negative gender stereotypes and contributed to the development of fear and shame among young people.[117] Beyond the important matter of efficacy, a United States House of Representatives report conducted by the Committee on Government Reform, Special Investigations Division, found that 80 percent of the abstinence curricula used by SPRANS-CBAE grant recipients contained "false, misleading, or distorted information about reproductive health."[118] The report documented that programs such as *Sex Can Wait, Why kNOw, Choosing the Best Life*, and *FACTS* contained numerous scientific errors, false information about the effectiveness of contraceptives and the risks of abortion, blurred the distinction between religion and science, and treated stereotypes about girls and boys as scientific fact.

This is not to say that the comprehensive approach to sex education is necessarily more effective. Historian Jeffrey Moran argues that out of the dozens of studies conducted by sociologists, psychologists, and educators, few if any draw conclusive findings to suggest that either side can claim victory on the grounds of efficacy: neither has "a significant effect in either direction on adolescent rates of intercourse, use of contraception and rates of unwanted pregnancies or births."[119] Correspondingly, Carlson claims that advocates on both sides of the debate conveniently overlooked the most important finding that emerged from all of the evaluation research: that it was of little consequence how much or what brand of sex education young people received in schools. He writes: "If sex education was about preventing or delaying sexual activity among adolescents, there was no indication it was making a difference."[120] By the same token, neither conservative fears that the comprehensive approach would lead to more sexual activity nor liberal claims that better or more knowledge about sex would change behavior is supported by the evidence.[121]

Perhaps the obvious ideological commitments of advocates, no matter on which side of the divide they sit, is enough to account for their continuing enthusiasm for sex education as an effective strategy to reduce pregnancy and disease. However, it is also worth considering whether advocates of both brands of sexuality education have also completely underestimated the complexity of the social problems they claim to be able to solve. As Moran puts it, perhaps sex educators have been locked into what he calls "delusions of expertise" or the belief that "all social problems may be solved if only reformers approach them with sufficient recourses, statistics and goodwill."[122]

We should also not overlook the role of self-interest. For example, advocating for particular kinds of sex education can have political advan-

tages. On the one hand, the Bush-Cheney campaign received enormous financial contributions from religious and socially conservative organizations that supported an abstinence approach.[123] On the other, sex education has also enabled political figures to appear as though they are addressing a social ill without really having to attend to the substance of the problem. According to Larry Cuban, few public officials have been willing to turn "down the chance to solve a national problem (even when they had no idea of how to go about it) or stopped to consider the adverse consequences of promising something that they could not deliver."[124] So while sex education may not make much difference to the sexual behavior of young people, it may be more effective as both a social blindfold and a vehicle for political advancement.

HABITS OF MIND

It is true that the three examples of school-based public health policy discussed in this chapter have all, in different ways, been implicated in party politics. As a result, some readers may wonder about their applicability to a discussion about the wisdom of school-based public health more generally. By way of response, we would reiterate that the purpose of this book is not to suggest that a school should never under any circumstances try to improve the health of the students who attend it. Rather, our focus has been and will continue to be the idea that America's school system can be used to achieve broad, collective, society-wide public health policy goals. With this as our frame of reference, we would argue that society-wide public health goals—like reducing obesity or teenage pregnancy or drug use—are *always* party political matters and yet it is this dimension which is routinely overlooked by advocates of school health. As often as not, school health performs a symbolic role that allows stakeholders to at least believe that something is being done. In fact, in order to be the kind of policy that is handed to the American public school system, it is inevitable that school health initiatives will either have party political origins or will have been molded and reshaped in order to pass through—as they must—the party political system. School health is, in part, a form of party politics; and this is why its actual effectiveness is often such a minor consideration when initiatives are formulated and announced.

But this is by no means all. We also need to accept that the kinds of school programs discussed above did, eventually, fall into the hands of government officials, school administrators, and teachers who believed in the value of these programs and sincerely wanted them to work. Invariably though, what these people have had to work with has been top-down, one-size-fits-all approaches to the health of young people. We would argue again that this is an inherent weakness in the idea of using

schools to solve society-wide public health problems. This difficulty is particularly acute where the focus of intervention is complex human social behaviors like eating, exercising, taking drugs, and having sex. Even if there were no other obstacles to contend with, such as the morally sensitive and politically contentious subject matter that school health often has to address, there would still be the hugely complex matter of trying to teach (and, in effect, tell) individual children in varying contexts how to live their lives. As we have seen in examples going right back to Horace Mann and America's first compulsory public schools, it is easy to dream the omnipotent dream of reshaping the minds, desires, and behaviors of young people. Schools, however, tend to be complex, busy places that juggle a huge range of priorities and community expectations. As a result, health concerns have always and will always have to compete for attention and classroom time with educational concerns that are seen by most people as far more pressing and important.

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SIX
Reforming the Self

For most of the remainder of this book we devote our attention to what has probably been, at least in Western countries, the twenty-first century's most written and talked about health concern: obesity. But before getting there, we think it important to set some context for the school health responses we discuss in chapters 7, 8, and 9. We have already seen that school health is a field of activity that reflects the political, social, and cultural circumstances and anxieties of the day. It would, of course, be surprising if school health did not do this, and yet our overriding point has been that schools are routinely saddled, both rhetorically and in practice, with broad collective panics, problems, and aspirations without detailed consideration of whether there is sufficient enthusiasm, time, expertise, or resources for schools to respond successfully.

Our central claim over the following chapters is that in order to understand the way American schools have been recruited into the war on obesity, a set of interlocking sociopolitical forces have to be factored into the picture. We need to stress here that we are not simply talking about the fact that schools have been asked to play a role in fighting obesity *per se*. It is quite obvious that the prevalence of overweight and obesity among American children has grown over the last fifty years and, therefore, not all that surprising that some policy makers would choose to involve schools. And while we think there are compelling grounds for doubting the capacity of public schools to do much about obesity, we accept that there also reasons for trying.

What the material covered in this chapter is intended to do, though, is to help us think critically about the *kind* of role schools are being asked to play. In other words, it is not so much that schools might choose to do something about obesity, it is the strategies used to do this which deserve attention. If we briefly cast our minds back to chapter 2, it will be recalled

that the sort of public health imagined by René Sand and George Rosen was politically engaged and concerned with the social inequalities that cause ill health. What would they make of the way obesity is being tackled in American schools? We think there are reasons to suspect they might be dismayed, particularly by the tendency for some obesity interventions, in effect, to demand that children take personal responsibility for their own weight status.

But we are jumping ahead. For now, we focus on sketching out what we see as the most important philosophical and political forces shaping how school health, particularly as it relates to obesity, is done. We begin with the neoliberal turn in public policy in general and its impact on schools in particular.[1] We do this in the knowledge that the term "neoliberalism" is understood and used in many different ways, a point that cautions against describing it as a singular coherent force. Nonetheless, it does serve as a useful shorthand for a range of widespread and reasonably well understood shifts in the way public policy is approached by Western governments.

THE NEOLIBERAL TURN IN SOCIAL POLICY

For a number of authors, such as Nickolas Rose, Graham Burchell, Bob Jessop, and Colin Gordon, neoliberalism has become the dominant ideological feature of Western political rationality.[2] On the one hand they see neoliberalism as accelerating the "hollowing out"[3] of the state and contributing to a "restructuring of government that favors market-based reforms, the application of non-binding and voluntary or self-regulatory mechanisms and greater public-private co-operation."[4] Some argue that neoliberalism has also been underpinned by an emphasis on privatization, deregulation, commercialism, devolution, and individualism.[5] According to Couldry, neoliberalism actually consists of a complex set of ideas that function as "common sense": ideas that legitimate the market and delegitimate the social at the same time that they require of its citizens "continuous loyalty, submission to surveillance and external direction even within the deepest recesses of private life."[6]

Neoliberal rationalities have transformed the role of government and the relationship between the individual and society.[7] Although a new form of political rule, they draw from aspects of classic liberalism, so the free market, individual autonomy and competition are seen as central to the smooth functioning of society. However, the extent to which neoliberalism helps people to be more rather than less autonomous is debated. Some see it as "not antithetical to political power, but rather is part of its exercise since power operates most effectively when subjects actively participate in the project of governance."[8] One key feature of neoliberalism that is central to the concerns of this chapter is its emphasis on com-

petition, accountability, surveillance, and responsibilization. No longer bound by sovereign rule, divine intervention, or threat of punishment, neoliberal rationality calls upon the entrepreneurial individual to "enter into the process of his or her own self-governance through a process of endless self-examination, self-care, and self-improvement."[9]

Concerning matters of health, neoliberalism offers individuals greater involvement in their own affairs, although this does not come without a price. Individuals must "assume active responsibility for these activities, both for carrying them out and, of course, for their outcomes, and in so doing they are required to conduct themselves in accordance with the appropriate . . . model of action."[10] Who gets to define the appropriate model of action is largely left to a diverse amalgam of agencies and institutions that have a vested, albeit tacit interest in shaping the new political subject. Some authors also point to the way neoliberalism seeks to "responsibilize" people, a process "in which the governed are encouraged, freely and rationally, to conduct themselves."[11] More than this though, taking responsibility for oneself is logically linked to the idea that failure is the result of personal failing and not the structure of society.

In some of his final writings, Michel Foucault discussed his ideas on governance through the concept of neoliberal governmentality.[12] The term governmentality is concerned with understanding the ways in which human lives are increasingly managed by institutional knowledges and practices. One way that this kind of governance takes shape is through the subtle micro-political practices which act directly on people through the shaping of their desires; those Foucault referred to as "technologies of the self."[13]

At the center of this new kind of disciplinary technology that Foucault describes is the goal of regulating and normalizing conduct through observation and surveillance. "The management of individuals is accomplished through disciplinary power, a strategy which allows the state to govern at a distance."[14] Because relations of power are by and large concealed, overt coercion is largely avoided.[15] It is through what Turner has called "the institutions of normative coercion" that individuals in contemporary society experience discipline and surveillance in their everyday life.[16] Turner uses the term coercive, however, not to describe a violent means of control because institutions like the school (or medical clinic, as Foucault described) are typically seen as legitimate means of authority. In this way they are unproblematically able to exert a kind of normalizing coercion via moral authority through defining, diagnosing, and offering solutions for problems, illnesses, or moral weaknesses. So while neoliberal governmentality may sometimes need to resort to overt domination and disciplinary techniques, it relies most heavily on the emergence of an ethic of self-governance. Foucault describes the state's power in this context as simultaneously totalizing and individualizing.

Caughlan explains: "It is totalizing in that it reasons in terms of populations and their control and government. It is individualizing in that it locates each individual and—through *both* disciplinary and pastoral techniques—seeks to instil *self*-regulation of desire and action."[17]

The vision of a healthy neoliberal citizen, then, is one who is not only *able* to examine themselves in a way that is consistent with dominant ideas about health, but one who also *desires* to do so. In fact, under neoliberalism it is no longer acceptable for citizens to exist in an unhealthy state. As Galvin states, ill health "clashes too uncomfortably with the image of the 'good citizen' as someone who actively participates in social and economic life, makes rational choices and is independent, self-reliant, and responsible."[18] Achieving and preserving one's health becomes necessary so that one might fulfil the other obligations of citizenship.[19]

We accept that there will be some readers who disagree with some or all of our discussion of neoliberalism here. Apart from anything else, it is important to concede that, to the extent that we can talk about a coherent neoliberal "project," in many places and in many ways it remains unfulfilled. It is not the case that we all live in a permanently and pervasively neoliberal state of being. However, since the early 1970s the ideas discussed in this section *have* shaped the way many people think about their own health and the health of others. As Howell and Ingham argue, following the economic shocks of the 1970s and the election of right-wing governments in the United States and Great Britain in the 1980s, a new language of "personal lifestyle" came to dominate the field of public health and the terms in which Western governments managed health policy. They write: "Through exercising smart lifestyle choices, the individual becomes personally responsible for his or her own quality of own [sic] life. The language of lifestyle is one of independence and self-sufficiency; it signifies pleasure, freedom, success and mobility."[20]

It is the pervasiveness of this style of thinking about health, rather than its absolute authority, that we are asking readers to keep in mind when they engage with the three chapters that follow this one. In the meantime, we now turn to the influence of neoliberal thinking on the governance of American public schools.

SCHOOL HEALTH IN A TIME OF REFORM

Neoliberal thinking has also had an effect on what is seen as the purpose of education and the indicators used to measure educational success. Felner and his colleagues argue that the impetus for neoliberal educational reform began following the 1983 publication *A Nation at Risk*.[21] As we mentioned in chapter 4, this document, authored by the National Commission on Excellence in Education, characterized American schools as mediocre, inadequate institutions, and that unless they were held more

accountable they would continue to erode the foundations of American society and its economy. It announced:

> Our Nation is at risk. Our once unchallenged preeminence in commerce, industry, science, and technological innovation is being overtaken by competitors throughout the world. This report is concerned with only one of the many causes and dimensions of the problem, but it is the one that undergirds American prosperity, security, and civility. We report to the American people that while we can take justified pride in what our schools and colleges have historically accomplished and contributed to the United States and the well-being of its people, the educational foundations of our society are presently being eroded by a rising tide of mediocrity that threatens our very future as a Nation and a people. What was unimaginable a generation ago has begun to occur—others are matching and surpassing our educational attainments. . . . We have, in effect, been committing an act of unthinking, unilateral educational disarmament.[22]

A Nation at Risk was followed by a series of similar reports during the late 1980s and early 1990s that claimed that America's economic decline could be blamed on the poor quality of its schools. This led to a wave of state and federal education reform agendas predicated on the goal of preparing students for global economic competition. One major effect of these reforms has been a general and significant narrowing of the curriculum in an effort to raise test scores, particularly in math and reading. This trend was given full expression in the George W. Bush administration's 2001 No Child Left Behind (NCLB) legislation, one of the most significant and influential federal educational reforms since the inception of mass public schooling.

The legislation is characterized by a rhetorical focus on tough standards, greater accountability, competition, and choice. It requires schools that receive Elementary and Secondary Education Act (ESEA) subsidies to annually test third to eighth grade students in reading and mathematics and aims to have 100 percent of students performing at the "proficient" level on those tests by 2014. Schools not making adequate yearly progress (AYP) toward proficiency are designated in need of improvement. After two years of failing to make AYP, schools are subject to a series of corrective measures, including allowing their students to transfer to other public schools. Fundamentally the act is premised on the ultimate authority of standardized testing mechanisms to measure school effectiveness.

This style of educational reform has been adopted to varying degrees all over the world. And while on the surface they may appear to have little to do with school health, concerns about children's health have over time become an important component of educational reform agendas. Joy Dryfoos, a leading advocate for school-based health services, claims there is growing recognition among those in the educational community that

school reforms such as the NCLB legislation will fail unless student health issues are prioritized.[23] Similarly, in 2003 the Centers for Disease Control and Prevention (CDC) claimed that it has never been more important to improve the health status of youth, and that school health programs and policies "play a critical role in promoting healthy behaviors while enhancing academic performance."[24] In their book *Schools and Health: Our Nation's Investment*, Allensworth and colleagues argued that students' academic performance will not improve without more attention on the health and well-being of youth.[25]

Discussion about the connection between health and academic performance tends to emphasize the need to reduce so-called "risky" lifestyle behaviors. Dryfoos, for example, claims that "an important outcome for effective schools is the promotion of healthy lifestyles and the prevention of high risk behaviors."[26] Referring to these as the "new morbidities," Dryfoos says that automobile accidents, homicide, suicide, violence, obesity, substance abuse, and unprotected sex are threatening a growing number of children and youth. Drawing on census data from the late 1990s, she estimates the proportion of youth at extremely high risk, high risk, moderate risk, low risk, and no risk to be 10 percent, 25 percent, 25 percent, 20 percent, and 20 percent respectively.[27] High-risk youth are characterized as "simultaneously . . . delinquent, failing in school, abusing drugs, and having early unprotected sex."[28] High-risk youths engage in similar behaviors but have not yet been placed in the juvenile justice system. Youth at moderate risk are occasionally truant, not doing well in school, experiment with drugs and alcohol, and have had sex. Low-risk youths may cut class occasionally but are in no serious jeopardy because of their behaviors.[29] The remaining 20 percent at "no risk" report none of these behaviors. Since poor decision making is primarily deemed responsible for almost all the health threats that youth face, teaching and regulating negative behaviors has become a primary goal of many school-based health initiatives. In short, school health has increasingly been linked to academic achievement while simultaneously encouraging students to see themselves as responsible, self-sufficient, risk-averse individuals.

The risky behaviors that have particularly dominated conversations about children's health in recent years include issues of obesity and poor nutrition. In fact, a growing body of research has focused on documenting the various ways in which children who are labeled overweight or obese routinely underperform in school. A study by Campos and colleagues found that children with "normal" weight had significantly higher IQ scores, had a broader range of interests, enhanced social skills, and greater speed and dexterity than those children who were labeled "obese."[30] A longitudinal study of 10,000 individuals tested at birth, age one, fourteen, and sixteen found that by age fourteen, obesity was associated with poorer school performance. This performance contributed to

a generalized low level of education, an effect the researchers claimed persisted until age thirty-one.[31] Another study concluded that "obese" children miss a mean of 4.2 days per school year when compared to 0.7 days for children of "normal" weight. Results of studies like these led Tara and Potts-Datema to conclude: "Despite the current lack of understanding about the directionality of the association between obesity and poor school performance, the fact that there is an association may be adequate to influence change in school policies and practices."[32]

In summary, the idea of an "effective" school has in recent years been tethered to the worldwide academic reform movement and its preoccupation with standardization and accountability. It is probably not surprising then that advocates for school-based health interventions, like those that focus on obesity, have linked their agendas to standardized test scores. One consequence of this has been to position school health in a subservient position to the standardization movement, thereby adding extra legitimacy to the movement. In fact, school health interventions are now seen as an economic investment with national benefits for the nation as a whole rather than an altruistic measure to compensate for social inequalities.[33] Of course, this also has the effect of making it harder to think of the value of school health initiatives outside of the narrow definitions of school "effectiveness" that justified them in the first place.

THE NEW PUBLIC HEALTH

It will come as no surprise to most readers that the impact of neoliberalism on public education has generated a huge amount of academic and popular debate. For many writers in this field, the application of neoliberal ideas to education represents nothing less than a premeditated attempt to demonize and dismantle public schooling in America. At the very least, it is blamed for causing untold damage to the fabric of public schooling and to the educational experiences of millions of students, particularly those from poorer backgrounds. We will admit to having considerable sympathy for this view and, as we argued in the previous section, we think there is clear evidence of the impact of neoliberal thinking on school health.

Nonetheless, there is a tendency among some academics who are critical of school health interventions to write as if neoliberalism were the root of all evil. This has particularly been true when school health activity has targeted obesity and young people's exercise and food-related behaviors. For some writers, the school-based war on obesity can be explained as a straightforward elaboration of neoliberal ideology.

Once again, our earlier discussions of neoliberalism should be read to indicate that we share some of these concerns. However, we also think there are grounds for complicating this analysis somewhat. We have

shown that policy makers have been recruiting schools under the public health banner for a very long time and, in some respects, the war on obesity is simply another example of this pattern. There is also something a little convenient in the mono-causal neoliberal narrative. In particular, blaming neoliberalism tends to frame discussions about school-based obesity interventions within a standard left-versus-right argument, such that the things we might not like about these interventions can be sheeted home to the friends of corporate capitalism and their ideological allies.

This line of thinking also overlooks that public health as a field of study and policy development changed and splintered during the twentieth century. For example, statistical epidemiology came to dominate the field after the Second World War, creating an unapologetically mathematical orientation toward public health. As we saw in chapter 2, a number of René Sands and George Rosen's social medicine contemporaries clearly thought public health could be turned into an ultrarational, statistically driven new science. More broadly, with the influence of the "sanitarians" waning in the years following the First World War, public health took on a more clinical and biomedical hue. This is a complex matter, but historians tend to characterize public health in the twentieth century as gradually moving away from its socially reformist roots during the Progressive era and morphing into a more industrial and hospital-focused enterprise. This is in some respects understandable; laboratory-based scientists were generating fresh insights into the biology of disease, thus generating new areas of medical specialization and bringing the individual body of the patient into greater focus at the expense of the population as a whole.

By the 1970s these developments had produced their own reaction in the form of what became known as the "new public health." Although far from unified or monolithic, the new public health brought together people with a range of grievances about the direction health policy had taken in the Western democracies. It is worth remembering that this was a time of radical and, in some cases, revolutionary left-wing thinking around the world. Health was no exception. We have already mentioned McKeown's book *The Modern Rise of Population* in chapter 2. First published in the mid-1970s, the book was the culmination of a thesis McKeown had been developing for some years: that improvements in life expectancy in wealthier countries were predominantly the result of improving living standards—particularly nutrition—and not advances in medical science or clinical procedures. So, while the prestige of medical science and its practitioners had risen enormously in the twentieth century, McKeown's thesis was an attempt to knock them off their pedestal. In this respect, he was by no means alone. Other lines of attack were also being pursued by writers with a wide range of ideological agendas: feminists, environmentalists, neo-Marxists, and many others.

One of the legacies of this period was the idea of a "new public health." Although used many times in the previous one hundred years, *this* new public health stressed the importance of thinking about health in holistic, political, socially just terms. In this view, biomedical approaches to health favored those with enough money to pay for it, while overlooking the social causes of ill health and, in particular, health disparities. Importantly, its proponents tended to stress the idea that people had the capacity to take a more engaged and "empowered" role in their own health. In other words, they wanted to democratize health by disrupting the image of the all-powerful and all-knowing white male physician.

As with much of the radical thinking of the 1960s and 1970s, the new public health affected a limited amount of immediate political change. Outside of mainstream politics, however, nongovernmental bodies like the World Health Organization proved especially receptive and, on the back of a blizzard of policy statements, manifestos, conferences, and calls to action, a fresh chapter in the intellectual history of public health was launched. One area where its influence was felt most acutely was in schools and health education curricula, although this varied greatly in different parts of the world. In fact, for a number of authors schools, like the home and the workplace, became one of the many nonmedical sites in which health could be pursued. Rather than something that happened *to* people in hospitals and the doctor's consultation room, health could be "promoted" almost anywhere.[34]

As a broad and diverse social movement, the new public health is not something about which one can offer glib judgments. The brief account we have offered here necessarily glosses over its complex history and the kaleidoscope of philosophies and political allegiances that shaped it. Certainly its broadly social outlook on health has infiltrated mainstream thinking including, but by no means only, the resurgence of interest in preventative health in recent decades. Inevitably, though, its ideas attracted many critics, especially those who also saw it as naïvely idealistic and too radical to be of any practical use.

For our purposes, though, one line of critique is particularly relevant. An early example of this is captured in Robert Crawford's 1980 article "Healthism and the Medicalization of Everyday Life."[35] While acknowledging its noble intentions, Crawford argued that the new public health had helped to expand the definition of health to such an extent that there was now little to stop it becoming not only a right but also a responsibility. In other words, if everyone *could* take a hand in their own health, it was a short distance to arguing that everyone *should* do so and, therefore, be held accountable for the conduct of their lives. Suddenly, health is everywhere and everything, and there is no escape from the pronouncement of experts who claim to have our best interests in mind. As Crawford pointed out, all social movements, particularly those with explicitly

and radically transformative agendas, contain the seeds of new forms of oppression:

> If, in our enthusiasm for changes oriented toward creating new individual and social capacities freed from domination, we fail to identify aspects which may contradict those objectives, we risk repetitive disablement. Even the most radical challenges to orthodoxy are at best partial and always contain within their conceptions and structure the very elements against which the challenges are aimed. In the process, dominant ideologies and social structures are reproduced. Whether from external manipulation or internal conception (in some ways a false dichotomization), movements contain ideological contradictions from their inception. Such contradictions cannot be grounds for dismissal, but neither should they be ignored.[36]

The coercive tendencies in the new public health and its socially oriented offshoots have provided social scientists with a rich vein of material. In the context of this book, however, the important point is that blaming neoliberalism for school health initiatives that we may not like is, at best, only a partial explanation. Readers with an interest in the subject could consult Michael Fitzpatrick's highly readable polemic *The Tyranny of Health*, which charts the way the socially progressive aspects of the new public health merged with, and were taken up by, conservative and neoliberal political agendas in the 1980s and 1990s.[37] For now, we would simply offer that contemporary school health interventions, and particularly the enthusiasm for using schools to fight obesity, are the product of a politically hybrid past, rather than the expression of any singular or coherent vision.

HANDING OBESITY TO SCHOOLS

While relevant to school health, the new public health, the general neoliberal turn in social policy and its elaboration in the international educational reform movement, are probably best thought of as the background against which American schools have been drawn into the war on obesity. In this section we deal with a far more immediate contextualizing force and one which has dominated discussion about the success or otherwise of schools in reducing obesity.

In 2004 President George W. Bush signed into law the Child Nutrition and WIC Reauthorization Act (P.L. 108-265, Section 204). The impetus for the bill came, in part, out of increasing concerns about rates of childhood obesity and the ways in which school environments may be contributing to them. Not surprisingly, the bill was also announced as a strategy to improve academic achievement.[38] In the early 2000s, a number of national organizations, including the CDC, the American Academy of Pediatrics (AAP), and the Institute of Medicine (IOM), urged schools to make a

greater contribution to the public health campaign against overweight and obesity. Schools were asked to change their nutrition policies and adopt more stringent standards governing the sale of competitive foods: that is, foods sold outside the federally sponsored meal programs.[39] However, as we discussed in chapter 5, legislative changes involving school food have been a historically contentious matter and, as such, legislators have been reluctant to impose rules that would take decision-making authority out of the hands of local educational governing agencies (LEAs).[40] With this in mind, the bill was designed to strike a compromise between public health advocates and LEAs that wanted to retain jurisdiction over school food. According to Republican John Boehner, chairman of the House Education and Workforce Committee, the "Act strikes the appropriate balance between encouraging healthy environments that will address the childhood obesity epidemic while preserving local control for states, communities, and schools."[41]

Not all agreed with Boehner's conclusion. According to many Democrats and members of the public health community, the Act represented yet another concession to private interests. Thus, while medical and public health advocates had intensified their calls for stricter anti-obesity legislation, the food and beverage industry lobbied hard against federal action that might undermine their ability to use schools to generate profits. Generally speaking, Democrats sided with the public health community and supported federal restrictions while Republicans resisted changes to the existing regulatory environment. If successful, the Democratic proposal would have given the secretary of agriculture authority over all foods in schools and was expected to result in either the removal of vending machines or, at the very least, would have subjected vending machine content to more stringent nutritional regulations. On the other hand, Republicans wanted authority to remain in the hands of LEAs, effectively allowing schools to continue to do as they had always done.[42]

Unable to reach consensus and ultimately bowing to industry pressure, Congress sided with Republicans and decided to require all LEAs to develop a wellness policy in which they would set their own goals for nutrition and physical activity for staff and students[43] as well as a wide range of other health matters. As a minimum, the mandate stated that their wellness policy must: (1) include goals for nutrition education, physical activity, and other school-based activities designed to promote student wellness; (2) include nutrition guidelines for all foods available on each school campus during the school day with the goal of promoting health and reducing childhood obesity; (3) provide an assurance that the guidelines for reimbursable school meals would not be less restrictive than regulations set by the secretary of agriculture; (4) establish a plan for measuring implementation of the local wellness policy by designating at least one person responsible for operationalizing an assessment protocol to ensure that the school meets the local wellness policy; and (5) involve

parents, students, representatives of the school food authority, the school board, school administrators, and the public in the development of the school wellness policy.[44]

On paper—and perhaps somewhat ironically, given that the legislation was essentially born of a desire to limit federal intervention—the legislation had the potential to significantly expand the reach and scope of federal control over schools. All LEAs participating in the Department of Agriculture's National School Lunch Program (NSLP) or any other federal child nutrition program was required to comply with the new legislation. Tying the legislation to school meal and nutrition programs was presumably intended to increase LEA compliance with the Act since 90 percent of students attend a school that participates in at least one federal program of this sort.[45] And while there is nothing novel about the federal government using participation in existing federally sponsored programs as a method of identifying policy targets and encouraging compliance, it often results—as it did in this case—in the creation of an unfunded legislative mandate.

According to Congress, giving LEAs the responsibility for developing their own wellness policies would secure the local community's involvement and endorsement. Additionally, while the federal legislation provided the broad policy framework, it was argued that the unique health issues of individual communities could be more adequately addressed with locally inspired policies as opposed to federally crafted ones. The legislation also required LEAs to develop accountability measures to ensure the mandate was not ignored by schools. LEAs were given until the first day of the 2006-2007 school year to meet the stipulations of the mandate.

The passage and subsequent implementation of the wellness legislation do not lend themselves easily to analysis. On the one hand, the legislation is a straightforward example of federal authorities using schools to avoid conflict with the powerful food and beverage lobby and its lucrative vending machine contracts with schools while still wanting to appear to be taking action on obesity. Complicating matters, however, was the crowded anti-obesity policy environment that already existed in many schools. In fact, across America in individual schools, districts, and states, myriad obesity-related policies, guidelines, and rules had been created in the late 1990s and early 2000s. With the passage of the 2004 legislation, many individual teachers and administrators were confronted with yet another complex and onerous compliance challenge.[46]

The passage of the federal wellness policy legislation set off a flurry of health-related policy activity in American schools. While it is difficult to know if all the subsequent measures enacted were created as a direct result of the federal legislation, state mandates, or in response to the attention childhood overweight and obesity were garnering in the news media, our research suggests that, for many schools, the legislation pro-

vided a further impetus to either formalize existing policies or create new ones. Either way, the wellness policy legislation became the platform for schools to develop and promote their anti-obesity initiatives. But despite giving the impression that schools were eager and able to create healthier environments, a critical examination of the actual policies crafted in response to the legislation reveals a much more complicated narrative.

As expected, many schools remained unwilling to compromise their lucrative vending machine contracts. At the same time, according to the wellness policy legislation, schools had to set nutritional standards for foods even though there was no specification on what these standards should be. In other words, the content of policies did not matter, as long one existed. Nonetheless, schools found themselves under pressure by nutrition advocates to eliminate high fat, high sugar items. As a result, many schools implemented a maximum "unhealthy" content policy in which, for example, a maximum percentage of unhealthy foods contained in vending machines was designated. Unhealthy foods could still be purchased from vending machines and could be presumably replaced if and when vending machines ran out of these products.[47]

Some schools developed wellness policies that contained exceptions for certain grade levels or time-of-day restrictions. For example, some turned their vending machines off at particular moments of the school day but turned them on again during other times. California's Phelan Elementary School's policy is even more curious. Their food policy states: "Students may bring a nutritious snack to eat mid-morning. Students bringing snacks without nutritional value (i.e., chips, cookies) will be asked to save those items for lunch time."[48] A slight variation exists in Arkansas where elementary students are only able to have three-fourths of a cup of French fries or fried potato products once per week. At the middle and high school level, however, students are allowed one cup and one and one-half cups of French fries and fried potato products, respectively, and are allowed to eat these as often as they like.[49] As with the other examples cited here, if weight reduction is the goal, it is difficult to see how small reductions in the availability of "unhealthy" foods could be seen as an effective or significant policy response. More to the point, if these foods are so unhealthy that portion and access maximums need to be set, why sell these foods in the first place?

Some schools have gone to great lengths to specify what foods are "appropriate" for children to bring from home and what foods are banned. In light of the additional effort required to create, communicate, and enforce these policies, the discrepancy from list to list is intriguing. For example, some schools banned items like fruit rollups, saltine crackers, pudding, vegetables and dip, and/or graham crackers while other schools find these items not only acceptable but actually placed them on their "appropriate" list. Strangely, in Mississippi the Frito-Lay Baked Doritos, Nacho Cheese Flavor, appear on both the approved as well as the

banned list. Specifically, the one-ounce bag was listed on the denied list and the 1 3/8-ounce bag is on the approved list. Despite containing more calories and fat, Mississippi officials claimed that the larger bag of Doritos is healthier as it contains at least 5 percent of the recommended daily value for fiber, Vitamins A, C, D, and E, calcium, iron, thiamine, niacin, riboflavin, zinc, and three grams of protein. Due to its size, the smaller bag does not meet these standards and is subsequently banned. Schools not wishing to engage in this kind of food administrivia could have followed the lead of one Chicago, Illinois, school. In April 2011 the principal of Little Village Academy banned home-packed lunches in an attempt to "protect students from their own unhealthful food choices."[50]

What kind of food can be served during classroom celebrations was also a subject of intense debate. In the early 2000s the state of California passed some of the most stringent school food policies in the country. Much of this activity was led by Democratic Senator Martha Escutia's attempts to strengthen nutritional standards at schools. For example, she proposed a bill that would require all vending machine snacks sold on campuses during school hours, and a half hour before and after, to meet certain nutritional requirements. She proposed that each item should contain no more than 35 percent of calories from fat, no more than 10 percent from saturated fat, and no more than 35 percent of the product's weight should come from sugar. Her proposal was met with mixed reactions around the state. On the one hand, some health advocates argued that the suggested requirements were not strong enough and urged the state to "completely ban junk food, even celebratory cupcakes, homebaked cookies and birthday cakes, on campus and during all after-school events."[51] According to reporter Stacy Finz, Escutia's plan sent another "faction of teachers and parents into an apoplectic fit."[52] Arguing that schools are dependent on the money generated from vending machine sales was the primary justification for their opposition. According to Angie Scott, a parent at a California high school, "Nutritious food is important, but it's expensive. And if we can't continue to fundraise, we're going to lose our athletic programs. And exercise should be the biggest component of keeping our children healthy."[53] Other schools simply wanted to bypass the state altogether and implement their own approach. Bret Harte Elementary School in San Francisco, for example, eliminated their vending machines including the one in the teachers' lounge because the principal thought selling soda to teachers sent children a contradictory message. The school also held regular "carrot parties" and in instances where homemade treats were permissible, teachers were to encourage parents to use healthier substitutes like yogurt when making baked goods.

In addition to efforts to regulate what students should be permitted to eat, there were also efforts to track students' consumption patterns. In San Antonio, Texas, the school district, working in collaboration with the

United States Department of Agriculture, implemented a $2 million research project that photographs students' food trays before and after they eat lunch. According to Paul Weber, reporter for the *Denver Post*, a "computer program then analyzes the photo to identify every piece of food on the plate—right down to how many ounces are left in that lump of mashed potatoes."[54] The program then calculates the number of calories that the student has consumed. The data are then sent home to parents, apparently in the hope that "eating habits at home will change when moms and dads see what their kids are choosing in school."[55] In a variation on this theme, Texas's St. Mary's Catholic School have implemented a lunch policy in which students are not allowed to refuse fruit and vegetables for lunch while staff are required to periodically monitor the amount of food waste.[56]

The increasing culture of surveillance is one of the most notable features of America's post-2004 school-based war on obesity. The testing and measuring of students' bodies and physical capacities is now widespread and exemplified by Delaware, Georgia, Texas, and California's FITNESSGRAM regime which collects and publicizes the results of a series of physical fitness tests on children. Another somewhat contentious example of this is the spread of weighing and Body Mass Index reporting although these have been discontinued in some contexts because of doubts about the value or ethics of these practices. Teachers, too, are subject to increasing surveillance.[57] While a call to weigh teachers in Hawaii seems to have been unsuccessful, other policy initiatives have restricted what teachers can eat and drink at school or, in other cases, forced them into lifestyle "improvement" programs that are linked to their health insurance benefits.[58]

The federal wellness policy legislation also required LEAs to create policies and practices to promote physical activity among students. Importantly, however, it made a clear and strategic distinction between physical activity (PA) and physical education (PE). That is, it did not specifically require schools to alter their formal, curriculum-based physical education requirements. Instead, it asked schools only to implement physical activity practices, a move that opened the door to rather creative interpretations about what actually constituted physical activity. Texas's 2005 Senate Bill 42 states that recess breaks could count toward the thirty minutes of daily physical activity that kindergarten to year nine students should participate in, raising the obvious possibility that schools might have to make no change at all in order to comply. Elsewhere, debate raged about whether participation in marching bands or cheerleading could count toward physical activity policy requirements. The controversy about the strenuousness or otherwise of playing in marching bands became the subject of research and elicited responses from a variety of professional bodies such as the California Association for Physical Education, Recreation, and Dance which came out firmly against marching

bands.[59] In fact, as we will suggest below, the introduction of physical activity and physical education policies and guidelines for schools has had little obvious effect other than to spark a great deal of discussion about definitions and compliance.

As these examples illustrate, independent local and state initiatives to address childhood obestiy were advocated for and enacted in addition to the federal legislation. With multiple directives coming from various governing bodies, schools and LEAs now faced something of a compliance nightmare. To manage the situation, some states created systems of bureaucratic oversight. The state of Mississippi provides an interesting case in point. In 2007, Mississippi passed the Healthy Students Act (S.B. 2369) into law, an Act widely praised in state and national media for its stringent standards. The Act created policies and guidelines about a great many food and physical activity matters, including food preparation, marketing, sales, consumption, the minimum number of weekly instructional minutes for physical and health education for each grade level, and definitions of "healthy" food and beverages.

As well as wide-ranging in its scope, the Act also increased the complexity of implementation by specifying the number and kind of individuals needed for local policy development. Overseeing the enactment of the entire bill, for example, was the recently created Mississippi Office of Healthly Schools, a branch of the Mississippi Department of Education. The legislation also created the position of "physical education coordinator," whose job was to assist school districts with

> current and effective practices and on implementation of physical education and physical activity programs . . . [and to] monitor the districts for adherence to current Mississippi school accountability standards and for implementation of the physical education curriculum on file with the State Department of Education.[60]

The Act stipulated the precise qualifications needed for the position and that the appointment process for the position needed to include consultation with the Governor's Commission on Physical Fitness and Sports, the Mississippi Council on Obesity Prevention and Management, the Task Force on Heart Disease and Stroke Prevention, the Mississippi Alliance for Health, Physical Education, Recreation and Dance, and the Mississippi Alliance for School Health. At the local level, district school boards were instructed to form a health council in every school in the district. Each school health council had to consist of parents who were not employed by the school district, the director of local school food services, teachers, administrators, district students, health-care professionals, the business community, law enforcement, senior citizens, the clergy, nonprofit health organizations and faith-based organizations. Among other things, school health councils were required to formulate and recommend policies on health education, physical education, nutritional ser-

vices, parental/community involvement, instruction to prevent the use of tobacco, drugs, and alcohol, physical activity, health services, healthy environment, counseling and psychological services, healthy lifestyles, and staff wellness. On all these policy areas, school health councils were instructed to "adopt rules and regulations that may be more stringent but not in conflict with those adopted by the State Board of Education."[61] Mississippi's actions, while comprehensive, are not unique. Most states have similar kinds of policy agendas with governing bodies to regulate them. Today, school leaders across the country are expected to navigate a complex, multilayered regulatory environment consisting of federal, state, district, and school-level policies, as well as doing all the apparently necessary compliance work.

As the Mississippi example suggests, the assumption that schools could and should be used to fight obesity has spawned a great deal of legislative activity. And while we might have doubts about the merits of the legislation and policies that have actually emerged, it is worth remembering that much of this legislative activity produced nothing at all. Between 2003 and 2005, for example, more than 700 obesity-related bills were introduced in U.S. legislatures. Of these, only 17 percent were actually enacted.[62] A report titled "State Legislative and Regulatory Action to Prevent Obesity and Improve Nutrition and Physical Activity," authored by the National Center for Chronic Disease Prevention and Health Promotion (a division of the CDC) estimated that during the 2009–2010 state legislative sessions, more than 1,700 bills related to issues of nutrition, physical activity, and obesity were proposed, of which less than 20 percent were actually enacted.[63]

Since its enactment in 2004, a number of studies have attempted to document the effects of the wellness policy legislation. It is perhaps not surprising that the research literature suggests that while the majority of American schools have attempted to comply with the wellness legislation, some teachers and administrators remain ignorant of its existence.[64] Where policies do exist, wellness policies tend to be weak[65]—in many cases woefully so[66]—and created in haphazard and problematic ways.[67] At the same time, we are not aware of any LEA being sanctioned under the legislation for not having a wellness policy or having a substandard wellness policy.

Belansky and colleagues' study of forty-five elementary schools in Colorado revealed that districts had a great deal of difficulty meeting the requirements of the bill as a result of competing educational priorities, lack of resources, expertise, and accountability measures.[68] They also found that the wellness policy initiative had led to a net *reduction* in physical activity among students at school; while physical education increased by fourteen minutes per week, general physical activity decreased by nineteen. Dyson and colleagues' in-depth study of the response of eight high schools in Mississippi and Tennessee to new physi-

cal activity and physical education policies found that "Even though new PE and PA legislation had been passed in both states, no substantive change occurred in any of the schools."[69]

A national survey confirmed that while 95 percent of students were enrolled in a school district with a wellness policy by the beginning of the 2007-2008 school year, only 56 percent of students were in a school district with a policy that actually complied with the federal mandate.[70] The survey also found that even within districts with established wellness policies, these were underdeveloped, fragmented, and lacked appropriate implementation and monitoring. Many policies were written with such vague language that they did not necessitate schools taking any action at all. For example, policies were often written as recommendations that schools *should*, *try*, *might*, or *make an effort to* implement a particular course of action, a not altogether surprising outcome given the unfunded nature of the legislation.

In their review of research into the effect of the wellness policy legislation, Metos and Murtagh concluded that schools experienced a long list of obstacles and disincentives in meeting the requirements of policies and guidelines, including a lack of resources and accountability measures, as well as the higher priority schools give to other activities such as high-stakes testing.[71] They found that few school districts had appointed staff to oversee policy development and implementation. Most fundamentally, Metos and Murtagh found no evidence of any kind of a relationship between wellness policies and child or adolescent body mass index (BMI).

Led by Jamie Chriqui, a 2009 Robert Wood Johnson report into the wellness policy legislation concluded that, "while the majority of the school districts are following the letter of the law, they aren't really following the spirit of the law." The report reiterates the complaints of public health officials and school personnel about the lack of technical, administrative, and financial support. Moreover, it points to the failure of the legislation to require "evaluation of the implementation or effectiveness . . . or any provisions for reviewing and revising the wellness policy."[72] We think it is telling, however, that Chriqui and her colleagues, along with the other reviews cited above, appear to assume that, first, the Act authentically embodied "a spirit" *to* violate and, second, that violating this "spirit" was the problem rather than the legislation itself.

Healthy, Hunger-Free Kids Act of 2010, Wellness Mandate

On December 13, 2010, President Obama signed into law an amended wellness policy provision, Section 204 of the Healthy, Hunger-Free Kids Act (HHFKA) (P.L. 111-296). Among other changes, the Act added Section 9A–Local School Wellness Policy Implementation, a change that effectively expanded the 2004 wellness policy requirements. The HHFKA is

generally seen as Congress's attempt to address some of the shortcomings we have just outlined in the 2004 bill, although whether the result is an improved policy framework, particularly as this relates to the wellness policy provision, is debatable. Specifically, the following changes were made to the bill in an effort to strengthen participation, increase transparency, and aid in its implementation:

- Elements of the Wellness Policy—Local wellness policies must now include goals for nutrition promotion.
- Stakeholder Involvement—LEAs are now required to include teachers, physical educators, and health professionals to participate in the development of the wellness plan.
- Public Notification—LEAs are required to inform the school community and public about the content and implementation of the wellness plan.
- Measuring Implementation—LEAs must routinely assess their wellness plan and make this information available to the public. In particular, LEAs must report on which schools are in compliance and how their wellness plan compares to state and federal model plans.[73]

Given these relatively minor alterations (including to nutrition promotion, involving more stakeholders, and greater efforts to disseminate implementation information), there must be doubts about whether the proposed changes adequately address the central concerns raised in the evaluation studies discussed above. In other words, the HHFKA's wellness provision is strikingly similar in form and function to the 2004 legislation. The 2010 wellness policy legislation still does little to discourage ineffective, onerous, ethically dubious, obtrusive, or just plain silly interventions. Where there have been attempts to discourage ineffective interventions (for example, by mandating that LEAs mirror "model wellness policies") this seems contrary to the initial justification for having local communities develop wellness policies in the first place: that they best understood the needs of their local community.

What is more, there remains a continued lack of concern for questions of efficacy. LEAs are expected document, measure, and publicize the implementation and evaluation of their policies, but to what end? In fact, perhaps the most telling aspect of this legislation is that it remains an unfunded mandate at the local and state level. Because of this, most state agencies that were charged to ensure LEA compliance have been provided little guidance or opportunity to develop the infrastructure, resources, or expertise to do this. In other words, when in fact LEAs do submit their wellness policy to their state agency, in many states there exists the possibility that these will not even be reviewed. Our multiple attempts contacting various state agencies to determine how wellness policies are assessed have been largely unsuccessful. As far as we can tell,

there are few, if any, states with a formal system of reviewing and assessing wellness policies. More than this, we are still unaware of any school that has been penalized for noncompliance or has had its wellness policy rejected. It appears to us as though the wellness policy initiative mirrors the entire field of school-based public health in that it is dogged by the mistaken assumption that schools have the necessary skills and resources to wage an effective war on obesity, a war which, it is worth remembering, has generally proved beyond epidemiologists and public health experts.

Again, we would emphasize here that the wellness policy legislation owes its existence to political compromise and expedience, a point amply demonstrated by its unfunded nature. While it had the effect of earning some praise for the federal government, it effectively shifted the burden and cost of substantive action to the states and LEAs. For the federal government, one way to avoid conflict with state and local authorities was to ensure that these mandates attracted at least some praise from health advocates without necessarily requiring significant material change on the part of schools. The wellness policy legislation and the policy environment it fostered are clearly characteristic of this tactic. Moreover, the wellness policy legislation was publicly justified as a necessary obesity reduction measure despite little empirical evidence that it could achieve this goal. We should hardly be surprised, then, if a policy primarily designed to achieve political compromise and lacking in theoretical or methodological rigor should fail to achieve its purported goal.

One goal of a book like this is to offer, however tentatively, some transhistorical "truths" that summarize the historical terrain we have covered. Most obviously, we have tried to show that school health always has a political and ideological motive behind it which may be more salient than its purported connection to health. Balanced against this, and as we argued in chapter 5, no two examples are identical. This will be important to keep in mind over the following three chapters because the context out of which school health initiatives emerge will help to explain the form they take. That is, by understanding the reasons behind particular examples of school health, we are in a better position to understand and respond to the misgivings we might have about them. In the case of obesity, we spend the next three chapters describing some serious misgivings indeed. Our hope is that the background we have provided in this chapter will give at least some readers reason to pause and consider our arguments rather than dismissing them as mere iconoclasm. Put another way, our hope is that a little history may at least offer some different ways of seeing the present.

NOTES

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SEVEN

Obesity, Schools, and History

So far we have said virtually nothing about a familiar and everyday part of school life that most people would see as health related: physical education. Historically, physical education's place in the curriculum has been predicated on a dizzying range of goals and aspirations, from preparing children for factory work and war to teaching them to co-operate, follow rules, and cope with the vicissitudes of life. Like the idea of the school itself, physical education has proved equally adept at meaning almost anything to anyone.[1] However, a constant through all of this has been the indestructible cliché of a healthy mind in a healthy body, an idea so powerful that it has ensured a place for physical activity in schools and jobs for generations of physical educators for well over a century.

Until recently, the health benefits of school physical education have rarely been measured or tested, a situation that seems perfectly reasonable given that the long-term benefits of using school time to study history, play musical instruments, learn a foreign language, or almost any other educational activity are also generally not measured. In the last thirty or forty years, though, the potential of physical education classes to prevent chronic disease and, more recently, obesity has become a pressing matter. The reason, of course, has the been the increasing attention given to non-communicable diseases in Western countries, probably starting in the 1970s[2] and, more recently, significant increases in the number of people classified as overweight and obese. The result of this been a proliferation of research that attempts to measure what children do in physical education classes, the benefits they might derive from doing so, and ideas about how to make physical education more health enhancing. In fact, it is probably not going too far to suggest that the health implications of physical education and school-based physical activity have become something of an academic industry in itself.

At the beginning of this book we asked readers to suspend their preconceived ideas about its subject matter. We did this not from the naïve hope that this alone would sway others to our point of view, but simply to invite them to think anew about questions they may have thought settled, uncontroversial, or not even worth considering. Perhaps because physical education and its purpose has been such a prosaic and taken for granted part of many people's school experiences, the need to keep an open mind is especially apposite here. Lest our intention be misunderstood, our objective here is not to completely discredit physical education or argue for its abandonment. Yes, we think there are currently far too many onerous and ineffective things happening in American schools in the name of health, but this does not mean that we think anything that is remotely associated with health has no place in the curriculum. We think that the bodies of young people deserve to be educated in just as skilled and professional a manner as their minds and that physical education is the obvious and proper place to do this. What is at issue in this chapter is the health-related claims that people tend to make for physical education, the plausibility of these claims and, most important, the effects these claims might have for students. What concerns us, in other words, is whether emphasizing physical education's health benefits is a good thing for students or the field of physical education.

Finally, it is worth mentioning that the health effects of physical education have figured in some of the discussions generated by the wellness policy legislation discussed in the previous chapter. However, for reasons that we will touch on later in this chapter, the legislation itself says almost nothing about physical education. For this reason, we depart from the legislation here although return to it briefly in chapters 8 and 9.

MAKING THE CASE FOR PUBLIC HEALTH

In their 1991 article "Physical education's role in public health," Sallis and McKenzie articulate an agenda for physical education that has been the mainstay of the field for a generation.[3] It begins, as all school health initiatives have done throughout history, by establishing its scientific credentials and then linking itself to what is presented as a large and pressing health problem. Sallis and McKenzie do this by referring to the various professional and scientific organizations that have called for physical education to make health enhancement a central goal and by stressing the seriousness of cardiovascular disease (CVD) as a public health problem.[4] They write:

> CVD accounts for more than half of all deaths in the United States each year. If physical education programs can contribute to the prevention of this number one killer, existing physical education programs should be reoriented.[5]

In some respects, Sallis and McKenzie acknowledge that asking schools to make a difference to CVD is not a straightforward task although, on the whole, they see the problem as one of policy and sufficient commitment to the public health goal. Above all, what is needed, they say, is enough appropriately trained teachers. At this point, however, Sallis and McKenzie once again use an argument that many have used before them; that schools are the *ideal* place for public health work to be done:

> Physical education in schools is an ideal point of intervention because virtually all children participate. Thus, an institution already exists that can potentially make large contributions to reducing the CVD epidemic in developed nations. The goals of public health regarding CVD prevention and the goals of physical education regarding the promotion of physical activity are similar and compatible. Few institutions in the United States can be so easily adapted to meet the important current and future health needs of the population.[6]

There is much in this formulation that is familiar: the use of the term "epidemic" to raise the rhetorical temperature of the problem, the positioning of the profession represented by the writer (in this case, physical education) as best equipped to solve the problem, and the reassuring language that schools are ready to meet the challenge. And yet there is a twist at the end of Sallis and McKenzie's account, a warning of the consequences if their call to arms is not heeded:

> If the public health role and goal are resisted, those in the physical education community many not only lose a valuable opportunity to positively influence the health of the nation, they may also lose some control over their own field. Given financial pressures and the return to educational "basics," support for physical educational programs could be lost altogether. The increasing interest of the public health community in physical education is a golden opportunity to improve the effectiveness, status, and possibly funding of school physical education. The opportunity should be seized, and a solid, lasting partnership between public health and physical education should be cemented.[7]

While it is rare for the self-interest of a profession to be stated so openly, Sallis and McKenzie's rhetoric neatly captures a great deal of the historical tendencies we have discussed in this book, especially the way advocates describe the course of action they favor as both urgent and self-evident. As leaders in their field of study, their thinking has been a touchstone for other researchers. With other colleagues, they themselves have also produced a string of studies in which the physical activity of children in various school settings has been measured, compared, and analyzed.[8] Many others have echoed their views. Here, the Australian researcher Stewart Trost goes as far as suggesting that in order to wage war on obesity, physical education teachers need to reinvent themselves as

obesity experts: part statistician, part epidemiologist, and part behavioral psychologist. He writes:

> Physical education teachers need to become more familiar with the population-level monitoring and surveillance data related to children's exposure to daily PE and the amount of physical activity provided by the average lesson. They also need to become critical consumers of scientific information pertaining to youth and physical activity . . . Most of all, there is an urgent need for physical educators to know and understand health behavioral change theory (e.g., social cognitive theory) and how to plan, implement and evaluate theory-based strategies to promote physical activity behavior in school physical education.[9]

Notice here the "colonizing" tendency that we first described in our opening chapter. What Trost appears to be describing is a hope that the terms, concepts, knowledge, and procedures that inform his own work as an obesity researcher will find their way into the knowledge and professional practice of other professionals, in this case physical education teachers. And while Trost would no doubt see this as friendly advice rather than a stern instruction, the question that is never explained by the many public health researchers who write about physical education's public health role is why they have taken it upon themselves to give this advice in the first place. As with Sallis and McKenzie, the assumption here appears to be that because all children go to school they should therefore be available to whatever intervention the field of public health decides. We are aware of very few instances in the scholarly public health literature in which the opinion of schoolteachers on these matters has been considered or, much less, where researchers have stopped to think how fighting obesity fits with the other responsibilities that teachers have. In a rare but rather instructive example, Keating, Silverman, and Kulinna surveyed 600 American pre-service physical education teachers about their attitudes toward using fitness tests in physical education classes.[10] The survey found that, on the whole, the pre-service teachers were not enthusiastic about fitness tests. Clearly confused and dismayed by their findings, the authors claimed: "As a part of physical education programs, fitness tests are widely believed to be a key factor in encouraging students to get involved in physical activity on a regular basis."[11] This is interesting because fitness testing has been severely criticized in the scholarly literature on both ethical and efficacy grounds.[12] Nonetheless, Keating, Silverman, and Kulinna end their paper by speculating that their respondents were just ignorant of the value of fitness testing and suggesting ways in which their minds might be changed. At no stage is the possibility considered that aspiring teachers might have sound reasons for choosing not to put children through fitness testing. Keating, Silverman, and Kulinna are, of course, entitled to their point of view on this matter. But as so often happens in the "physical education meets

public health" literature, one gets the sense that alternative points of view strike proponents of the public health mission as, at best, literally unthinkable or, at worst, a kind of heresy.

Sallis and McKenzie's views about physical education's chronic disease crusade appear to be shared by the vast majority of the teaching and academic physical education community. A long list of publications since 1991 have echoed their thinking,[13] while those who have contested it are in the distinct minority.[14] This is not surprising since, as we have already said, the idea that physical education promotes health has been around for a very long time.[15] It is, in many respects, the profession's founding myth.

MEASURING UP?

Because there are many things that can be meant by the terms "physical education" and "health," any attempt to be definitive about the relationship between the two will always be incomplete and contentious. We also do not expect to settle the matter here. Instead, we invite readers to at least reflect on what it might mean for physical education to promote health.

Almost everyone who writes on the subject agrees that physical activity is good for human health. In fact, this is one of those cases where ancient belief has been consistently supported by scientific findings. Beyond the general healthiness of physical activity, though, opinion tends to be much more divided about what amount, frequency, and kind of physical activity delivers optimum health benefit in the most time-efficient manner. Despite the fact that we will often read or hear about recommended guidelines concerning how much physical activity young people should do, it is well known in the literature that these are not based on strong evidence.[16] This is important because it makes it virtually impossible to be sure whether the amount or type of physical activity students do in physical education classes is health enhancing.

As it happens, though, the point is probably moot since virtually every research study published on the matter over a long period of time has found that students do very little vigorous physical activity of any kind in physical education classes.[17] This is not to say that under certain circumstances students could not *be made* to be very physically active during physical education classes, but simply that in practice this generally does not happen.

One of the most striking aspects of research into the health benefits of physical education is the apparent tenacity of the researchers to draw positive conclusions. Take, for example, a study published in the journal *Medicine and Science in Sports and Exercise* in 1999 by Trudeau and colleagues.[18] The study was based on written questionnaires that were sent

to 147 Canadian women and men who had participated in a five-day-per-week physical education program during their elementary school education between 1970 and 1977, as well as a matched control group. The questionnaire was completed during 1995 and 1996 and asked participants questions about their current physical activity behaviors as well as other health-related behaviors. According to the authors:

> Our results strongly suggest that daily physical education at the primary school level has had a significant long-term positive effect on the exercise habits on women, despite similar perceived barriers, attitudes, and intention to exercise in the two groups. The program has also had a significant health effect in men, substantially reducing the risk of becoming a regular smoker.[19]

However, whether the results of the study warrant such an optimistic conclusion is debatable. To begin with, most researchers in this field agree that asking people to recall how much physical activity they do, regardless of which data collection method is used (such as diaries, questionnaires, and interviews), is a generally unreliable estimate of how much physical activity they actually do. Putting this to one side, the study found no difference between the frequency of physical activity participation between experimental or control group participants or the type of physical activity they did. It also found that experimental group participants, male or female, were no more likely than controls to have a positive attitude toward physical activity, to have more opportunities to be physically active, or to have a stronger intention to do more physical activity in the future. The same was true for perceived barriers to physical activity or whether participants thought their family and friends were supportive of their physical activity. In fact, in almost every respect the questionnaire respondents who had participated in the five-day-per-week physical education program were indistinguishable from those who had not. While the experimental group males were a little taller than the control group males, they were also heavier meaning that there was no difference in their Body Mass Index (BMI).[20] This was true for males, females, and both genders combined.

Two areas of difference were found, however. First, after separating the data by gender, the researchers found that the experimental group females reported more frequent physical activity than the controls. Second, the experimental group males reported lower levels of smoking than controls. The interesting aspect of these apparently positive findings is that it is hard to see what relevance they had to the physical education program that the experimental group had experienced twenty years earlier. For the females, the experimental group reported higher levels of participation than the control group females in "lifestyle" activities like walking, jogging, and going to the gym. But, as the researchers point out, the physical education program had been explicitly sports-focused; life-

style activities had not even been part of the program. Likewise, although the experimental group males reported smoking less, the program had contained no anti-smoking education of any kind.

If, once again, we ignore that all the data presented in this study are self-reported, a number of interpretations seem equally possible. Perhaps the initial physical education intervention had the undesirable effect of turning females away from sports participation. More plausibly, though, this just seems an obvious case in which no effect of the intervention can be claimed since differences between experimental and control groups were either nonexistent or unrelated to the intervention. Indeed, the authors of the study admit to knowing almost nothing about the amount or intensity of the physical activity that happened during the intervention or even the quality of the teaching that occurred.

Remarkably, though, the authors of the study conclude by claiming: "Because the program was not specifically designed to promote health, we hypothesize that a health-oriented physical education program could have an even stronger effect."[21] In other words, as well as attributing the very few intergroup differences that actually emerged to a physical education program that happened two decades previous, the researchers claim that even better results could have been achieved if the original intervention had had a general health education component.

Although one needs to read through to the end of the study to find them, the attitudes of the researchers to the general absence of health benefits are telling. They write: "Finally, the lack of effect of the experimental program on the intention to exercise, attitudes toward exercise, and perception of social support and opportunities for exercise are difficult to explain."[22] Why the negative findings of the study are any less difficult to explain than the ones in favor of the researchers' clear expectations is totally unclear. Despite being the most obvious conclusion to draw, the possibility that a physical education program might have no effect on any of the health outcomes measured in the questionnaire is not entertained anywhere in the paper. Meanwhile, the headline finding that physical education classes are good for your health sits happily in the paper's abstract, ready for any busy researcher, PhD student, or interested reader to skim read and add to their store of preconceptions.

In a similar example, Datar and Sturm's 2004 study for the *American Journal of Public Health* concludes with the following statement: "Expanding physical education programs in schools, in the form in which they currently exist, may be an effective intervention for combating obesity in the early years, especially among girls."[23] The basis for the conclusion is a set of BMI measures taken from 9,751 American infants and questionnaire data about their exposure to physical education classes. In essence, the researchers wanted to know whether one extra hour of physical education per week made any difference to a child's BMI as they moved from kindergarten to grade one. The study found that extra exposure to physi-

cal education was statistically correlated with a lower grade one BMI for girls who had already been overweight or nearly overweight in kindergarten. Even though the researchers claim that exposure to physical education had "reduced" the BMI of these girls, this seems an unjustified conclusion. There is simply no data in the study on which to make any conclusion about causation. More important, though, the headline conclusion quoted above that physical education "may be an effective intervention for combating obesity in the early years, especially among girls" is, again, hugely misleading. The results showed that physical education exposure had *no* BMI impact at all for all the boys in the study and all the normal weight girls. In other words, there was no effect on the vast majority of the children. This begs the obvious question of why the study's conclusion did not report that extra physical education exposure was largely ineffective in reducing BMI. Rather than being "especially" effective for girls, it was *ineffective* for most girls.

There are many reasons to be worried about the way this study's findings are reported. One is that it implies that the quality of the educational experience children receive is inconsequential; more physical education, no matter how badly taught, is better than less. This is very bad news for anyone who believes that teacher quality matters. A second reason is that examples like this bring us face-to-face with the power of preconceived ideas to determine what people allow themselves to see, even when obviously contrary evidence is placed before them.

In passing, it is worth contemplating the effect of publication bias in this area of study. As we are about to see, the accumulated literature concerning physical education's health benefits is littered with studies of varying quality and equivocal findings. In many other academic fields it is normal to assume that researchers are less likely to submit studies with no significant findings for publication because they are assumed to be less interesting and therefore less likely to survive peer review. The result of this bias toward intervention studies that *do* show some effect can be a published literature that overestimates the effectiveness of the intervention being studied. Were publication bias a factor in the physical education literature—and while there is no way to be sure, there are few reasons to think that it is not—the "true" health benefits of physical education classes would be even less than the extant literature currently shows.

The tendency to seize on any favorable statistical relationship between time in physical education and BMI or a specific health outcome is dangerous for a number of reasons. Most obviously, in most studies there is no way of knowing whether a change in a measured variable has been caused by exposure to physical education. There are, after all, many variables that impact on a person's health, even something as apparently straightforward as the amount of physical activity a child or adult does. For example, there is evidence that social class is the most significant factor in determining how much physical activity a person does as they

grow older.[24] In addition, knowing how much physical education a child does may not be a good predictor of how much physical activity they do. Mallam and colleagues' study found that English children attending three different primary schools were offered different amounts of timetabled physical education but accrued the same amount of total physical activity.[25] The reason is that the children who did the most physical education did less physical activity outside of school and vice versa.

But the most curious aspect of the research that attempts to link good health to physical education exposure is its disregard for teaching quality. As we have seen, most studies simply assume that if a health variable can be statistically linked to exposure to physical education, then it must have been the physical education that caused it. The perversities of this assumption are numerous, including that it endorses the possibility that many hours of very bad physical education experiences could be good for a child's health.

INTERVENTION-COLORED GLASSES

Despite the less than promising research findings described in the previous section, many researchers have attempted to use physical education classes and school physical activity generally as the sites of public health interventions. However, despite the amount of work done in this area it is remarkable how little evidence supporting these interventions has been accumulated. For example, writing in a 2007 issue of the journal *School Health*, Davidson's review of school-based physical activity interventions found very little evidence to support their effectiveness. She writes:

> There have been a myriad of school-based obesity prevention programmes used in schools. However, the results of these and other programmes have shown a range of results, making it difficult to establish which strategies or combination of strategies will be effective. Effectiveness itself also varies between programmes/interventions as some programmes are designed to reduce BMI or other anthropometric measures, while others are designed to increase knowledge and awareness, or to establish long-term patterns of behaviour.[26]

What this review highlights is the lack of definitive evidence in many aspects of obesity prevention work, particularly in the area of schools and their contribution to this issue—this at a time when schools are being placed under increasing pressure to deal with such issues.[27]

She concluded: "This is not to suggest that PE is not an important element of a child's education, but the idea that PE is the solution to the childhood obesity problem does not appear to be sustainable in the face of the evidence available."[28]

Focusing specifically on whether physical education or school-based interventions had an impact on children's BMI, Harris and colleagues

reviewed available literature up to the year 2008.[29] Of the 398 relevant studies they located, only eighteen were deemed suitable for robust statistical analysis:

> Our meta-analysis indicated that school-based physical activity interventions did not improve BMI. Therefore, such interventions are unlikely to have a significant effect on the increasing prevalence of childhood obesity. Our inferences appeared consistent among the many secondary analyses that we performed. Variation in the duration, intensity and structure of school-based physical activity interventions had minimal effects on short-term or long-term BMI change. The consistency of the BMI results among the studies included in the meta-analysis was striking (r = 0.97). This finding is important for policy-makers who continue to promote schoolbased physical activity as a central component of the strategy to reduce childhood obesity.[30]

Drawing on papers published between 1990 and 2010, Dudley and colleagues conducted "a systematic review of published literature on the effectiveness of physical education in promoting participation in physical activity, enjoyment of physical activity and movement skill proficiency in children and adolescents."[31] Despite locating 27,410 potentially relevant academic papers, only twenty-three used research designs that allowed robust conclusions about the measurable impact of physical education interventions. The review found that in some cases physical activity levels and skill development could be lifted where teachers used direct instructional teaching methods and were given ongoing professional development in these methods. It also found that there was insufficient data on which to base a conclusion about whether these interventions improved students' enjoyment of physical activity.

These findings lead to what seems a relatively unremarkable conclusion. It is certainly within the realms of possibility to design, conduct, and monitor a school-based intervention that, at least in the short term, increases the amount of physical activity that students accumulate. If the intervention is sufficiently intense, it might even lead to students losing weight or having a lower BMI. For example, Trost shows that specifically targeted interventions can increase the amount of physical activity done during physical education classes and that this can increase children's physical fitness.[32]

But this raises a number of questions. For example, as Trost himself points out, being physically active as a child by no means guarantees that a person will go on being physically active. In fact, the idea that physical activity behavior "tracks" from childhood into adulthood enjoys very little empirical support. Trost writes:

> Although studies vary considerably with respect to length, age group studied, measurement of physical activity, and method used to assess tracking, there is consistent evidence that, over short time periods (3-5

> years), physical activity tracks well. However, over longer periods of follow-up (6-12 years) there is little evidence that physical activity behaviour tracks during childhood and adolescence. Presently, there is no strong evidence to support the notion that physical activity tracks from childhood to adulthood.[33]

More fundamentally though, we could ask what might be the effect of focusing on physical activity levels in school. A great deal has been written about the negative sport and physical education experiences children have been made to suffer at the hands of overzealous teachers and coaches. By stressing the need to accumulate physical activity for public health purposes the obvious risk is that more and more teachers will interpret this message literally and lose sight of the educative and pleasurable potential of school-based physical activity. This is a particular risk for elementary school teachers because, as some physical educators point out, the continuous calorie-burning exercise many of us assume to be good for health and weight loss may be not be appropriate for younger children.[34] In her article "The obesity epidemic: how non-PE teachers can improve the health of their students," Sarah Yaussi demands that *all* teachers should constantly seek out opportunities to work vigorous physical activity into their instruction, no matter how tangential to their subject matter.[35] The obvious danger is that teachers might do exactly as Yaussi suggests, thus subjecting students to untold gratuitous, boring, repetitive, and potentially dangerous bouts of exercise by teachers with no expertise in this area.

Given the weight of evidence, why do physical education and school-based physical activity interventions persist? Advocates for these interventions consistently argue that while the results so far have been poor, their capacity to improve public health is "enormous."[36] We think that there is a different explanation, neatly captured by Tim Byers in a short editorial for the *American Journal of Clinical Nutrition* titled "On the hazards of seeing the world through intervention-colored glasses":

> Producing unbiased interpretations of truth can be a difficult challenge in behavioural intervention studies because the amount of behavioural change expected is often small. Having been repeatedly told what behaviour change is expected, subjects may display the natural human tendency to perceive and report their behaviour biased toward the expected change. Having put years of hard work into an intervention trial, study investigators also have a natural human tendency to interpret trial results in the most positive light.[37]

Many people are invested in believing that physical education classes and other forms of school-based physical activity can make a difference to population levels of childhood obesity and public health in general. Researchers who conduct funded interventions are not the only ones; teachers, parents, and politicians all have reasons for joining in. But as

with Mary Hanchett Hunt before them, this belief rests on refusing to think about the realities of school life. To take one obvious example, obesity-minded researchers seem to take no account whatsoever of the financial and policy pressures facing schools that we discussed in the previous chapter. Reading their research papers, one gets the impression that some researchers think that fighting obesity is the only thing schools have to do.

TRYING TO MAKE IT WORK

In the period leading up to the passing of the Bush administration's wellness policy legislation, it became apparent that it may say something about physical education. After all, this was to be the federal government's most comprehensive statement to date about the role of schools in the war on childhood obesity. Not surprisingly, the administration was lobbied to introduce a variety of mandates concerning the provision of physical education, including the amount of time students should spend doing it and the qualifications of teachers who teach it. For some states, of course, robust requirements for physical education provision would have meant considerable extra costs in employing and training specialist teachers.[38] As a result, they argued against strong mandates for physical education. In the end, the legislation said virtually nothing about physical education and instead asked educators to develop measures for encouraging student participation in physical activity. This, then, set off a further round of claim and counterclaim about whether, for example, recess times should or could count toward total daily physical activity minutes.

On a straightforward level, this episode should remind us that focusing on public health invariably means reducing the way we think about physical activity, in schools and elsewhere, to minutes spent burning calories. And once the discussion has moved in this direction, it is extremely difficult to retain any sense that children go to schools to learn and think, instead of just being made to exercise. More subtly perhaps, debates about physical education versus physical activity reveal a deeper truth: when schools become an arm of public health policy, of which the wellness policy legislation is but one example, the issue of compliance, rather than efficacy, takes center stage. We will return to this issue in more detail in the following two chapters, but for now it is sufficient to repeat the point we made in the previous chapter: most schools treated the problem of complying to the legislation as an exercise in finding the least disruptive way to meet their new obligations.

The reasons why schools do not and mostly cannot turn themselves into weight-loss clinics are many and varied. For example, a recent study of schools in Mississippi and Tennessee by Ben Dyson and colleagues

found a long list of obstacles preventing recent federal and state anti-obesity policies being implemented.[39] Putting to one side doubts that they would work even if fully implemented, the researchers found a high level of ignorance among some school leaders concerning the policies. On the other hand, while some school leaders knew about them, their knowledge was patchy or they indicated a strong unwillingness to act until resources were allocated. Others reasoned that because there was no credible accountability mechanism attached to the scheme, there was no need to act on the policies. At a more basic level, some schools had few or poor-quality facilities to implement recommendations for physical activity and, where they did, the school's sporting teams dominated these facilities.

In many ways, Dyson and colleagues' paper captures a universal set of problems which the school-based public health movement has rarely been able to come to terms with. That is, the study demonstrates how badly suited a massive bureaucratic system like public education is to addressing complex and subtle human behaviors such as body weight management.

In a similar vein, consider the study by Donetta Cothran and colleagues reported in their paper "Top-down public health curricular change: the experience of physical education teachers in the United States."[40] The researchers interviewed forty-six elementary school physical education teachers grappling with their school district's mandate that they reorient their teaching toward public health goals. The study found that the teachers had great difficulties understanding how or why they should change their practice and received very little professional development to support this shift.

Another interesting aspect of this study is captured in the following passage:

> At first glance, the suggestion to use school-based physical education as a primary intervention site seems logical and a relatively straightforward proposal. What is overlooked in these reform suggestions, however, is the difficulty involved in making such changes within an educational setting with a long history of curricular focus on sport, not the physical activity and health needs of students. Although not true for all programs, many current physical education programs are led by teachers who lack physical activity and fitness knowledge. This may be particularly true for more experienced educators, as the current emphasis on physical activity and wellness promotion in teacher education programs is a relatively new emphasis area. Even when teachers have fitness knowledge, however, they may not be able to design effective delivery programs within their curricula. Few physical educators have ever seen a program based on physical activity initiatives, and therefore lack the personal experiences and knowledge base necessary to provide those experiences for their students.[41]

In the public health literature, it is argued that physical education classes should move away from a sports focus toward what is often called "lifestyle" activities. The logic of this argument rests on the assumption that physical education should be introducing students to activities they can pursue for the remainder of their lives.[42] In short, from a public health point of view sports are bad while walking, jogging, and going to the gym are good, and this is why the teachers in Cothran and colleagues' study found themselves being told to change their ways. At this point we are reminded of the public health researchers we mentioned in an earlier chapter who wanted to place restrictions on what time celebrity chef television programs could be viewed. That is, what we see here is the idea that public health concerns should trump all others. So, even though many children enjoy sport, a public health focus dictates that ten-year-old children need to participate in the same activities that they might do when they are seventy. Of all the perverse outcomes that flow from public health's colonization of physical education, this is perhaps the most dispiriting.

The broader point to take from Cothran and colleagues' study, though, is that it is one thing to decide that a brand new approach to school education should happen, but a very different thing to make it happen. It is curious, for example, how rarely the Daily Physical Education (DPE) intervention, conducted in the Australian state of South Australia in the 1970s and 1980s, is mentioned. As its name implies, the idea of promoting public health through regular physical education is not new. There is even some research which reported the intervention having a statistically significant impact on children's fitness and body fat levels.[43] And yet, as Richard Tinning and David Kirk point out, enthusiasm in schools for this intervention and others like it quickly ran out of steam as time passed, the money dried up, important staff moved to other jobs, and higher educational priorities took precedence.[44]

There are many reasons why physical education and school physical activity cannot carry the burden of public health's expectations. For the most part, though, they relate to the huge, many-jointed beasts public education systems tend to be. They simply do not operate in a unified, coherent, and consistent manner, and this makes them much too blunt an instrument for most, though not all, public health purposes. Moreover, showing that certain effects can sometimes be achieved if enough time and resources are devoted to interventions does not solve the problem. First, we should recall, instead, that most interventions do not have the desired effect. But second, well-organized and funded interventions are not what physical education or school physical activity are. Most children will never be part of these interventions, and the constant refinement of the techniques used in them will never change this fact.

ONE STEP FORWARD OR TWO STEPS BACK?

In 2012, a little over twenty years after their 1991 paper calling for physical education to take on the public health mantle, Sallis and McKenzie took stock of what they saw as the successes and failures of the previous two decades.[45] Overall, they present a mixed picture. They argue that physical education's public health mission enjoys widespread acceptance in the field of public opinion and has been endorsed by federal and state policy makers. They write:

> Major accomplishments include development of evidence-based programs, documentation of health and academic benefits of physical education, and acceptance of physical education as a public health resource. Additional work is needed to evaluate the uptake of evidence-based programs, improve national surveillance of physical education quantity and quality, establish stronger policies supporting active physical education, and achieve wide acceptance of public health goals within the physical education field.[46]

One cannot help but be struck by the similarity of the situation Sallis and McKenzie describe with the one that seems to have confronted Mary Hanchett Hunt at the end of the nineteenth century after twenty years of campaigning for scientific temperance instruction. In both cases, a great deal of legislation is in place, although much of it not nearly as strict as its proponents would like. In both cases, ever more vigilant systems of surveillance are being proposed to find out if teachers really are doing what they are supposed to do. In both cases, models of teaching practice have been developed and programs of study for teachers to follow have been produced. However, also like Hunt, Sallis and McKenzie are disquieted by the level of resistance among teachers, a state of affairs they appear to think best remedied by stricter policies and more teacher surveillance.

However, what is most interesting about this historical echo is that, in Hunt's case, the construction of a policy-based and legislatively endorsed fortress proved to be a sign of fatal weakness, not strength, and all her hard work was only a few years away from an inexorable unraveling. In other words, getting politicians to pass laws and textbook makers to produce teaching materials was the easy part; getting teachers across the land to teach in the way she wanted them to teach was beyond even Mary Hunt and her formidable network of supporters. In Sallis and McKenzie's war on obesity and chronic disease, their 2012 article notes that physical education provision in schools has probably gone backward since 1991 and that the creation of new policies does not seem to have had much practical impact:

> Federal, state, and local policy makers develop, implement, and evaluate physical education policies that conceivably could achieve both health and education goals. However, state and federal policies, such

> as the requirement for local wellness policies, do not appear to have been sufficient to substantially improve physical education implementation, although the lack of surveillance makes it difficult to reach a definitive conclusion.[47]

We seem to have arrived back at the same point made many times in the schools and public health literature; the idea of physical education's huge but as yet unrealized potential to improve the public's health. In her 2006 article, "Riding to the rescue while holding on by a thread: Physical activity in the schools," Katherine Thomas essentially endorses Sallis and McKenzie's views. As her title suggests, there is less, not more, physical activity happening in American schools than there used to be.[48] While she cites financial pressures and the rise of high-stakes testing as having had a particularly negative impact, we would also mention the lengthening list of other public health concerns schools have been asked to address. The inescapable conclusion to be reached here is that authors like Sallis and McKenzie are asking more from schools in terms of their contribution to the war on obesity at a time when they are, for a range of financial and policy-based reasons, less and less able to do so.

It is probably too much to ask researchers interested in schools' role in reducing childhood obesity to consider the fate of an obscure historical figure like Mary Hanchett Hunt. However, it would seem reasonable to wonder why so little mention is ever made of the more mainstream and contemporary school health literature. It is true that this literature suffers from exactly the same hubristic optimism that dogs physical education, but there are some important insights to draw from it nonetheless. After many years working in and writing about school health promotion, Lawrence St. Leger questions the optimism of the school health movement in his 2004 article "What's the place of schools in promoting health? Are we too optimistic?"[49] He reminds readers that most of the factors that shape the health of young people are beyond the influence of schools and points out that schools are, in the end, educative rather than medical or health institutions. In fact, St. Leger argues, "The main reason why schools address health and related issues is to enhance the attainment of educational goals. Schools are largely ineffective if they are asked to address health issues as a way of solving society's problems."[50]

Perhaps most important, he demonstrates how vexed the question of efficacy has been for the school health movement, primarily because physical health is such a multifactorial phenomenon, regardless of whether we are talking about drug and alcohol use, nutrition, or any other dimension of health.

In other publications St. Leger also describes how many school health researchers have tended to lose faith in classroom instruction *per se* and turned to a more "whole of school" approach to health.[51] This is interesting on a number of levels. The move to "whole of school" has been, as

much as anything else, a recognition that curriculum and classroom instruction approaches are not very effective, even though, as we have seen in this chapter, there are many people who still believe children can be taught in physical education classes to not get fat. But of course, a "whole of school" approach is a far more complicated business than getting students to do regular bouts of exercise or go to a couple of extra physical education classes per week. In fact St. Leger and others[52] suggest that a school-based health intervention is most likely to be effective when: the autonomy of students and teachers is encouraged; the goals and objectives of the intervention are clearly communicated to teachers and students; teachers and students are heavily involved in the enactment of the intervention; supportive relationships are established between all stakeholders and participants; the intervention focuses on cognitive outcomes; the intervention is reinforced across the entire culture of the school; the knowledge of teachers is increased; the intervention is differentiated not just by student grade but by the developmental and social needs of individual students; the intervention is consistent with the rest of teachers' work; and the intervention lasts over a long time, preferably a few years.

This list may seem a rather tall order, but it does go some way to explaining why most obesity-focused school health initiatives do not work or do not work for very long. And yet there is nothing special about obesity here. These challenges face any school health agenda and should be a warning against anybody who imagines that, *a la* the vaccination programs of the nineteenth and early twentieth centuries, schools can inoculate children against any of the risks we imagine modern life throwing up.

NOTES

1. For a critical scholarly review of the varied benefits claimed for school physical education programs, see Richard Bailey, Kathleen Armour, David Kirk, Mike Jess, Ian Pickup, Rachel Sandford, and BERA Physical Education, "The Educational Benefits Claimed for Physical Education and School Sport: an Academic Review," *Research Papers in Education* 24, no. 1 (2009): 1-27.

2. The point at which non-communicable diseases became the dominant concern of Western health policy makers and researchers is a complex matter. For a detailed history of what he calls the "health movement" through history, including the emergence of the fitness movement in the 1970s, see Michael S. Goldstein, *The Health Movement: Promoting Fitness in America* (New York: Twayne Publishers, 1992).

3. James F. Sallis and Thomas L. McKenzie, "Physical Education's Role in Public Health," *Research quarterly for exercise and sport* 62, no. 2 (1991): 124-137.

4. Ibid., 124.

5. Ibid., 125.

6. Ibid., 131.

7. Ibid., 134.

8. Such as James F. Sallis, Terry L. Conway, Judith J. Prochaska, Thomas L. McKenzie, Simon J. Marshall, and Marianne Brown, "The Association of School Environments with Youth Physical Activity," *American Journal of Public Health* 91, no. 4

(2001): 618-620; and Thomas L. McKenzie, Simon J. Marshall, James F. Sallis, and Terry L. Conway, "Student Activity Levels, Lesson Context, and Teacher Behavior During Middle School Physical Education," *Research Quarterly for Exercise and Sport* 71, no. 3 (2000): 249-259.

9. Stewart Trost, "Public Health and Physical Education," in *Handbook of Physical Education*, ed. David Kirk, Doune Macdonald, and Mary O'Sullivan (London: Sage, 2006), 184.

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EIGHT

The "New" Body Work of Being a Teacher

As we have seen, the idea of winning America's battle with obesity via its schools can have unexpected and even undesirable consequences for students. Increasingly, though, the same can be said for teachers. In this chapter we explore the different role that teachers are being called to play in order to fight obesity. In particular, we consider how the idea that American teachers are not only responsible for inspiring students to be healthy but to be healthy themselves, has been articulated in legislation, policy documents, and academic articles. These examples of teacher-focused anti-obesity intervention suggest a novel and, in some cases, alarming trajectory in school health policy and practice.

TEACHER HEALTH IN A NEOLIBERAL MOMENT

A number of scholars have described the ways in which health promotion interventions, whether in schools or outside them, employ a range of strategies to regulate people's behavior and the tendency of these strategies to rest on narrowly normative ideas about health.[1] For many of these authors, this tendency is partly attributable to the rationalities of neoliberalism.[2] In this context, the contemporary vision of a healthy, neoliberal citizen is of one who has the capacity to constantly examine and improve him/herself. People are expected to be "autonomous, choosing, and self-invented," both willing and obligated to continually work on themselves and be responsible for the outcomes of this work.[3]

With regard to health and bodies, this kind of responsiblization has a variety of effects. On the one hand, it influences the form and function of health interventions deemed appropriate or inappropriate. In other

words, the ways in which health is conceptualized and understood will shape our ideas about how people should behave, what they can be expected to do and what actions authorities can reasonably take in the name of health. According to Greco, neoliberal logic has inspired new monitoring techniques that "are no longer geared towards eliciting the truth of an objective environment but a subjective truth" located within individuals.[4] In the case of public health, we could paraphrase this by saying that people are increasingly expected to *want* to be healthy and to internalize the health policy goals. This shift carries important consequences for those targeted by public health campaigns, a point that has been developed in empirical research exploring the ways in which young people understand and negotiate their own health.[5] Much of this work suggests that even well-intentioned policies and practices are often predicated on a desire to measure, assess, and compare student bodies. For some youth, these imperatives become "incredibly difficult to resist" and may encourage self-harm or at least extreme forms of self-discipline.[6]

On the other hand, and at the same time as students are encouraged to work on themselves in particular ways, teachers are often positioned as important facilitators in this process.[7] In the war on obesity, American teachers have increasingly been depicted as needing to be a kind of health evangelist, such that they must simultaneously homilize and embody health, while their appearance, behaviors, and values all become supposedly important teaching instruments and symbols. These developments are not entirely unprecedented. The twentieth century was littered with examples in which the bodies of teachers were the subject of instruction, coercion, and regulation. There were also instances in which teachers were explicitly saddled with the task of inspiring healthy dispositions among students.[8] These imperatives have invariably been driven by ideological assumptions about who children are, who they should become, and the role of the teacher. We think, however, that there is something distinctive in the contemporary context, a shift attributable in part due to the attempts by health authorities to prescribe the ways in which people should conduct more and more aspects of their everyday life.

In what follows, we will suggest that teachers' health and even their bodies have been recast using neoliberal concerns with efficiency and value maximization. As we saw in chapter 6, these are values that pervade schools and educational policies and agendas. The teaching profession, and teachers themselves, have been subject to new styles of management that stress quality and excellence and new forms of entrepreneurialism that stress the role of markets and competition.[9] Teachers are now depicted and encouraged to think about themselves and their professional performance in calculable ways; as enterprising subjects who "add value," improve productivity, and strive for excellence.[10] On matters of health, neoliberal logic has had the effect of normalizing the ways "individuals and institutions think of the body and, in particular, how to make

one's self more valuable and productive within a highly competitive and market-driven educational culture."[11] Using this as our frame, we can better understand the ways in which teachers are enticed and rewarded for embracing self-responsibility through health-related initiatives that warn of the danger of bodily misuse or neglect.[12]

Drawing on the thinking of Michel Foucault, health imperatives directed at teachers can also be seen as a style of discipline that is "marked by an increasing reliance on the motivation of workers towards self-management, self-monitoring and self-correction."[13] They function as a form of power that uses discipline and surveillance as a productive and enabling method of control. At the same time, these imperatives can also be understood in the context of Foucault's description of pastoral methods of care. In this sense, they might appear to be redemptive in nature: attempts to convert and reform the unhealthy teacher for the greater good of a future society (read children) and the self.

Most research into the impact of public health's war on obesity has focused on its effect on students, although a small number of studies have specifically considered physical and health educators.[14] We think this is important work, but what we present in this chapter widens the analytical lens to examine disciplinary and surveillance techniques that incite all teachers, not only those officially charged with the task of shaping young people's health, to be "healthy."[15]

This chapter draws on research carried out by the authors of this book between the years 2010 and 2013. Our intention in this work was to report on the ways in which the nature and function of teachers' health was being understood. To do this, we selected a range of formal and informal policy documents and scholarly articles that explicitly or implicitly articulated a position on teachers' health, particularly with respect to body weight. Our work was guided by our interest to better understand the ways in which health and American schools are co-articulated within policy texts. We reviewed a cross-section of texts from a diversity of sources. We included documents authored by local, state and federal agencies. We also analyzed texts representing various organizations and interest groups. In particular, we chose texts that helped to shed light on a set of key questions: How is teacher health problematized? What are teachers told to do or be in order to improve their own health and what reasons are used to justify these exhortations? What techniques are used to measure a teacher's commitment to health? And finally, what consequences are predicted for teachers (and students) if they are not healthy?

In truth, our research turned up a very large amount of material such that a robustly representative or comprehensive sample is beyond the scope of this chapter. However, our contention is that the school health policy environment that we describe here is characterized by a consistently narrow set of intellectual resources, or what we might call rationalities.[16] In fact, we will suggest here that assumptions about teachers'

public health role in solving the obesity epidemic rest on three central ideas: teachers as health role models, teachers as fiscal liabilities, and teachers as instruments of policy compliance.

For international readers, we acknowledge, of course, that the American context in which this research was conducted is specific and that we should be cautious before generalizing the results of this examination to other countries and contexts. For example, American school systems are somewhat unusual in that they provide health insurance for many teachers. On the other hand, it is absolutely clear that schools and teachers have been and continue to be folded into a similar anti-obesity public policy milieu across the world. Moreover, our point here is to invite readers to think about both the logic and policies that are advocated, apparently, to make teachers more conscious of their body weight and its significance to their work as teachers. On the whole, while most of us would support respectful, sensitive, and effective measures that help teachers to be better teachers or even live healthier lives, we think the current policy environment makes this unlikely. In fact, our contention here is that the policy environment we describe is a mixture of untested assumptions blended with neoliberal logic that scarcely makes sense in either educational or public health terms.

TEACHERS AS HEALTH ROLE MODELS

The idea that healthy teachers produce healthy and successful students is not new. In the relatively recent past, a 1988 *American School Board Journal* article written by influential advocates for the development of school-based employee wellness programs argued that health messages are "diminished or increased in effectiveness by the teacher's behaviors. . . . A nonsmoking message will have much more clout coming from a nonsmoker (or a former smoker) than from someone who rushes to the teachers' room to light up as soon as class is over."[17] These authors go on to assert that unhealthy teachers are simply less effective in the classroom and that healthy teachers conduct "a better academic program."[18]

However, with anxiety about obesity rapidly intensifying after the year 2000, the voices echoing this point of view have proliferated. According to a 2009 report in the *Journal of the American Dietetic Association*, greater attention should be directed toward improving the health of educators "not only for their own health status but also to improve their effectiveness as role models for their students."[19] Identifying them as "key target groups" for improving the health of children, the authors assign teachers the task of providing students with appropriate health knowledge and values.[20] Similarly, the Council of State Governments contends that schools should support teacher health programs so that teachers can serve as better health role models and increase school *pro-*

ductivity.[21] According to the Alliance for a Healthier Generation, an organization partly founded by the William J. Clinton Foundation, "School employees interested in their own health are more likely to take an interest in the health of their students; students, in turn, are more likely to engage in health-promoting activities when school staff models such behaviors."[22] The document goes on to claim that "healthy employees are more productive, have increased energy and reduced stress, and set a positive example for students."[23]

A policy document included in the World Health Organization's (WHO) series on school health reiterates this point. Teachers are advised to "encourage students to follow a healthy life by demonstrating healthy eating."[24] The document also includes recommendations for additional teacher training so teachers can "improve their own eating practices and make [students] aware of the behavioral messages they give as role models."[25] Similarly, an article in the *American Journal of Public Health* argues that "teachers who place greater value on health . . . may serve as more effective student role models."[26] Apart from the absence of any robust corroborating evidence, perhaps what is most odd about these statements, and many others like them in the documents we read, is the way they talk about a curious and (as far as we are aware) undocumented subgroup of American teachers who are uninterested in their own health.

According to a United States Department of Agriculture document, it is the role of every teacher to help make children healthier.[27] Educators are encouraged to "walk the talk" by letting students see them "making healthy food choices and being active at school."[28] Teachers are advised to engage in a number of specific health-related practices; incorporating nutrition and physical activity into their curriculum, inviting students to join them for a walk and organizing vegetable consumption competitions. Teachers are told to "use their influence" because "students will get the idea that" health is important when teachers actively demonstrate their own commitment to it.[29] For Yaussi, demonstrating commitment to health can also take the form of teachers sharing their "interests in certain sports or activities" or "tell(ing) students about their own health goals." She also provides teachers with specific examples such as participating in an athletic race or losing ten pounds.[30] Engaging with students in this way, she claims, is beneficial as it "assists students to achieve their goals."[31] Teachers also need to be watchful about what food they consume when students are present. As Winter writes: "When teachers eat only healthful meal and snack options in view of children, they provide strong modeling that may influence children to choose more healthful snacks."[32]

School districts in Minnesota take the task of monitoring teachers' health behaviors a step further. In this state teachers as asked to complete the "Teachers are You a Fitkid Role Model?" survey. The survey asks

teachers to answer the following questions about their health behaviors and activities during school hours:

1. Do your students see how active you are around the school?
2. Do you encourage your students to move at recess time?
3. Do you provide information to parents about safe recreation centers or after-school programs in your area?
4. Do your students see you eat nutritious foods?
5. Do your students see you drink milk instead of pop/coffee?
6. Do you serve nutritious foods in your classroom?
7. Do you refrain from talk about dieting in front of your students as well as your likes and dislikes?
8. Do you encourage your students to eat school breakfast and lunch?
9. If you notice a student is hungry or comes to school without breakfast do you refer them to the breakfast or lunch program?
10. Do you help your child's school create a healthy school environment?
11. Do you incorporate nutrition messages into the curriculum you are teaching?
12. Do you eat school meals (breakfast and lunch)?[33]

After completing the questionnaire teachers are asked to commit to individualized health goals pertaining to each of the twelve survey items. For example, if a teacher is not currently eating nutritious foods in front of their students, they are asked to create a goal that would assist them in meeting this objective. Teachers are further asked to record their progress in meeting their individual health goals. To further aid teachers in realizing their health goals they are directed to various documents titled "Teachers as Lifestyle Role Models: Ideas to Help Your Students Lead Healthy Lifestyles" and "Ideas to Help Your Children Lead Healthy Lifestyles."

Minnesota's admonitions are echoed in the WHO's policy document on health-promoting schools. Under the heading, "We Have a Policy on Healthy Food," school leaders are encouraged to implement one of four "action" items: a) ensuring locally grown foods are available at their school; b) having teachers act as role models by eating healthy food in school; c) making healthy food choices available at school events; d) ensuring schools comply with food safety standards.[34] The document potentially leaves readers with the impression that there is a policy equivalency between efforts to maintain adequate food sanitation (i.e., complying with food safety standards) and ensuring teachers consume healthy foods in front of students. As these examples illustrate, a good teacher is taken to be one who embraces healthy values and dispositions for himself or herself and, perhaps just as important, displays this commitment to children in performative ways.

The inverse is also assumed to be true. According to the Directors of Health Promotion and Education (DHPE), a Washington, D.C.-based policy group, teachers who "lack good health" are unable to serve as "healthy role models for their students."[35] Likewise, a study examining the dietary patterns of school employees noted that, "Elementary school personnel educate students on healthful eating in the classroom and school cafeteria, and serve as role models. Yet, in this locality, they have high rates of overweight and obesity and consume too much fat and too little fiber."[36]

The public health role of teachers is regularly presented as a matter of acute urgency. Walker, for example, warns that teachers must act quickly and decisively in order to take advantage of their "window of opportunity to effect change on health outcomes and divert the pathogenesis of disease."[37] By "disease" Walker is referring here to obesity among children. This is an interesting case of what we might call the contagion of urgency. While most readers will be familiar enough with the apocalyptic tone that pervades the field of public health's engagement with the "obesity epidemic," much of the literature we describe in this chapter appears simply to have absorbed this sense of panic. Rather than a robust assessment of the evidence for and against, advocates have instead relied on the rhetoric of impending crisis to justify their recommendations for schools and teachers.

As well as influencing student health, teacher health has increasingly been linked to academic achievement. According to the Connecticut State Department of Education, "healthy, engaged teachers and staff are essential supports for student learning."[38] Likewise, the DHPE argues that the health of school employees has the potential to "improve or diminish students' learning."[39] Writing for *School Business Affairs*, Herbert and Lohrmann warn that frequent absences caused by ill health "can have a negative effect on student learning, especially among low-income students, due to the lack of continuity."[40] They also argue that teacher "presenteeism"—or going to work while one is sick—is just as detrimental as absenteeism. Presenteeism is specifically a problem for "teachers who are sick, overweight or lead sedentary lifestyles" as these teachers "do not have the energy to give students the attention or motivation they need to learn."[41]

Unhealthy teachers are also said to affect students' academic achievement in circuitous ways. In their document *Fit, Healthy and Ready to Learn,* the National Association of State Boards of Education argues that it is critical for educators to support academic success among students by encouraging students to adopt healthy lifestyles.[42] In other words, academic achievement is best supported when teachers themselves are healthy and when they can inspire health among children. This is a causal pathway of events that enjoys no empirical support that we are aware of.

Another interesting aspect of a teachers' health obligation is the assumption that health imperatives can and should be seamlessly woven into every academic domain. According to the White House Task Force on Childhood Obesity, more policy effort needs to be aimed at encouraging teachers to "explore interdisciplinary approaches to incorporate healthy eating in the school curriculum."[43] The report suggests that history lessons may "have a subject related to healthy diets, math may include how to calculate the needed caloric intake [and] foreign languages may have students design a menu."[44] These federal recommendations are echoed in Steele's article titled "Health and Fitness: An Issue for High School Teachers and Students."

In it she claims:

> Teachers could suggest that students select topics on fitness when assigning a research paper in an English class, thereby incorporating related ideas while accomplishing the composition goals and objectives. Mathematics examples might include heartbeat monitoring for problem-solving tasks. Integrating lessons on anatomy and physiology related to exercise and nutrition in appropriate science courses can be used to focus on fitness topics. Teachers might clarify the economic impact and public health improvements when individuals and groups increase their fitness and health efforts in a related social studies lesson.[45]

In fact, one of the most striking aspects of contemporary thinking about school health is the way it imagines itself logically infiltrating nearly every aspect of school life and, therefore, affecting all teachers.[46] In addition to teaching about health-related issues, all teachers are encouraged to help students be physically active by providing them with opportunities to move their bodies throughout the day. According to the National Association for Sport and Physical Education, all teachers "have the potential to influence children's healthy behaviors and lifetime choices."[47] They can do so by "including bouts of physical activity into the total learning experience, and in turn, maximize student learning during academic activities that are mostly sedentary."[48] Physical activity breaks are not only assumed to enhance achievement, they are advocated as a way for teachers to address childhood obesity. According to a recent Centers for Disease Control and Prevention (CDC) report, "teachers might read a book aloud while students walk at a moderate pace around the room."[49] The report suggests that "such activities contribute to accumulated physical activity during the school day. Physical activity within the regular classroom also can enhance on-task classroom behavior of students and establish a school environment that promotes regular physical activity."[50] Likewise, the author of Washington State's school health policy tool kit, instructs teachers on how to play "mathercise":

> Teams of students collect one popsicle stick for every lap they run around the perimeter of the playground during their daily 10 minute running activity break. When the laps and popsicle sticks for the teams are tallied up and averaged in the classroom afterwards, a math lesson is incorporated in the exercise break.[51]

Taking the idea of a school that inserts health messages at every possible opportunity one step further, Herbert and Lohrmann suggest that students acquire health messages from every adult working in the school. They write:

> Students spend an average of six hours a day in school surrounded by adults whose actions can influence them profoundly. All school employees, from bus drivers to food service workers, security officers, and custodians have an impact on children.[52]

Taken together, these examples describe school environments in which the bodies and behaviors of all adults at all times are, whether they like it or not, determining the academic and health futures of school students. There is seemingly no escaping one's duty to be healthy and inspire health among children. In this scenario, "healthy" adults "create" healthy students either by displaying their health or through integrating health-related initiatives into classroom instruction. In either case, there is the clear sense that students are assumed to have little or no agency in developing their understandings about health and that the transmission of health knowledge and healthy lifestyles by teachers is a moral obligation and a simple, automatic, and continuous enterprise.

TEACHERS AS FISCAL LIABILITIES

Concern with the health of American teachers is also regularly articulated as a part of broader anxieties about school district finances. Employee ill health is said to contribute to rising health care and insurance expenditures, negatively influence worker productivity, and increase absenteeism.[53] In response, workplace wellness programs are frequently advocated as prudent fiscal investments that will help school employees better manage their health and, in turn, help their district avoid the financial consequences incurred by employee ill health.[54] According to the results of a 2005 survey of school officials responsible for monitoring the finances of American public schools, the cost of employee health care average nearly 10 percent of a district's total expenditures and hinders its ability to provide academic services for students.[55] When asked about ways to control the increase in health-care costs, approximately 70 percent of respondents recommended shifting expenditures to employees through higher insurance deductibles and co-pays. A majority of the respondents also identified district wellness plans as a viable solution.

While policies and programs to address employee health vary in range and scope (i.e., level of coordination, sites of intervention, whether they are voluntary or mandatory), most place emphasis on encouraging health through the reduction of lifestyle-related behaviors. O'Donnell makes the dubiously precise claim that individual health-care costs are lowered by $153 for every decrease in the number of personal health risk factors and rise $350 with every increase.[56]

In an effort to save money and help employees better "manage" their health, advocacy groups encourage school districts to implement lifestyle interventions that address issues such as weight, tobacco and drug use, physical activity, and stress.[57] Some districts intervene in even more specific ways. A notable example is the Washoe County School District's (WCSD) "Wellness Program" in Nevada. Created in 1994, the initiative encouraged employees to follow a range of behaviors including brushing and flossing their teeth, eating less during holidays, drinking water, reducing television viewing time, getting adequate sleep, exercising, and wearing a seatbelt. Employees in the district are provided regular and unambiguous admonitions in the form of reports and newsletters. In one such report employees are told:

- If you smoke, quit. If you don't smoke, don't start.
- If you continue to smoke, avoid smoking around children or individuals with health conditions.
- Avoid illegal drugs and the abuse of alcohol.
- Practice responsible sexual behavior; abstinence where appropriate.
- Buckle up.[58]

Employees who engage in these behaviors are told that they will yield "happiness, fulfillment, productivity and eventually, a retirement free from the pain, suffering and disability associated with decades of poor health and lifestyle choices."[59] Similar to other employee wellness initiatives, WCSD's plan is not simply an altruistic endeavor to promote employee "happiness" and "fulfillment." The financial benefits are promoted as a central purpose of the initiative. In documents aimed at increasing participation, employees are told that the district's current financial crisis is directly related to their lifestyle and "irresponsible health behaviors."[60] These avoidable and unhealthy behaviors are estimated to account for 70 percent of the district's health-care costs, a sum of approximately $81,170,110. Certain lifestyle issues are deemed especially costly:

> Obese individuals spend more on both services and medication than daily smokers and heavy drinkers. For example, obese individuals spend approximately 36 percent more than the general baseline population on health services, compared with a 21 percent increase for daily smokers and a 14 percent increase for heavy drinkers. Obese individuals spend 77 percent more on medications. Only aging has a greater effect—and only on expenditures for medications.[61]

To encourage employees to adopt more healthy behaviors, the district organizes a variety of health-related initiatives throughout the year. These programs are often seasonally themed, such as spring gardening contests and weight-loss incentives around the winter holidays. Employees are encouraged to participate through various incentives including monetary prizes (such as $10 for ever pound lost), gifts (water bottles, gym towels, or gym memberships). A few specific initiatives include:

Brighten your Smile

All participants received a year's supply of dental floss and were encouraged to brush twice and floss once each day during February. Individuals who were completely compliant were entered into a draw for one of ten Sonicares [toothbrush] or one of fifty dental kits.

Exercise for Life

Participants committed to eight weeks of exercise. The Surgeon General's recommendation of five thirty-minute exercise sessions each week was followed. Individuals who were completely compliant with this program received either a 1/4 zip pullover or a v-neck wind shirt with the district's logo embroidered onto the left side.

Buckle Up America!

Participants committed to buckle up each day during October. Individuals who were completely compliant with this program were entered to win one of five $300 prizes to improve the safety of their vehicle or one of twenty-five car safety kits. To receive credit for each day in October, participants and any occupants of the vehicle they were in were to be buckled up properly.

Holiday weight challenge

Participants weighed themselves on any accurate scale before Thanksgiving and then again, under the same conditions, after the New Year. If individuals lost weight or maintained their original weight they received a new pair of exercise pants with the district's logo embroidered.[62]

Another component of the district's wellness initiative is the "Good Health Incentive Program." For this program employees must take a "responsible" action in four specific areas: health screening, blood pressure measurement, tobacco use, and body mass index measurement. By completing each of the requirements employees can reduce their mandatory contribution to the district's "Wellness Program" by $40. Employees are given the following instructions:

Screening Attendance

Take part in the Good Health Incentive Screening each year. If screening is completed, the contribution is reduced $10/month.

Blood Pressure Measurement

"At Risk" status is determined if systolic blood pressure is over 139mmHg and/or diastolic blood pressure is over 89mmHg. If "At Risk," a responsible preventive action is to have a current blood pressure prescription or have a doctor complete the exemption part of the screening form. If "Not At Risk" or a responsible action is taken, the contribution is reduced $10/month.

Tobacco Product Use

"At Risk" status is determined if any tobacco products are used. If "At Risk," a responsible preventive action is to stop tobacco use for ninety days and be rescreened, complete a smoking cessation class, or have a doctor complete the exemption part of the screening form. If "Not At Risk" or a responsible action is taken, the contribution is reduced $10/month.

Body Mass Index Measurement

"At Risk" status is determined by the WCSD Body Mass Index Chart which takes into account age. If "At Risk," a responsible preventive action is to lose weight and be rescreened, complete one of the three approved weight-loss programs, or have a doctor complete the exemption part of the screening form. If "Not At Risk" or a responsible action is taken, the contribution is reduced $10/month.[63]

A similar "Wellness Incentive Program" exists in the School District of Osceola County, Florida. In this program the district "rewards" all qualifying participants with a $100 bonus which is deposited in employee's Health Care Flexible Spending Account. In order to qualify for the bonus employees must a) complete an online health assessment; b) attend a health fair and submit proof of attendance; and c) receive an annual physical and have their physician certify their visit on official letterhead. In addition to the $100 bonus, employees who meet these three requirements will also be entered into a "$100 gasoline gift card give away."[64]

New York's Utica School district employs a similar strategy. Employees participating in the "Maintain, Don't Gain Holiday Weight Challenge" are required to be the same weight on January 4th as they were on November 23rd (during the Thanksgiving and Christmas period). On the promotional material describing the challenge, employees are shown a

picture of two gingerbread cookies. One cookie is lean and happy while the other is fat and sad. To avoid the fat and sad cookie's fate and be eligible for prizes and gift certificates, employees must perform a minimum number of "health activities" and either maintain or decrease their weight during the challenge's duration.[65] Each of the following activities counts for one point and employees are asked to accumulate thirty points each week (but no more than five points can be accumulated per day):

- Be active for twenty minutes
- Eat a healthy breakfast
- Do a random act of kindness each day
- Sleep six to eight hours a night
- Take fifteen minutes for yourself

While just notable examples, organizations such as DHPE and Alliance for a Healthier Generation feature programs like the WCSD and Utica initiatives in their publications and websites, which may add to the proliferation of such programs.

Programs and initiatives like this present lifestyle habits as calculable and alterable. There is an assumption that most individuals, if informed of the *risk* and provided the appropriate intrinsic and extrinsic incentives, will make rational attempts to change their behavior. These programs also rely on a consumer-oriented culture motivated either by cash and prizes or knowledge about the risks associated with unhealthy behaviors. Through these incentives, the "ethos of self-betterment and quality-of-life through consumption [become] the normative code of conduct—and therefore that by which bodies [are] judged, celebrated, or condemned."[66]

Not surprisingly, the use of financial incentives to promote employee behavior change has its critics. The American Heart Association, American Cancer Society, and American Diabetes Association recently issued a joint policy brief arguing that the evidence in support of incentivized behavior change programs is lacking and that the "risk that these plans could be used to discriminate against persons who are less healthy than their counterparts is not insignificant."[67] These kinds of programs also appear to overlook that one's health is mediated by a number of social factors, many of which are beyond most people's immediate control. Factors such as family history, poverty, or congenital predispositions influence one's susceptibility for many of the illnesses outlined by districts. Instead of referring to a number of complex factors that may engender differing states of health, wellness programs reduce health to one single factor: personal choice. By drawing on the rhetoric of freedom and personal choice, these programs also reason that since individuals can choose to be healthy by adopting appropriate or "responsible" behaviors, illness must be the result of choices made to engage in inappropriate or "irresponsible" behaviors. In this way, illness becomes "an instance of

personal moral failure for if we can *choose* to be healthy by acting in accordance with the lessons given us by epidemiological and behavioral research, then surely we are culpable if we become ill."[68] Said differently, unhealthy individuals have broken the neoliberal contract by infringing on the freedom of others, in this case through the additional financial burden incurred by their illness. As Goss writes:

> This type of pressure may lead to situations where employees are prepared to risk damaging their health by, for example, concealing illnesses or disabilities that they fear many serve as the basis for exclusion from work (as has been the case with may people infected with HIV) or engaging in excessive/compulsive dieting or exercise in an attempt to conform to a perceived standard of acceptability.[69]

Another potentially problematic issue is that these kinds of performative programs may inspire a kind of negative collegial policing. Consider the wellness initiative at North Idaho College. Speaking about the drawbacks of the program, Human Resource Director Wade Larson admitted that the program does not always enhance collegial camaraderie. For example, while grocery shopping he had to explain to a coworker that the corn dogs that were in his grocery cart were for his seventeen-year-old son. As with many similar wellness programs, employees at North Idaho College can earn up to $2,000 toward medical expenses if they sign affidavits pledging that they will adhere to certain program requirements, such as not smoking. This, however, has led to some employees ratting each other out when they catch their colleagues breaking the rules. According to an article in the *Chronicle of Higher Education* Larson admitted to receiving telephone calls from employees:

> "Do you know so-and-so is smoking in front of Albertson's?" He ended up calling the employees to tell them they'd been busted. They could either quit smoking and abide by the wellness program's rules, or keep on smoking and get out of the program.[70]

The criticisms of wellness initiatives seem to carry little weight with employers. A recent article in the *New York Times* suggests that the use of incentives to encourage employee health is a growing trend and, increasingly, "employers are taking the programs a step further, by penalizing employees who do not make healthy choices and linking incentives to measurable results."[71]

Whether or not school-based employee wellness programs result in significant fiscal dividends for school districts is a complex matter. What interests us more is the way teachers are positioned as responsible—and therefore potentially irresponsible—for their school district's financial predicament. At the very least, these initiatives send mixed signals about whether the health and happiness of teachers or district finances are the primary motivating concern. What seems less debatable though is that

these programs are informed by a number of key assumptions: that one's health can and should be managed by the individual; that districts can and should attempt to shape teachers' health behavior as well as their subjective feelings and attitudes toward their own health; and that teachers' health decisions directly and substantially determine the fiscal stability of school districts. Alongside the ideas discussed in the previous section, what emerges is a rhetorical environment in which teachers are constructed as responsible for a huge and diverse range of educational, medical, and economic outcomes. Under these conditions the professional and personal autonomy of teachers are now fair game for a torrent of advice, instruction, coercion, and regulation, much of it insulting, trivial, and of dubious merit.

TEACHERS AS INSTRUMENTS OF POLICY COMPLIANCE

In this final section we consider the passage of the 2004 Local Wellness Policy (Section 204 of P.L. 108-265) and its subsequent amendment, the Healthy, Hunger-Free Kids Act of 2010 (Section 204 of P.L. 111-296). Since its enactment the legislation has contributed to the creation (or in some cases the expansion) of a large school-based wellness bureaucracy. Multiple layers of governance at both the federal and local level now exist to implement or assist LEAs and schools implement this mandate.[72] At the federal level, multiple agencies including the CDC, USDA, Department of Education and Department of Health and Human Services (DHHS) are involved. Representatives from these agencies have established an Interagency Workgroup to assist LEAs with information and technical assistance. At the local level, the Wellness Councils—comprising parents, students, representatives of the school food authority, members of the school board, school administrators, teachers, health professionals, and members of the public—are responsible for policy creation.

On the one hand, it is interesting to note that these policies can be developed in the complete absence of any professional expertise in public health intervention. Closer to the concerns of this chapter, though, all school employees—even teachers who had no role in their development—are required to implement whatever measures the Wellness Council decides upon, whether or not they agree with them.[73] In many instances teachers are told to ban, encourage, and/or monitor the consumption of certain foods, address issues of nutrition and wellness across the curriculum, and provide regular opportunity for physical activity.[74] Teachers are further required to document these activities in an effort to assist their schools to demonstrate wellness policy compliance.

At the same time, it is widely acknowledged that the capacity of teachers to fulfill responsibilities associated with school wellness policies is limited. Writing in 2011, the Interagency Workgroup reported, "More

support is needed from school and district personnel, including teachers, principals, and superintendents, to implement and enforce" wellness policies.[75] Snelling, Belson, and Young's article for the *Journal of Child Nutrition and Management* concurs, while calling for improvements in teachers' knowledge and practice in order to help schools achieve the goals (i.e., obesity reduction) of the federal legislation.[76] Teachers themselves report that they lack the necessary time, resources, and support to effectively implement wellness policies.[77]

The picture that emerges from all this legislative and policy activity is one in which the performance of policy compliance has become the main concern of schools and the teachers whose working lives are impinged upon. There are few signs, if any, that the wellness legislation has unleashed a wave of innovative and effective childhood obesity measures. In fact, the bureaucratic structures created in the wake of the legislation appear now to exist solely for the purpose of helping schools to comply with the legislation, a not insignificant problem given the long list of competing priorities (such as high-stakes literacy and numeracy testing) with which public schools must grapple, all in the context of increasingly severe budgetary pressures.

While these developments raise different issues from those discussed in the previous two sections, what all three sections share is the chorus of governmental voices—politicians, academics, lobby groups, policy advocates—that school teachers must be healthy, are responsible for student health, and that failure in this area will have negative personal, professional, bureaucratic, medical, educational, economic, and moral consequences. And even if, as it appears, many teachers have simply remained ignorant or resisted it, the very existence of the wellness legislation is emblematic of an all too familiar neoliberal "carrot-and-stick" policy dynamic in which goals and targets are set from above and the personal and professional autonomy of teachers counts for little.

These examples also illustrate the way school health policies demand a highly performative response from teachers. That is, they are called upon to aspire to particular healthy ideals as a way to demonstrate their commitment to children and the rest of the profession. In a 2005 article published in the journal *Critical Public Health,* Kelly and Colquhoun discussed the ways in which professional educators are being seen, and increasingly seeing themselves, as psychologically stressed. They question why the self is so widely imagined in terms of stress and, more specifically, inquire into the "processes that make it possible . . . to link the success or otherwise of a massive institutional process of state-regulated schooling to the health and well-being of teachers."[78] In this chapter we have taken up similar kinds of questions and broadened it to consider the construction of the "healthy" teacher as a necessary instrument of educational effectiveness in American public schools. Our research suggests that this is achieved by emphasizing three apparently quite unrelat-

ed imperatives: student health and academic achievement, district finances, and policy compliance.

These three imperatives, particularly as they are rhetorically linked to institutional effectiveness, have the potential to responsibilize teachers in new ways. Teachers are compelled, for example, to *manage* their health and engage in forms of self-reflection and surveillance. Caring for the self emerges as new kind of professional duty, an ethical responsibility and obligation for "individual teachers and those that govern the work practices of teachers."[79] In this way, losing weight, eating healthy foods, exercising, refraining from smoking, and implementing various health instructional practices is not done simply to make one healthy, but becomes a kind of performance and professional ethic. The justifications for the bureaucratic and ideological control of teachers' health are normative at the same time that they represent new forms of responsibilization. Put another way, teachers are receiving the message that they must look over their shoulders *and* into the mirror in an effort to be good teachers and good employees.

Stephen Ball's work on the subject of teacher identity and performativity is particularly instructive here. Ball argues that performativity acts as a "technology, a culture and a mode of regulation that employs judgments, comparisons and displays as means of incentive, control, attrition and change based on rewards and sanctions (both material and symbolic)."[80] He further suggests that contemporary educational reform mandates have contributed to a recasting of teacher identity. Reform imperatives provide teachers with new roles, as they are "reworked, as producers/providers, educational entrepreneurs and managers and are subject to regular appraisal and review and performance comparison."[81] In this new professional environment, teachers experience a kind of ontological insecurity: unsure whether they are "doing enough, doing the right thing, doing as much as others, or as well as others, constantly looking to improve, to be better, to be excellent. And yet it is not always very clear what is expected."[82] As the above examples illustrate, the messages are presented as apparently simple yet in many cases are saturated with contradictions—should they tell students they have lost ten pounds as Yaussi recommended or avoid talk of dieting altogether as the Minnesota's Department of Education recommended? And, in either case, to what effect?

These health imperatives have the potential to contribute to the kind of ontological insecurity Ball describes. Thus, while they offer teachers new professional identities, recommendations, and rules for living, these identities seem to take little account of the material reality of modern schools, ranging from the vague to the onerous and from the impractical to the trivial and insulting. Moreover, we think it is particularly telling that so much research into school-based anti-obesity initiatives is concerned with measuring whether teachers have the "right" attitudes and

dispositions about health and whether or not schools and teachers are doing what the various commentators in this policy space are telling them to do, rather than whether there is any prospect of schools and teachers being able to make children thinner. In fact, the consistent and well-documented lack of success among school-based anti-obesity interventions, even under carefully controlled conditions, is very rarely acknowledged.[83]

HEARTS, MINDS, AND BODIES

The tendencies to hand intractable social problems to schools and invest unrealistic moral and medical faith in the work of teachers are both old, widespread, and unlikely to disappear any time soon. At the very least, however, we would make the point that critical voices in the research and scholarship of school health are rare and hugely outnumbered by what amounts to an academic-industrial complex devoted to promoting the public health mission of schools. In some respects, the goals and achievements of this movement are laudable. However, we think it striking that so little research in the field of school health actually questions the idea of schools as an instrument of public health policy and, closer to the concerns of this chapter, takes an interest in the experience of teachers within the policy maelstrom that now exists. Not only is so much of what is claimed about the ability and responsibility of teachers to magically infect students with good health fanciful and unfair; the wildly disparate reasons offered for why they should do this suggest a determination not to think carefully about some of the health problems that concern us. In their haste to see schools and the work of teachers as mere instruments in their own professional project, public health workers, advocates, and researchers have failed to recognize the suffocating regimes of neoliberal accountability, sanction, and de-professionalization that teachers are already subject to.

What seems most striking about all these efforts is the sort of environment that would exist were the policies described in this chapter consistently and assiduously applied across the country. Teachers would need to be constantly vigilant about the food they ate, both in front of students and elsewhere, the amount of exercise they did, and, above all, the body shape they took to work. Although there is no evidence to support the claim, if a teacher's health profile really did affect the academic achievement of students we would also expect parents, school administrators, and educational leaders to put ever more pressure on teachers to be healthy. We might even expect some kind of screening such that only teachers who looked healthy and displayed the right health behaviors would be allowed to teach.

What we do know is that there appears to have been at least some examples of teachers' resistance to health measures that have affected their working lives.[84] And while the extent of this disruption and discomfort will probably always remain unknown, we would simply ask whether the working lives of teachers and the educational experiences of children have been helped. We would remind readers that teachers have always been on the receiving end of advice about what they should value and how they should look, think, behave, and present themselves in front of children. What is different in these contemporary examples is the way it is framed, partly in economic terms, but also the way it adds to the long and growing list of things for which teachers and schools are called on to be "accountable." There also appears to be a growing variety of voices prepared to hector teachers about their personal lifestyles: obesity researchers, politicians, health economists, and even the World Health Organization. The hearts and minds of teachers are, it appears, everyone's business.

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15. It is important to stress that we do not deny that material health problems exist for individuals and collectives and that structural inequalities inform access to and distribution of programs and resources that influence individual health trajectories. What interests us here though is the manner in which these health states are articulated, discursively legitimated, and regulated. Our ultimate aim is to stimulate thought and discussion about the multiple ways in which teacher subjectivities are implicated in contemporary health injunctions.

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74. Bogden et al., *Fit, Healthy and Ready to Learn*; Centers for Disease Control and Prevention, "School Health Guidelines,"; Patterson, *School Health Connection*; White House Task Force on Childhood Obesity, *Solving the Problem of Childhood Obesity*.

75. Interagency Workgroup, *Five Year Technical Assistance and Guidance Plan for Local School Wellness Policies* (USDA Food and Nutrition Service, U.S. Department of Education, and DHHS Centers for Disease Control and Prevention, 2011), accessed November 15, 2013, http://opi.mt.gov/pdf/SchoolFood/Wellness/LocalSchoolWellness_Overview.pdf.

76. Anastasia M. Snelling, Sarah Irvine Belson, and Jessica Young. "School Health Reform: Investigating the Role of Teachers," *Journal of Child Nutrition & Management* 36, no. 1 (2012): n1-6.

77. Elaine S. Belansky et al., "Early Impact of the Federally Mandated Local Wellness Policy on Physical Activity in Rural, Low-income Elementary Schools in Colorado," *Journal of Public Health Policy* (2009): S141-S160.

78. Kelly and Colquhoun, "The Professionalization of Stress Management," 138.

79. Peter Kelly and Derek Colquhoun, "Governing the Stressed Self: Teacher 'Health and Well-Being' and' Effective Schools,'" *Discourse* 24, no. 2 (2003): 191-204.

80. Ball, "The Teacher's Soul," 216.

81. Ibid., 217.

82. Ibid., 220.

83. Fiona Davidson, "Childhood Obesity Prevention and Physical Activity in Schools," *Health Education* 107, no. 4 (2007): 377-395; Kevin C. Harris et al., "Effect of School-based Physical Activity Interventions on Body Mass Index in Children: A Meta-Analysis," *Canadian Medical Association Journal* 180, no. 7 (2009): 719-726; Patricia Constante Jaime and Karen Lock, "Do School Based Food and Nutrition Policies Improve Diet and Reduce Obesity?," *Preventive Medicine* 48, no. 1 (2009): 45-53.

84. See, for example, Wilson, "College Employees Lose Weight"; Michelle Cole, "Teachers Want Junk Snack Back—For Themselves," *The Oregonian,* February 14, 2009, http://www.oregonlive.com/politics/oregonian/index.ssf?/base/news/1234587316281120.xml&coll=7; Jonathan Kleppinger, "Sugared Drinks Return to Teacher Vending Machines," *Central Kentucky News,* May 15, 2013, http://articles.centralkynews.com/2013-05-15/jessaminejournal/39289397_1_vending-machines-teachers-sugared-drinks.

NINE
Health for Sale

Finally, our attention turns to a more recent development in the area of school health policy making, that of privatization schemes and industry involvement in the construction and implementation of school health initiatives. This involvement is presented against broader historical, political, and economic trends within educational policy in the United States. In particular, we contend that privatization must be understood alongside the changing dynamics of the state; its diminishing role in some areas of public policy, particularly schools but also social welfare more generally. In part, we attribute these changes to the growing influence of the neoliberal turn in social policy we discussed in chapter 6, and which has resulted in a growing set of connections between public institutions, political figures, and corporations.

McCarthy and Prudham describe neoliberalism as "a complex assemblage of ideological commitments, discursive representations, and institutional practices, all propagated by highly specific class alliances and organized at multiple . . . scales."[1] A central feature of this logic is the belief that the "unfettered market, not democratic institutions, should be the organizing agent for nearly all political, social, economic, even personal decisions."[2] The notion that private enterprise is the mechanism for addressing policy issues is not just the mantra of the representatives of corporations themselves but is also echoed by public and political figures who depend on those corporations for support.

A result of this phenomenon is the tendency for politicians, corporations, and schools themselves to articulate support for privatization schemes in a variety of forms. And while American public schools have long engaged in various forms of privatization (i.e., custodial services, transportation, text book adoptions) we would contend that the contemporary political and economic environment has enabled the expansion of

their scope and reach. Privatization is increasingly "taking place 'of,' 'in' and 'through' education and policy and 'in' and 'through' the actions of the state."[3] Private stakeholders serve as key advisers, evaluators, service deliverers, philanthropists, researchers, reviewers, brokers, "partners," committee members, consultants, and auditors.[4] And because of these kinds of public/private collaborations, the distinctions between advice, support, and lobbying are often difficult to discern.[5]

One effect of privatization on public policy, then, is that it contributes to a generalized blurring of public/private distinctions. Boyles goes as far as suggesting that schools have so "broken down under the weight of economic forces of privatization" that any distinction between the public and private sphere is more ideological than material.[6] There is, in other words, a sense in which the "public" part of public school policies and practices is almost entirely symbolic or nostalgic, not substantive. The kinds of interdependencies that Boyles describes have had a particularly strong impact on the health priorities of schools and have come to characterize and/or inform most, if not all, contemporary school health policies and practices: from the contracting out of school food processing and the sale of soft drinks, to schools' dependence on the private sector to develop "standards-based" health curriculum and compliance reporting.

This chapter describes some of the ways in which private and public entities work on and through health policies and practices in schools. We first contextualize the issue by providing a brief overview of the private sector's influence over school food and meal programs. This discussion highlights those forms of corporate influence that are perhaps most obvious, such as product placement and industry lobbying. We then consider some less obvious forms of industry influence, such as the formation of strategic health "partnerships" between industry and schools as well as state and federal regulatory agencies. These partnerships are perhaps most interesting because of the way they are constructed and justified by their advocates as necessary for the health of children. However, our investigation suggests the existence of a complex set of self-serving connections between industry and government in the crafting, execution, and evaluation of school policies that only purport to address children's health. These entanglements clearly function to increase corporate profits, enhance the image of particular industries, and fend off more stringent government regulations. Our analysis also suggests that regardless of whether industry influence over school health policy occurs overtly or more subtly, both sets of tactics have potentially negative discursive and material consequences for students, teachers, schools, and educational governance.

INDUSTRY AND SCHOOL FOOD

While there is nothing necessarily new or surprising about the influence of food industry lobbying, it receives surprisingly little scrutiny in the academic education literature. Perhaps most obviously, their activities have direct consequences for both educational policy generally and school health policies and priorities in particular. In the case of school foods, industries have long attempted to control what, when, and how much children are permitted to consume. More than this practical implication, however, the food industry also works to shape ideas about what foods are considered healthy and acceptable or, conversely, unhealthy and unacceptable. After all, given the recent escalation of health consciousness in schools, a food item's continued inclusion in the federally-sponsored school meal program—a program, at least theoretically, intended to ensure all children have access to healthy meals—may suggest to children or the wider community that food products offered in schools are indeed healthy.

Another reason to document the lobbying of the food industry is to contrast it against industry-sponsored health "partnership" work. This contrast reveals important tensions and contradictions when it comes to industry "concern" with children's health. And while this latter point is perhaps most conspicuous when considering the work of those industries accused of selling "unhealthy" foods in schools, it remains our contention that private influence in school food policy is inherently problematic, irrespective of the nutritional content of the products they are selling.

As we discussed in chapter 5, the food industry and its complex assortment of alliances have a long history of influencing school food policies and regulations. On the one hand, participation in federal meal programs is a potentially lucrative area of business. Today, approximately 32 million children in the United States participate in federal meal programs with 21 million of these children qualifying for free or reduced-priced meals.[7] Federal meal programs are also ostensibly public initiatives managed through joint government and industry collaborations. The federal government allocates approximately $14.8 billion for food programs in schools each year.[8] About $1 billion of this funding comes in the form of raw food commodities like chicken, beef, and potatoes. Because many schools lack the facilities, finances, or personnel to transform raw commodities into school meals they must turn to privately operated food service management companies (FSMC). These companies take responsibility for the operation and management of school meal programs, its facilities maintenance, staffing, accounting, and state and federal reporting. Because not all FSMCs directly process the raw food commodities schools are sent, they further contract out with other manufacturers such as the Tyson and Schwann Food Co. In 2011, a *New York Times* article reported that $445 million worth of food commodities was sent to compa-

nies like Tyson and Schwann Food Co. for processing, a figure that has risen around 50 percent since 2006.[9]

As we also mentioned in chapter 5, aside from contracting food services to FSMCs, many schools also partner with soft drink companies as a way to generate additional funding. Recently, a ten-year contract with Coca-Cola netted a school district in Rockford, Illinois, $4 million upfront and a subsequent $350,000 each year thereafter. This money "funded field trips, gym uniforms, SMART Boards and other frills that individual school budgets may not otherwise have afforded."[10] Rockford's experience is not unique. According to a study published in the journal *Pediatrics*, more than 80 percent of high schools have made similar kinds of contracts.[11] All of these food and soft drink contracts were made possible by the 1983 U.S. Court of Appeals decision that sided with the National Soft Drink Association (NSDA). This decision determined that the United States Department of Agriculture (USDA) had gone beyond congressional intent in establishing time and place restrictions on the sale of competitive foods in school. Because of this ruling, decisions about the sale of vending machines and lucrative *à la carte* items were left to the discretion of Local Educational Authorities (LEAs).

After significant pressure by public health advocates more than twenty-five years later, the 1983 decision was successfully challenged by the 2010 Healthy, Hunger-Free Kids Act which featured, among other things, the Wellness Policy provision (Section 204 of P.L. 108-205). In addition, the Act called for the USDA to reestablish national nutrition standards for all foods sold on campuses throughout the school day. This included foods sold as part of the federal meal programs as well as food sold outside the program, including *à la carte* items, soft drinks, and foods sold in vending machines, school stores, and school fund-raisers. Congress instructed the USDA to utilize the Institute of Medicine's (IOM) nutrition recommendations to align school food standards with the USDA and Department of Health and Human Services' (DHHS) *Dietary Guidelines for Americans*. These guidelines, often referred to as the "cornerstone of federal nutrition policy," are designed to provide "authoritative advice about consuming fewer calories, making informed food choices, and being physically active to attain and maintain a healthy weight, reduce risk of chronic disease, and promote overall health."[12] In January 2010 and in response to Congress's directive, the USDA presented its first set of nutrition standards for public comment. These recommendations only affected foods sold in conjunction with federal meal programs (i.e., they did not include *à la carte* items, vending machine sales, and foods sold in fund-raisers).[13] Among other things, the recommendations included reductions in starchy vegetables, sodium, and trans fats, and increases in vegetables, fruits, and whole grains. And while previous standards permitted schools to serve milk of any fat content, the USDA directed

schools to offer only unflavored 1 percent or fat-free flavored or unflavored milk.

Shortly following the publication of the proposed rules, various industry trade groups voiced their opposition. The United Dairy Council, for example, protested the elimination of 1 percent flavored milk. The Milk Processor Education Program (MilkPeP) and the National Dairy Council partnered to run an aggressive "Raise Your Hand for Chocolate Milk" campaign. The campaign was intended to educate about the benefits of chocolate milk in schools, and parents and educators were asked to sign a petition of support for its continued inclusion on the school menu.[14] The campaign successfully garnered the support of some nutritionists, celebrities, and national organizations such as the American Academy of Family Physicians, American Academy of Pediatrics, American Heart Association, National Hispanic Medical Association, National Medical Association, and School Nutrition Association. The campaign specifically targeted mothers of schoolchildren. In the official MilkPep press release, dietitian and mom Felicia Stoler argued:

> As a mom and nutrition expert with a particular focus on kids' health and wellness, I've joined this campaign to make sure moms know the facts and raise their hands. . . . Moms can't be with their kids at every meal. I think it's essential to make sure schools are offering nutrient-rich options that kids will actually choose without mom standing over them.

In addition to these efforts, the campaign posted a youtube video to further convince people of the health benefits of chocolate milk.[15] The flavored milk campaign achieved a degree of success; while 1 percent flavored milk was ultimately not placed back on the menu, fat-free flavored milk was not taken off—a recommendation that was increasingly being made by a number of educators and nutritionists.[16]

Other industry trade groups affected by the proposed rules also intensified their congressional lobbying. For example, in 2011 the American Frozen Food Institute spent $543,000 (up from $334,000 in 2010), Schwann Food Co. spent $50,000, and ConAgra Foods Inc. spent $400,000.[17] These groups also recruited legislators to lobby the USDA on their behalf. Senator Amy Klobuchar, a Democrat from Minnesota, issued a letter to the USDA arguing against the rules which, if implemented, would no longer permit pizza to qualify as a vegetable. Under the previous nutrition standards, the tomato sauce component of pizza afforded it vegetable status. Perhaps not surprisingly, Minnesota is home to the Schwann Food Co., a business with nearly $3 billion in annual sales, which controls more than 70 percent of the school frozen pizza market. Klobuchar's industry connections were further highlighted when a Minnesota Public Radio report revealed that her letter to the USDA contained a passage identical to Schwann Food Co.'s letter to the USDA. Both letters

contained the sentence: "By changing the crediting, many tomato-based sauces and salsa-type applications would no longer be factored into the weekly requirements for vegetables."[18]

Republican Representative John Kline also voiced opposition to the USDA's changes. As chairman of the House Education Committee, Kline cited concerns about the overall cost of the new rules in his letter to Agriculture Secretary Tom Vilsack. Kline also told reporters that he has a philosophical objection to the federal government setting nutritional rules for school lunches. "That presupposes the only way you can address childhood obesity or get responsible behavior on the part of adults is to have a law from Washington, D.C., . . . I fundamentally reject that notion."[19] According to Minnesota Public Radio reporter Brett Neely, both Klobuchar and Kline have received regular donations to support their political campaign from Schwann Food Co.'s political action committee (PAC) and the PAC that represents the American Frozen Food Institute.[20] Legislators also critiqued the proposed limits on starchy foods. Arguing that new rules had no basis in nutrition science, Republican Senator Susan Collins of Maine and Democrat Senator Mark Udall of Colorado opposed the USDA's decision to reduce servings of starchy foods. According to Collins, "The department was well intended in trying to improve the nutritional quality of school meals . . . but in this case it just missed and went too far."[21] Voicing a similar perspective Udall argued, "the problem is not with the potato, but with how it is sometimes prepared."[22]

In the end, industry's lobbying proved largely successful. Pizza remained a vegetable, and the recommended reductions in starchy vegetable servings were overturned. However, to further curtail the USDA's authority, Congress drafted a separate agricultural bill to block what it called "overly burdensome and costly regulations" that would limit the "flexibility for local school districts to improve the nutritional quality of meals in the National School Lunch and School Breakfast Programs."[23] In particular, it decided that no federal funds could be used to set any maximum limits on the serving of vegetables in school meal programs and that the tomato paste used on pizzas could count as a vegetable. Their bill secured the potato's presence on the menu and affirmed pizza's status as a vegetable. And while the issue received some media attention, Michelle Simon, a public health attorney, wrote that mainstream reporters overlooked the most significant aspect of the story:

> This issue isn't just that the processed food industry is upset with proposed improvements to school meals, it's how they are flexing their political muscle to get their way. The critical (and most under-reported) part of this story is how Congress has hijacked the USDA regulatory process to do the food industry's bidding.[24]

In other words, in a rather surreptitious political maneuver Congress used the agriculture bill to work outside of the usual legislative process, thereby undercutting the USDA's authority.[25]

Lobbying continued even after the rules were legislated. In October 2012 Republican legislators Kristi Noem of South Dakota, John Kline of Minnesota, and Phil Roe of Tennessee coauthored a letter arguing against USDA's new rules on the grounds schools were having difficulty meeting the more stringent standards, specifically—and not surprisingly—the new grain and meat maximums. Under the new rules schools needed to limit the amount of grains and meats/meat alternates served each week, a recommendation informed by the IOM's research. In their letter to the legislators they issued a formal request for a Government Accounting Office (GAO) investigation on the matter.[26]

In response, the GAO conducted a study, and in June 2013 published its report calling for the USDA to permanently remove the meat and grain maximums. The finding was based on interview data collected from food service employees and "relevant industry representatives" in eight school districts across the country.[27] Interestingly, however, the GAO's justification for removing the proposed meat and grain maximums had nothing to do with nutrition. Instead, echoing the legislators who prompted the study, they recommended eliminating the maximums on the basis of logistical and financial reasons, finding that "all [school districts] were challenged by the new limits."[28] According to the report, in one district:

> The tortilla wrap size change was followed by a significant decrease in the number of students selecting their lunches from the previously popular deli sandwich line in the high schools, as well as a decrease in the percentage of students purchasing school lunches in those schools. Another district's change to its submarine roll prompted a student boycott of the lunch line that lasted for three weeks.[29]

Similar to the rationale made for changing the vegetable requirements, the GAO argued that lifting the grain maximums would provide schools greater flexibility in choosing meal products and thereby increase school meal participation. Aside from the fact that the GAO's recommendations completely sidestep issues of nutrition, we also question whether school food personnel and industry representatives were the most objective or appropriate individuals to solicit views on what was, at least originally, a USDA mandate originating out of concerns about children's health.

Industry representatives have also reacted to the recent proposed nutrition amendments to The Fresh Fruit and Vegetable Snack Program (FFVP). A relatively small program, the FFVP provides produce to elementary schools with high percentages of low-income students. In 2013, for example, the program was allocated more than $165 million in annual funding for schools to provide snacks to approximately 3 million chil-

dren.[30] According to the USDA the new rules better reflected the intent of the policy; to provide *fresh* produce to children. Under the proposed rules published in February 2012, frozen, canned, dried, vacuum-packed, and other types of processed fruits and vegetables could no longer be served. According to ElBoghdady, a *Washington Post* reporter, this decision "touched off the ultimate food fight . . . pitting factions of the food industry against one another in a bout of frenetic lobbying."[31]

Following the release of the proposed amendments, the Food and Nutrition Service, an affiliate agency of the USDA responsible for the regulation of school food, opened the proposal for public comment. On one side of the debate were various Republican legislators and industry representatives from the frozen, canned, and dried fruit industries. Generally, these groups argued against the ban, maintaining that all forms of produce are equally as nutritious as fresh produce. According to Corey Henry, spokesperson from the American Frozen Food Institute, "if the goal is to expand and improve upon childhood nutrition, it doesn't make sense to limit the kinds of fruits and vegetables that schools serve."[32] He went on to claim that individual schools, not government agencies, should decide what to serve children. Among those taking a similar position was a powerful alliance of fifty-seven industry groups including Del Monte Foods, the California Dried Plum Board, The Schwann Food Co., the California and Texas School Nutrition Associations, and the Pennsylvania Association of School Business Officials. The group drafted a letter to Debbie Stabenow, chairwoman of the Committee on Agriculture, Nutrition and Forestry, and other senior officials, in which they claimed that broadening program requirements to include frozen, canned, and dried produce was not only an effective way to promote "healthy eating habits that will last a lifetime" but would also "teach kids how to get the most nutrition bang for their buck as frozen, shelf-stable and dried produce are often the most affordable."[33] The letter goes on to argue that many of the low-income schools the FFVP "is meant to reach do not have the staff or infrastructure to handle raw, fresh-cut produce."[34]

Allen Scott, the Northern California regional manager of Wawona Frozen Foods, concurred with this perspective. Scott drafted a letter to the Food and Nutrition Service (FNS) claiming that frozen, canned, and dried produce are more "consistent and reliable" and that there is "strong documented evidence that [these foods] are as nutritious as fresh produce."[35] While Scott does not provide examples of this evidence, he did offer the FNS yet another reason to allow frozen, canned, and dried produce in schools. He writes: "The FFVP is targeted to at-risk schools. In many of these neighborhoods, there is limited access to low-cost fresh produce. So the children cannot replicate what they learn in school when they get home."[36] Not only are Scott's justifications for serving children frozen, canned, and dried produce an obvious departure from the originally stated purpose and function of the program, they are indicative of

the curious intellectual maneuverings that financial self-interest tends to provoke.

According to the USDA, the FFVP was established to expand the variety of fruits and vegetables children experience, increase fruit and vegetable consumption, improve children's diets, and introduce children to a variety of foods they may not have otherwise had the opportunity to sample. In other words, the FFVP is designed to *counter* exactly what Scott is proposing; that is, to serve children those foods that they may *not* have access to in their homes. Scott's ideas appear to suggest that children in the most unfortunate circumstances should have school foods served to them that reinforce the "limited access to low-cost fresh produce"[37] that already exists in their community. Given the highly racially and socioeconomically stratified nature of schools in the United States, his argument also appears to be that nutritional guidelines on school meals should vary by geographic, racial, and socioeconomic location.

Scott's statement also implies that the FFVP was established with certain functional goals in mind, such as that children should learn to replicate at home what they learn about food in schools. According to the USDA, however, the FFVP was not established with this didactic purpose. Rather, it was intended as a socioeconomic safety net aimed at countering the negative effects of poverty by providing a direct transfer of nutritious food to target individuals, in this case, children of low-income families.

On the other side of the FFVP debate were industry representatives of the fresh produce sector and public health advocates who praised the USDA's proposed rules. Issuing a position contrary to their state's own School Nutrition Association, the California Department of Education called for fresh produce to remain the program's priority. The Department of Education maintained that children already "have plenty of exposure to frozen, canned and dried produce in federally subsidized school meals."[38] United Fresh Produce Association (UFPA), a produce industry trade group, issued a similar statement in support of the ban on processed produce.

The fresh versus processed food controversy certainly raises an important and legitimate debate about what foods federally sponsored meal programs should endorse, or more generally, what foods children should consume and what foods contribute to a healthy diet. Perhaps more fundamentally, though, the issue raises questions about which groups can or should be seen as credible stakeholders and be allowed to have a major influence over policy decisions. The controversy also accentuates the tensions created by economic interests that are competing for a sanctioned spot in school meal programs. Fueled by the imperative to protect market share, the outcome of these clashes can result in school food policies that may have little to do with health and the well-being of children—even as concerns over children's health and well-being are surreptitiously used to

publical rationalize industry agendas. According to Senator Tom Harkin (Democrat—Iowa), the FFVP's lead sponsor, legislators are routinely pressured by industry to modify the program's nutritional stipulations. "I'm regularly lobbied to add nuts to the program . . . I once had someone suggest that Congress add beef jerky."[39] For Harkin, catering to the special interests of industry is both time consuming and distracting: "Every day we spend in countless debates about pistachios or Craisins is a day we don't spend fighting for why the FFVP should be expanded and protected."[40]

While the lobbying of industry may seem relatively unproblematic (for example, fresh produce versus beef jerky), our point here is to highlight that most (if not all) industry attempts to influence policy are not driven by a concern with young people's health even though they may be represented this way. United Fresh Produce Association (UFPA), a produce industry trade group, has regularly lobbied to expand the FFVP so that it is offered in schools across the country, not simply low-income schools. According to their calculations, implementing the program in just one hundred additional schools in each state "would bring $200 million in immediate annual incremental sales" for the industry.[41] With students not currently served by FFVP in mind, United Fresh also predicts that "if those students catch the fruit and vegetable 'snack habit' and continue choosing one snack a day, they'd buy 14 billion dollars in fresh produce before retirement."[42]

As their statement highlights, UFPA's participation in school meal programs has an eye on both immediate and future profitability. In fact, they remind their members that lobbying efforts are critical to realize the "strongest public policy impact."[43] At the same time, however, there exists a lack of transparency with respect to the kind of influence these industries exert over policy makers, such as via campaign donations. Consider, for example, their public relations strategy outlined in the document *2012 Government Relations Priorities*.[44] In it, the UFPA tells its trade industry members that they will work to "shape [the] USDA's proposed regulations on nutrition standards for competitive foods and beverages sold in schools."[45] Later in the document UFPA promises to "continue to work closely with the First Lady's Let's Move! office and the Partnership for a Healthier America" to support the interests of trade members.[46] Their statement clearly positions themselves as policy partner—indeed, a policy shaper. And yet how this "shaping" and "working with" policy makers will be realized is not disclosed. Lobbying of this kind creates complex webs of interdependence between various industry groups and government agencies; webs that reflect both alliances and antagonisms as groups vie for influence over a range of school food policies and programs.

PARTNERSHIP WORK AND SCHOOL HEALTH

In addition to engaging in direct forms of lobbying, industry also attempts to influence school policies and practices in more subtle ways. In this next section we provide an overview of the various forms of industry-sponsored activity in schools that opportunistically capitalizes on concerns for children's health as a way to influence policy or establish a presence within schools. As we have already suggested, attempts to expand private/public partnerships involving schools need to be understood against the backdrop of the neoliberal turn in public policy that favors privatization, deregulation, commercialism, devolution, and individualism.[47] According to Ball, public/private partnerships have become a key neoliberal strategy and part of the "new landscape of public sector provision."[48] As a rhetorical device, the discourse of partnership helps to harmonize the interests of business, philanthropic and nongovernmental agencies with public sector actors. In particular, partnership work tends to be positioned as an essential feature of successful public sector reform. Partnerships are said to inject innovation, creativity, entrepreneurialism, and solutions for public sector actors that are assumed to be resistant and risk adverse.[49] Partnerships, in other words, "are the smiling face of intervention, change without pain."[50] And while they certainly act as "elements of government and governance" they are also praised for their ability to "work outside of or around the rational-bureaucratic aspects of government and bring commercial and social entrepreneurship to bear on policy problems."[51] Thus, the belief that there are social problems the public sector cannot independently or efficiently solve helps to create, legitimize, and multiply the points of entry for private sector involvement. As we will see, the intersection of public schooling and children's health represents fertile ground for these partnerships.

The Alliance for a Healthier Generation, an organization formed by the American Heart Association and the William J. Clinton Foundation, provides an interesting example of the multi-faced nature of partnership work. According to their website, "change comes when individuals, groups and systems work together to create healthy environments for kids."[52] They claim to offer advice and resources for school professionals, teachers, and students on matters of health, specifically as this relates to obesity. To this end, they provide curricular materials, tools, and templates to assist schools in developing local school wellness plans. They also oversee the Healthy Schools Program and the Healthy Schools National Recognition Award, a competitive program designed to encourage schools to implement various health policies and practices by awarding them platinum, gold, silver, or bronze status.

Although the Alliance for a Healthier Generation itself is a nonprofit entity, its ultimate, though less visible function is to secure profits for the corporations that support it. Their efforts to unite food and beverage

companies with school food purchasers is one example of this. Advertised as a way to assist schools to purchase healthy foods, the Alliance for a Healthier Generation maintains a list of purchasable "approved" food products; those food items *they* designate as nutritious. The website contains a "Product Navigator" tool to help schools "find a growing list of Alliance approved products," manufactured by companies such as Annie's Frozen Yogurt, Blue Bunny Ice Cream, the Coca-Cola Company, Dole Food Co., Del Monte, Dominoes Pizza, PepsiCo, Kraft, McCain, Smoothie King Franchises, Slush Puppy, Tyson, and Popcorn Indiana, to name only a few.[53] Schools are also encouraged to purchase Alliance-approved products to improve their chances of receiving a prize in the Healthy Schools Program. Winning schools must show evidence that all school food and beverage products are in compliance with their guidelines.

Another important aspect of the Alliance's work has been to help broker voluntary agreements between schools and industry on what foods and beverages can be sold on school grounds. For example, they worked in conjunction with various food and beverage companies to develop "Competitive Food Guidelines, School Meal Guidelines and School Beverage Guidelines." Perhaps most notable is that the School Beverage Guidelines (SBG) were developed in collaboration with the American Beverage Association (ABA). The 2006 SBG were voluntary and industry regulated; purportedly created to limit students' access to high-calorie soft drinks. The SBG recommended the sale of bottled water, low-fat and nonfat milk, and 100 percent fruit juices at the elementary and middle school level. Recommendations at the high school level included the sale of low-calorie juice drinks, sports drinks, and diet sodas. Industry signatories included The Coca-Cola Company, PepsiCo, and Dr. Pepper Snapple Group.

By and large, the media praised the SBG, applauding the soft drink industry's attempt to prioritize public health over corporate profits. These reports also congratulated the Alliance for a Healthier Generation for its ability to effectively negotiate with an industry that has a history of routinely circumventing government regulations. Former President Clinton told the media that he believed it was a "truly significant thing for an industry to do, not entirely free of risks on their part."[54] According to the Alliance for a Healthier Generation, the development of their "Memorandum of Understanding" regarding the sale of beverages in schools "represents a landmark event in the prevention of childhood obesity as it will be the first time that companies responsible for providing schools with food for children will be making a coordinated effort to transform the nutritional content of food."[55]

Receiving less attention, however, were the voices of those who criticized these maneuverings, arguing that it was actually a form of political subterfuge and a defensive tactic that enabled the industry to deflect or

delay calls for more stringent government regulations. These critics also pointed to a number of aspects of the SBG that actually weaken its regulatory scope. First, the deal only applies to the distribution and sale of products from signatory companies (such as PepsiCo and The Coca-Cola Company) rather than all beverage manufacturers. Second, the regulations did not apply to third-party distributors. This is important as many schools do not purchase directly through the signatory companies but rely on an assortment of third-party industry-affiliated vendors.[56] And while the "Memorandum of Understanding" requires signatories to encourage their distributors to adopt the SBG, third-party vendors are not bound by the agreement nor are signatories forced to stop doing business with bottlers who do not comply with them.[57] Another potential problem is that the SBG were often less restrictive than existing state and local policies. For example, sports drinks and other sweetened beverages have been banned in many schools because of their high caloric content, but are permissible under the SBG. Issues of enforcement and compliance are also potentially problematic. The SBG, for example, are completely voluntary for schools to adopt. And while the ABA claims that they are effectively monitoring industry compliance, they have no real regulatory authority to accomplish this.

A recent study highlighting the voluntary nature of the Guidelines was published in the August 2012 issue of the journal *Archives of Pediatrics and Adolescent Medicine*. The researchers used the SBG as their framework to examine beverage availability in schools. Their analysis revealed that many schools continue to sell beverages restricted by the SBG. They also found that in the 2010-2011 school year 23 percent of middle schools sold high-calorie fruit drinks, 36 percent sold higher-fat milk products, and 55 percent sold sports drinks. Twenty-five percent of high schools sold regular calorie soft drinks, and 48 percent and 31 percent sold high-calorie fruit juice and higher-calorie milk beverages, respectively.[58] All of these drinks are banned under the SBG.

In their conclusion the researchers urged the USDA to use their authority to establish nutritional standards for competitive foods that include the "removal of regular colas or sodas with sugar or caffeine; limiting access to sugar-free, caffeine-free beverages to high school students only . . . and strongly limiting sports drinks."[59] In response to these findings the ABA issued a news release discrediting the results. "This research," they wrote, "looks at beverages available in schools from *all* sources, including from third party providers—many of which may not follow the Alliance for a Healthier Generation's national SBG."[60] The ABA's defensive posturing is hardly surprising. One reason the SBG were created was to avoid the need for federal regulatory oversight. And while the USDA did not have the regulatory authority to govern the nutritional quality of foods sold in federal meals programs in 2006,[61] the ABA was under increasing pressure in the media to address the ways in

which their products contributed to childhood obesity. The industry was also facing a lawsuit from a coalition of lawyers (the same group who had successfully sued the tobacco industry) and the Center for Science in the Public Interest. The lawsuit was dropped after the SBG were developed.

One could argue that the creation of the 2006 SGG served a number of political and economic purposes. On one hand, it created some timely and necessary positive publicity for the ABA. The industry was able to rebrand its products as part of the solution, rather than the problem. At the same time, they recommended nutrition standards that ensured their continued economic viability. For example, their decision to ban sugary sodas yet permit the sale of sports drinks reflects existing market trends that report declining sales in soda sales compared with increases in sports drink consumption.[62] According Simon Lowden, chief marketing officer for PepsiCo, the industry foresaw this trend several years ago enabling them to "get ahead of it with things like Gatorade and Tropicana."[63] Not surprisingly, Gatorade and Tropicana are allowable beverages under the SBG. According to Mello, Pomeranz, and Moran, the ABA's self-regulation technique reflects the ABA's best effort to navigate a middle path between two strong and conflicting influences: their fiduciary obligation to maximize shareholder value by maintaining and improving their market position, and strong public and policy pressure to withdraw from schools.[64]

Recently the Alliance for a Healthier Generation announced that it will no longer accept funding from food, beverage, and health-care industries because these are groups with which they are currently in policy negotiations. Presumably this was part of an attempt to distance itself from industry influence and establish itself as a credible health advocate. Despite this attempt, however, the Alliance for a Healthier Generation's advocacy work bespeaks their continued commitment to industry interests. On a fundamental level, their work helps renegotiate and affirm the private sector's role in the creation of school health policies. Rhetorically, this involves promoting the belief that corporate assistance, cooperation, and partnership are necessary and critical to address children's health. According to the Alliance for a Healthier Generation, there is virtually no limit to potential partnership work. On their website they write: "We believe that we need multi-faceted solutions and diverse partners to reverse the childhood obesity epidemic—even unlikely partners."[65] This statement is somewhat curious given their new refusal to accept corporate donations from those businesses with which they are negotiating. It also raises questions about who these "unlikely partners" are, what role they can or should play in solving the "problem" and, to what extent they can be trusted to do so. Further exploration on the website reveals that "unlikely partners" are members of the food and beverage industry: industries that have historically undermined and actively lobbied against

more stringent government regulations on school meals and the same industries from which they are no longer accepting funding.

The "Let's Move Salad Bars to Schools" initiative provides another interesting example of partnership work via strategic philanthropy. The purpose of the initiative is to help schools raise the funding necessary for the placement of salad bars in school cafeterias. The initiative is sponsored by a variety of organizations and industries including Whole Foods Markets, UFPA, the National Fruit and Vegetable Alliance, the Produce Marketing Association (PMA), Dole Food Co., and Chiquita Banana, to name a few. According to UFPA, "Salad bars are the most practical way to help schools add the 1-to-2 fruit and vegetable servings required to meet the new Dietary Guidelines for school lunches."[66] Helping schools comply with the Dietary Guidelines, however, is not UFPA's only concern. They go on to state that "adding 1-to-2 servings to school lunches would mean adding over 1 billion dollars *today* in annual incremental sales."[67] Aside from the benefit of increasing profit via sales, similar to most school partnering endeavors, the salad bar initiative promises a number of other industry benefits.

Consider, for example, the work of PMA, one of the sponsoring organizations of the salad bar initiative. In a nutshell, the PMA exists to encourage and recruit businesses to donate salad bars to schools. It does this in part by describing the various ways companies could benefit by joining the program. The PMA argues that, because participating organizations are able to post their logo and link on the "Let's Move Salad Bars to Schools" website, companies can improve national visibility. Involvement in the program also represents a potential tax savings because donations are tax deductible. They also mention that participating businesses receive the satisfaction of "improving the lives and healthful eating habits of our nation's youth."[68] PMA even instructs participating organizations to use their donation to "gain extra recognition by including [their] elected officials in a salad bar presentation." Elected officials, PMA claims, "are equally concerned about children's diets and health."[69] On their website they include sample letters to send to elected officials and a template press release to disseminate to the local media. They further urge companies to utilize a number of media outlets to publicize their donation: "Put an announcement and photo on your Facebook page." PMA recommends, "Tweet about it. You can even videotape the presentation for YouTube."[70]

The work of the Alliance for a Healthier Generation, UFPA, and PMA provide just a few examples of the ways in which the rhetoric of "helping schools" is recruited and made to sit unproblematically alongside economic self-interest and profitability. These rhetorical strategies are, of course, designed to make it easier for people to see industry as a policy partner; one that offers crucial social services, akin to those provided by the public sector. In this way, industry solutions are constructed as neces-

sary because of the way they assist schools with improvements, program innovations, or in complying with government regulations, in many cases the same regulations they had a hand in crafting. Thus, at the same time the Alliance for a Healthier Generation partners with the ABA to create policies, it also provides resources and products to assist schools in complying with them. It is a classic form of what Ball refers to as retailing policy[71] or the commercial use of educational policy as a tool for the generation of profit and capital. According to Burch, this is not unique to health policies but happens in virtually every aspect of education. She writes: "policy creates demand for products and services that will help schools and districts comply with mandates. Policy also becomes a tool for ensuring and maintaining over time the revenues that flow to the vendors of these products and services."[72] In other words, partnerships like these are fundamentally geared toward expanding industry market share often by increasing schools' reliance on the products they are selling or promoting on someone else's behalf.

The 2010 Healthy, Hunger-Free Kids Act's Local School Wellness Policy (Section 204 of P.L. 108-205) provision provides another telling example of the ways in which policy retailing occurs. As mentioned in chapter 6, the legislation required each local educational agency (LEA) participating in federal nutrition programs to create a local wellness plan (LWP) that included goals for nutrition education, physical activity, and nutrition promotion, all in the name of promoting student health and wellness. In creating their LWP, LEAs were instructed to work with parents, students, teachers of physical education, health professionals, representatives of the school food authority, school administrators, and the public. LEAs were also instructed to establish a strategy for measuring LWP implementation. On the one hand, the legislation created a legitimate role for members of the business community to participate in the development of LWPs. Acting as community members, schools were told that partnering with business leaders would provide expertise and support to schools on matters of health and nutrition. On the other hand, the LWP provision contributed to the establishment of a new market aimed at helping schools comply with the legislation. This new market included a wide range of industry representatives; those selling "healthy" food products, fitness equipment and services, health curriculum as well as those organizing school health contests or programs. In fact, there appears to be no limit to the kinds of "healthy" services or products that can be sold to schools as tools of policy compliance.

Table 9.1. Industry-Sponsored Health Initiatives

"Eat Breakfast Win Cash!"	The "GOT MILK?" campaign, funded by the California Milk Processor Board (CMPB), began the "Eat Breakfast Win Cash!" program in August 2011 in ten school districts across the state of California. Citing a connection between skipping breakfast and the

rise of childhood obesity, the CMPB stated that the goal of the program was to increase student participation in the federal School Breakfast Program (SBP). The program awards the school with the greatest breakfast participation in each district during a three-week period $3,000 toward student activities. According to Steve James, executive director of CMPB, "This contest allows rival schools to compete against each other, while instilling the message of proper nutrition with milk. We want to inspire young people to help form healthy habits for life."[73] In addition to breakfast sales, the "Eat Breakfast Win Cash!" program sponsors a photo contest for high school students. Participating students are required to submit a photo showcasing why "breakfast with milk is an important part of their health and academic performance."[74] The winner of the contest receives a $1,000 prize and is featured on a "GOT MILK?" billboard in her hometown. According to an industry press release, the billboard was intended to highlight why breakfast with milk is critical for health and academic success.[75]

"All About Eggs" The "All About Eggs" program, sponsored by The Egg Board, provides teachers a variety of free curricular resources including a colorful poster displaying the path eggs take from barnyard to table, lesson plans revolving around eggs, and promotional material.[76]

"Let's Move Salad Bars to Schools" The "Let's Move Salad Bars to Schools" began in 2010 as a collaborative venture between the Food Family Farming Foundation, National Fruit and Vegetable Alliance, United Fresh Produce Association (UFPA) and Whole Foods Markets. Since this time the project has aligned itself with additional private and public sector agencies and initiatives including Michelle Obama's "Let's Move!" campaign, Home Box Office (HBO), Chiquita Banana, Dole Food Co., The National Dairy Council, Publix Super Markets Inc., and Grapes from California, to name a few. The goal of the partnership was to fund and award 6,000 salad bars to schools by the end of 2013.[77] All schools participating in the National School Lunch Program (NSLP) were eligible to submit a grant application. If a school's application was accepted, the initiative placed the school's name on the website's donation page. This enabled members of the school community to electronically donate to a particular school, helping it to raise the necessary $2,625 for the salad bar. To date, the initiative has raised more than $7,057, 819 enabling the placement of 2,810 salad bars in schools.

"Share Your Breakfast" The "Share Your Breakfast" campaign is a joint venture between the Kelloggs® and Action for Healthy Kids®. The program provides grants for schools to "manage and support innovative breakfast programs." According to Doug VanDeVelde, senior vice-president of marketing and innovation, the "Share Your Breakfast" program is designed to give "'more kids a chance to start their day with the nourishment they need to increase their potential.'"[78] To raise this grant money Kelloggs® has asked for individuals to "share" their breakfast on Facebook or Twitter. For each "share" Kelloggs® has agreed donate the cost equivalent of one school breakfast to the grant program, with donations not to exceed $200,000.

"Henkel Helps Kids Get Fit"	The "Henkle Helps Kids Get Fit" program is a joint venture between Henkel—manufacturer of home, laundry, and cosmetic products—and the Alliance for a Healthier Generation. The program is designed to award schools $25,000 to improve health and fitness facilities, equipment, and services to students. The winners were selected on the basis of their essay response to the question: "What would your school do with $25,000 to improve youth fitness?"[79]
"Love Your Veggies"	The "Love Your Veggies" program is a joint venture between Hidden Valley Original Ranch Dressing® and the School Nutrition Association. The program provides grants for schools to "instill a life-long love of vegetables in children."[80] Grants are awarded to schools that demonstrate "creativity and innovation" in their vegetable program.[81]
"Fuel Up to Play 60"	The "Fuel Up to Play 60" program is a health initiative sponsored by a number of private and public interests. Among a number of others, program partners include the National Football League, the National Dairy Council, Centers for Disease Control and Prevention (CDC), United States Department of Agriculture (USDA), and the National Association for Sport and Physical Education. According to its website participation in the program "empowers students to create and implement activities and reward them for making healthy choices and inspire change in their school."[82] Participating schools are provided a tool kit including the "Fuel Up to Play 60" health playbook. Schools are provided advertisements to post around their school to help them "draft players" and "build teams" to participate in various health challenges throughout the year. Participating schools can earn prizes and are also eligible to apply for additional grant funding through the program's partners such as the General Mills Foodservice and the National Dairy Council®.
Brita "Water for Kids Campaign"	The Brita "Water for Kids" campaign is a joint venture between Brita and the Alliance for a Healthier Generation "to promote water consumption and introduce Brita's new filtered water bottles for kids."[83] The campaign donated more than $90,000 worth of water bottles to various schools participating in the Alliance for a Healthier Generation's "Healthy Schools Program."
"Subway® Fresh Start Challenge"	The "Subway® Fresh Start Challenge" invites children to track their diet and exercise habits for three weeks in an effort to be placed in a drawing to win a submarine party for their class and a $1,000 fitness grant for their school. According to a Subway® promotional flyer "the more students who participate from your school, the better chance your school has of winning the $1,000 grant."[84]

CURRICULAR SPONSORSHIP

As tables 9.1 and 9.2 exemplify, industry also "partners" with schools by providing teachers curricular and supplemental educational resources, advertising (posters and classroom decorations), sponsoring school

health and incentive programs, and grant funding. For example, some readers may be surprised to learn that companies like Coca-Cola have developed and distribute health and physical education teaching resources to schools in America and all around the world.[85] These kinds of curricular initiatives are often jointly sponsored or endorsed by government or other nonprofit agencies. For example, Kellogg's "Mission Nutrition," Dole Food Co.'s "Superkids," Chartwell's "Balanced Choices®," the Produce for Better Health Foundation's "Fruits and Veggies—More Matters®," and the Cattlemen's Beef Board's "Teachfree" are listed as "Sources for Nutrition Education Materials" on the USDA's website.[86] In many cases these programs have also been aligned with various state and federal learning standards and have received the endorsement of nutrition professionals. Nestlé's "Healthy Steps for Healthy Lives™" program, for example, is a joint venture between Nestlé and the National Education Association (NEA) Health Information Network;[87] Kellogg's "Mission Nutrition" was developed by Canadian Dietitians; and the Cattlemen's Beef Board's "Teachfree" health curriculum was developed in conjunction with the American Dietetic Association. These endorsements obviously help establish industry as a credible and trustworthy source of nutrition information, aligning industry-sponsored health messages with federal agencies like the USDA or CDC.

Table 9.2. Industry Sponsored Curricular Materials

Dole Food Co.'s "Five a Day Superkids Program"	Dole Food Co.'s "Five a Day Superkids Program" is designed to provide teachers "everything they need to get their students excited about eating fruits and vegetables." The program offers teachers a variety of health and nutrition lesson plans and activities. Lesson plans are grade-level specific and are customized for music, language arts, math, science, and social studies classes.[88]
The Dairy Council of California	The Dairy Council of California's K-12 nutrition curriculum is aligned with California's state education standards and is promoted as easily integrating into existing units of math, social science, health, language arts, and physical education. The Dairy Council of California also provides teacher training in an effort to "increase the educator's comfort with the material."[89]
Campbells' "Labels for Education"	Campbells' "Labels for Education" K-3 nutrition curriculum is designed to help promote healthy eating activity patterns among children.[90]
McDonald's "Educates"	McDonald's offers K-12 curriculum for teachers on various topics including nutrition, the environment, and career planning.[91]
Cattlemen's Beef Board's "Teachfree"	"Teachfree" offers PK-12 educators "high quality educational materials" to supplement the curriculum. Lessons are focused on issues of health and nutrition.[92] "Teachfree" is funded by the Beef Checkoff and managed by the Cattlemen's Beef Board.

Nestlé's "Healthy Steps for Healthy Lives"	Nestlé's K-3 curriculum was written in collaboration with the National Education Association's Health Information Network and was "developed as a resource for educators to help support your ongoing efforts to teach students about being healthy."[93]
Kelloggs'® "Mission Nutrition"	Kelloggs'® "Mission Nutrition" K-8 curriculum includes "easy-to-use lesson plans, [and] fun student activities" to encourage healthy eating, physical activity, and positive self-esteem.[94]
Chartwells' "Balanced Choices®"	Chartwells, a leading food service management company, offers educators "nutrition education and a Meal Guidance System which assists students in making the most nutritious options when selecting meals, snacks, and beverages at school." In addition the company provides ten-minute lesson plans on nutrition-related topics. Lesson plans coincide with their "promotional calendar" (i.e., the school's lunch menu) "and are scripted to be quick and easy to teach, fun, and age appropriate."[95]
Produce for Better Health Foundation's "Fruits and Veggies—More Matters®"	The "Fruits and Veggies—More Matters®" curriculum was developed by the Produce for Better Health Foundation. The program provides educators with nutrition resources and curricular materials. The Produce for a Better Health Foundation also establishes partnerships between the school's foodservice staff and with local supermarkets so that "students can turn nutrition knowledge into real-world practice." The effort is funded by a variety of industries including General Mills, McDonald's, The Produce Marketing Association (PMA), and Sun-Maid Growers of California.[96]

The kinds of arrangements exemplified in table 9.2 help to cast particular brands in a positive, healthier light. The beverage industry routinely pursues partnerships with health and medical organizations such as the National Hispanic Medical Association, American Cancer Society, and the Academy of Nutrition and Dietetics as well as government agencies like the National Institutes of Health. Recently, Coca-Cola's "Live Positively" logo was posted on the American Academy of Pediatrics' consumer education website. Partnerships also involve supporting academic research. PepsiCo has funded a nutritional science fellowship at the Yale School of Medicine, and Coca-Cola has sponsored a number of public health programs at the University of North Carolina's Gillings School of Global Public Health. These kinds of partnerships have the effect of entwining industry-sponsored health improvement efforts with academic research that inform the development of government policy and blur the distinction between commerce and the public good.[97] Consider also the blurring of expertise, celebrity, and corporate interest that has taken place through President Clinton's work with the Alliance for a Healthier Generation. Symbolically, these kinds of arrangements "credentialize" industry as a potentially legitimate public policy partner, akin to public sector actors like Clinton. And while President Clinton is not currently an elected offi-

cial, he does embody a degree of impartiality by representing the face of social policy provision.

A closer look at corporate curricular resources reveals the subtle ways these help to sanction industry-friendly messages. In one classroom activity titled the "Hidden Fat Caper" included in the Cattlemen's Beef Board's "Teachfree" health curriculum, students are provided the following instructions:

> It's okay to eat a little fat because it gives you energy, but you don't need to eat too much. Help secret agent TAF (that's "fat" spelled backwards) solve the case of the hidden fat. Follow the path through the grocery store and circle the foods you think contain hidden fat. Clue: Foods like t-bone steaks have fat surrounding them that you can see and easily remove before eating. Foods that are fried, gooey or greasy have fat hidden inside of them that can't be removed.[98]

In another exercise students are asked to compare the nutritional content of four foods: beef jerky, cola, corn chips, and milk shakes. Working through a series of comparisons students are guided to come to the conclusion that out of the four foods, beef jerky is the correct "power food," a food that provides the body with the necessary nutrients and helps keep the body healthy.[99] In a perhaps more inconspicuous example, this time from Nestlé's "Healthy Steps for Healthy Lives™" curriculum, elementary students are supposedly being taught to understand the purpose of food group slogans. In one question students are asked to explain what a nutrition campaign slogan is. The teacher is provided the following prompt to help students understand the concept:

- A campaign slogan is a way of advertising or telling a message.
- Various organizations create slogans to help us remember how to eat healthy.
- There are slogans that remind us of the recommended daily amounts to eat of each food group.[100]

Students are then provided examples of various nutrition slogans such as the National Dairy Council's "3 Every Day® of Dairy," the Produce for Better Health Foundation's "Fruits and Veggies—More Matters®" campaign, and the Whole Grains Council's "Whole Grains at Every Meal." The exercise is potentially problematic as students might be left with the impression that industry-sponsored health slogans like these are generally neutral and trustworthy.

As with these curricular examples, many of the industry-sponsored health initiatives described in tables 9.1 and 9.2 also contain explicit advertising and/or industry-friendly messages. For example, the Egg Board's "All About Eggs" initiative includes a Back to Breakfast contest in which teachers are required to write an essay on how they would use a $5,000 grant to promote breakfast consumption. Winners of the grant

must create videos of their ideas and post them on Youtube. According to *New York Times* reporter Tamar Lewin, "In one video, 'Eggucation Week Back to Breakfast Challenge' a Chicago fourth-grade teacher tells of teaching her students about the benefits of eating eggs, and asking them to create egg recipes."[101]

CAUSE FOR CONCERN?

Many thousands of health-related initiatives, both large and small, happen every year in American schools. Many of them have no connection to large corporations or other commercial interests. So, why should we be concerned with the ways in which private enterprise has involved themselves in school health? We think there are three obvious points to make in this regard.

First, it seems absolutely clear that the idea that American schools can be an effective instrument of public policy, the idea that we have focused on throughout this book, is now facilitating a fresh wave in the ongoing process of commercializing American schools. In other words, "health" is increasingly be used as rhetorical camouflage for commercial activity. In an environment in which many schools are under intense financial pressure and where links with private enterprise have been an explicit and relatively long-standing policy setting in American education, this should not be surprising.

Second, given the myriad curricular and extracurricular demands that are made on schools and teachers, it should also not be surprising if schools turn to the private sector to meet these demands. In fact, while we have mainly dealt with the health-related areas of food, physical activity, and obesity prevention in these last three chapters, we would also point out that the number of health problems schools are asked to address is long indeed. In the case of the wellness policy legislation passed by both Bush and Obama administrations, no funding was allocated to meeting the goals of this school health policy.

Third, whatever else we might say about the initiatives described in this chapter, there is no compelling evidence of any kind that they have improved the health of young Americans. As with the wellness policies that schools have been asked to create, it appears that when it comes to doing school health, it is widely believed that something is better than nothing. But as we saw in chapter 7, doing something may not be better than doing nothing. School-based health initiatives may be ineffective, take up school time, or even be detrimental to children's well-being. The initiatives that we have described in this chapter have all shared a kind of commonsense appeal, such as the idea of having salad bars in schools. But there are multiple reasons why a salad bar may have no affect on the health of students. Students might refuse to eat the salads or the actual

content of the salad bars may, in practice, turn out not to be particularly healthy. On the other hand, even the healthiest salad bar possible will be of little use if the funding that created it disappears after a short period. In other words, after the feel-good headlines have disappeared, who will pay for the ongoing costs of the initiative if and when sponsors decide to take their money elsewhere?

In chapter 2 of this book we described a range of historical examples in which public health activities might not have had, or even been intended to have, a positive effect on public health. The corporatization of school health is a modern-day example of three of these reasons: financial self-interest, questionable efficacy, and ideological motivation. In short, we would argue that the policy developments we have discussed in this chapter are a significant part of the picture of what school health is and is becoming in America: not a health policy but simply another sphere of commerce.

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TEN
A Future without Limits

It is customary for the final chapter of books of this kind to concentrate on summarizing and distilling everything that preceded it into a set of conclusions. While this is a reasonable thing to do, in this case we suspect (or at least hope) that readers will have formed a clear sense of where we stand and that this will not require lengthy recapitulation. Although we will offer some slightly more concrete concluding thoughts at the end of this chapter, in simple terms we have argued that:

- the idea of using schools to address public health problems is a habit of mind that is as old as public schooling itself;
- public health activity, including when it happens in schools, is very often initiated for reasons that have very little to do with public health;
- the range of public health problems that schools are asked to address is huge and probably growing;
- the evidence supporting the use of public schools to address public health problems is extremely weak.

For our part, we see these points as interconnected. For example, the fact that school health interventions often originate out of political or economic considerations makes them less likely to succeed as health measures. In the case of the wellness policy legislation we discussed in chapter 6, this is a clear case of political machination dressed up as school-based public health. In fact, there is remarkably little about the measures articulated in the legislation, in either its original 2004 or updated 2010 incarnations, to inspire optimism about its health impact. From its unfunded policy goals to the rather bizarre expectation that busy American public schools would generate, implement, evaluate, and indefinitely maintain effective anti-childhood obesity interventions—a task that has proven be-

yond most childhood obesity experts—there was the unmistakable odor of political expediency. By placing the responsibility of policy development on schools, policy makers implicitly conceded that they did not actually know how the wellness policy legislation was meant to work or how schools would find the time or the resources to make it work. But, as we have said, this should not be surprising since the policy was created to solve a political impasse—a goal it achieved reasonably well—rather than to enhance health.

As we discussed in chapter 8, the same can said about increasing rhetorical and policy pressure on school teachers to be "healthy role models" for children. As far as we can tell, this rhetoric makes no concession to the lessons of history nor articulates a methodology based in the study of public health. Instead, it recruits a set of "commonsense" assumptions—we would call them habits of mind—that children automatically copy and absorb the behavioral signals of teachers and that teachers can be made to feel sufficiently guilty about the health costs of their lifestyles to change their ways. Whatever else we might say about this policy development, there is little sign that a careful consideration of how to improve anyone's health is guiding its formation.

THE DIGITAL TREADMILL

Despite what the arguments and examples we have offered in this book might imply, we are not so naïve or dogmatic to imagine that school-based public health is ever likely to stop completely or that this would necessarily be a good thing if it did. Schools and teachers are clearly in a position of care, and it would make no sense to completely dismiss the opportunities, as well as risks, that this presents. Once again, we will offer some slightly more concrete points about where this leaves us in a positive sense at the end of this chapter. For the moment, though, we want to use the bulk of this final chapter to consider two developments that are likely to shape the way school health is done in the future. The first of these is the impact of technology.

In a recent speech, the media proprietor Rupert Murdoch said the following:

> I now wear a Jawbone. This is a bracelet that keeps track of how I sleep, move and eat—transmitting that information to the Cloud. It allows me to track and maintain my health much better. It allows my family and I to know more about one another's health too, which means it encourages more personal and social responsibility—instead of just running to the doctor when we don't feel well.[1]

The "jawbone" that Mr. Murdoch is referring to here is just one form of a proliferating range of wearable digital devices that collects information about the wearer. While the form and function of the devices vary, they

are all examples of a growing social trend toward what is sometimes called the "quantification of everything." The manifestation of this that has garnered the most media coverage is probably the Quantified Self movement, otherwise known as QS, in which participants collect, analyze, share, and compare quantitative data about themselves. Depending on whom you listen to, QS is part philosophy, part ethical stance, and part an exercise in futurism. For its more messianic advocates, QS is a technological path to a better world in which people will lead healthier, smarter, more self-aware lives.

Many readers will also be aware that there is considerable and, in some cases, unbridled enthusiasm for a digital revolution in health care more generally. According to some commentators, digital technology will improve general health, increase life expectancy, and reduce the financial strain on medical systems. It will do this, it is said, by increasing people's understanding and interest in their own health and by making the early detection of health problems easier. In fact, not only will "eHealth" save lives and money, new arguments about the capacity of digital technologies to transform human experience, increase self-knowledge, and empower citizens are in common usage. In short, yet another new "new public health" is upon us.

Given the underwhelming past record of school health interventions to actually make a measurable material difference to the health of young people, it seems reasonable to expect that new methods will be sought and that digital technology will be seen as one solution. There are also few reasons to think that the same arguments used in the sphere of eHealth will not be used to advocate for the use of digital technology in school health. In fact, the potential for digital technology to radically transform health and physical education instruction is now receiving widespread support. In this vision, smartphone apps, wearable devices, and cloud-based computing will give health instruction a more objective and scientific foundation, and empower and inspire young people to be healthier. It will do this, it is claimed, by generating unprecedented amounts of personal and collective data that can then be analyzed, manipulated, and acted upon in creative and fun new ways.

But as with the application of digital technology to other areas of educational practice, there are both risks and possibilities. For curricular and extracurricular school health, the emergence of new technological possibilities may have already outstripped our capacity to fully understand them. Put simply, what kind of thing might school health—both curricular and extracurricular—be in the process of becoming?

To begin with, there is the possibility of teacherless school health. There now exist a range of technologies which just need to be turned on before the user is taken through a virtual physical activity experience of some kind. These include technologies that simulate sports or prompt the user to run or perform some other exercise according to a set of predeter-

mined parameters. Certainly if the purpose of school health is taken to include simply engaging students in physical exercise, a proposition with apparently wide support, it is easy to see why some policy makers would be happy to not pay a human to facilitate this if a cheaper technology can do the job just as well.

However, as we have argued, it is something of a red herring to imagine that school health interventions always happen for health reasons. Taking a line from digital technology's use in general education, there are reasons to expect that commercial rather than educational or health imperatives will be paramount in deciding whether, which, and how digital technologies are used in school health. Just as happened with food, deals between technology companies and state and local educational authorities are likely to be struck which will tie teachers into using technology that they may not otherwise choose to use. People whose livelihood depends on making and selling digital technology are always likely to be most interested in inventing uses for this technology, whether or not there is a need for it.

In one recent example a Department of Agriculture-funded school health intervention in Texas used digital cameras to capture before and after images of students' lunch plates.[2] The images were then used to calculate the number of calories children had consumed. Although it was claimed that these data would be used only to inform parents about the behavior of their children, it is not difficult to see how data of this kind could be sold for commercial purposes or collected by educational authorities to monitor the compliance of schools to food-related policies. In a similar example, fingerprint or eye-scan technology is being used in some English schools to monitor and restrict the food that children can buy at school canteens. While we accept that there will be different views on the value of interventions of this kind, we would contend that this is a classic example of a use being found for the technology rather than technology being employed to solve a pressing problem. It is surely not unduly pessimistic to suspect that if a technology can be marketed to schools in terms of its "wow" factor or by exaggerating its "scientific" sophistication, then this will be done. It is also not difficult to imagine students devising strategies to deceive these systems or to think of ethical misgivings about a regime that apparently seeks to use surveillance technology to coerce students into particular behaviors.

We would also argue that precisely because the range of public health problems entrusted to them is extensive and growing, schools are increasingly turning to commercial providers of educational teaching resources and services, especially digitally delivered content. This mushrooming field of activity inevitably throws up questions about the source and reliability of this information. For example, large food and soft drink corporations have for some time been producing both offline and online health education resources and distributing them enthusiastically around

the world. As a number of scholars have argued, these appear to have been constructed primarily with corporate image enhancement in mind rather than the health of young people (Dorfman et al. 2012; Mandel, Bialous, & Glantz 2006; Mello, Pomeranz, & Moran 2008; Powell & Gard in press).

Digitally delivered educational content has also quickly emerged as an efficient portal through which businesses, whether health related or not, advertise to children. Moreover, quite apart from the commerce of buying and selling the hardware and software on which they take place, almost all of the social media platforms that young people use—and are increasingly being used in school health—exist in order to generate data that are bought and sold by commercial interests. In short, there is a range of purely commercial as opposed to educational reasons why teachers and schools will be encouraged to adopt digital technology to deliver school-based health.

In passing, it is worth keeping in mind that almost all of the most popular social media platforms, whose use in school health is being enthusiastically encouraged, are, first and foremost, businesses. This is a point made forcefully in the most recent book by the computer scientist and Internet pioneer Jaron Lanier, *Who Owns the Future?*[3] Lanier points out that most users of social media and a huge range of Internet services such as search engines are, at best, only dimly aware that the data they generate through their use of these technologies is worth money to someone. For example, aggregated data concerning the topics people are talking about on social media are sold to advertisers. It is true, of course, that schools have always bought products of various kinds in order to carry out the work that schools are expected to do. The difference in this case, though, is that it is difficult for the users of these technologies to know how much money is being made.

Developments in digital technology are also rapidly increasing the capacities of schools to collect huge amounts of individual and collective data about children. These capacities are already being used to determine the content of school health education. For instance, the California state government now collects statewide fitness and body weight data on children which is published online and used to compare and reward schools. As a result, there is the obvious risk that some California schools might structure their health education programs—and therefore the health information they use to instruct children and explain their programs to the broader public—in ways that prioritize student performance in these data collection exercises.

This convergence of technological, commercial, and surveillance processes poses ethical and educational questions too numerous to name here. However, it is not difficult to see how the educational and health interests of young people might be sacrificed or at least subordinated to other imperatives. As technology becomes more ubiquitous it also be-

comes more difficult to refuse its use, especially when it is presented as "health enhancing." An Australian educational commentator has speculated about the ways in which schools, operating within an increasingly competitive environment, might use data about children's weight or fitness to advertise their health and well-being programs. This, in turn, might lead to undesirable new enrollment or non-enrollment pressures or the escalation of already worrying developments in which the bodies of students are scrutinized and compared.

Perhaps above all, in recent years a number of scholars in the field of health and physical education have described the drift of school health toward an increasingly individualized, performative, instrumental, and, in some cases, punitive approach.[4] Rather than nourishing the intellectual resources students might employ to think about themselves and their well-being, there are growing pressures for school health simply to be a vehicle for making children and schools more accountable for health outcomes. While no technological change comes with inevitable consequences, maximizing the benefits and minimizing the risks of technological change in school health will require very sophisticated knowledge about that technology, its ethical use, and the commercial imperatives driving it. In the future there will also be, we suspect, little to stop digital technology being used to turn physical education classes into bouts of exercise on an actual or virtual treadmill for the purposes of burning calories. If it is virtual, the treadmill might be thrilling, multicolored, and even lifelike, but it would still be a treadmill and it is debatable whether anyone should see this as a valuable use of school time.

The argument we are putting here is that so long as school health is interpreted as *public health*—that is, concerned with making children healthier—it will be very difficult to resist the commercial forces that will see schools as simply another market for the latest gadgets. While we foresee neither technological Nirvana nor apocalypse in the future, a more mundane and plausible possibility is that technology will hasten the transformation of school health into a commercial enterprise rather than an educative one. As we discussed in chapter 9, this is already a process well under way.

Of course, creative teachers and students will still find interesting and innovative ways to use digital technology to broaden their knowledge and range of experiences. Balanced against this is the danger that it will only make it easier for adults to measure, monitor, and coerce young people into a narrow set of behaviors. Not only could this be a waste of money, educationally empty, and quite boring or unpleasant for students, if history is any guide it will also probably not work.

SOCIAL AND EMOTIONAL LEARNING

The field of education has a historical association with psychology stretching as far back as the Progressive Era. The most significant early manifestation of this was the mental hygiene movement, a forerunner of what we now call "mental health," which grew in popularity throughout the first half of the twentieth century. According to the historian Sol Cohen, "Few intellectual and social movements of this [the twentieth] century have had so deep and pervasive an influence on the theory and practice of American education as the mental hygiene movement."[5] The reasons for this are many but, in essence, Cohen's point is that the mental hygiene movement extended the medicalization of schools to psychological matters. It also marked the point at which psychologists and educators began to see children's personalities as things that could be modified via rational educational processes. Writing in a 1948 edition of the *The Elementary School Journal*, Wilson H. Guertin argued that each school include a team of professional psychologists and administrative support staff that would work methodically and carefully through each case that was referred to them.[6] In an uncanny pre-echo of Sallis and McKenzie's demand that physical education join the war on childhood obesity, Guertin claims:

> There are many pupils in the schools who need help. What is more, they need it now! Mental difficulties are insidious; children's problems of today are forerunners of more serious difficulties in the future. Just as the physician is obliged to provide surgical treatment for a newly recognized cancer, so the educator is morally required to provide guidance for the child who begins to manifest behavior problems.[7]

As Michael W. Sedlak points out, the goal of providing mental health services to children was also part of a broader Progressive Era movement to offer "a comprehensive package of social services, including mental and physical health, social welfare, and vocational preparation programs, in elementary and secondary schools."[8] This is an aspiration that resurfaced later in the century in the notion of the "full-service school," the idea that schools should be turned into a kind of one-stop shop for the complete range of child health services.[9] Regardless of what we might think of the wisdom of such a grand vision, it is a reminder of two enduring tendencies in the history of school health: first, the prosaic desire of professional bodies or fields of study such as psychology to secure employment for its members in schools; and, second, their more idealistic and yet plainly coercive hope that everyone else, but especially teachers, will think in the same way that they do. Stuart Trost's call to fight childhood obesity by turning teachers into a kind of epidemiologist/exercise scientist/behavioral therapist hybrid will be recalled from chapter 7. Like-

wise, Cohen reminds us that precisely the same sort of dream animated mental hygiene:

> A key plank of the hygienist platform was to persuade teachers to take the "mental hygiene point of view" towards children's behavior problems. What hygienists desired, simply, was that the concepts and techniques that psychiatrists were then applying to the study and rehabilitation of delinquents and criminals be applied by teachers to the misbehavior of children in school. A specific set of assumptions can be identified. Children's misbehavior was "not a sin, but a symptom." Hygienists called upon teachers to adopt a "scientific approach" toward children's behavior, to adopt the "scientific detachment" of "the student of a problem."[10]

It is tempting to say that, in terms of its presence in schools, psychology is resurgent, although this would probably be to overlook that it never actually went away.[11] Once again, though, the mental health of young people is being described as a health emergency and once again schools are seen as a vital place to start solving the problem. Readers should also not be in any doubt that this is also another "colonizing" moment when many members of a particular field of study and professional practice see themselves having greater influence over what happens in schools. As Braden and colleagues wrote in a 2001 issue of the *Journal of School Psychology*: "If school psychologists are to become more effective in modern schools, they must become more successful in working proactively with students and teachers in the everyday activities that constitute school life."[12]

Around the world, the enthusiasm for turning schools into instruments of mental health intervention has generated a torrent of both clinical and curriculum-based interventions. At the curriculum end of the spectrum, the Orwellian sounding field of "social and emotion learning" (SEL) has emerged, an area in which the state of Illinois has led the way by becoming the first state to develop SEL standards for all K–12 students.

In 2001 the National Conference of State Legislators passed a resolution calling for a greater emphasis of teaching social and emotional skills in schools. This was followed by a 2003 report authored by a group of Illinois educators and mental health and child advocacy leaders titled *Children's Mental Health: An Urgent Priority in Illinois.* The authors claimed that schools were not doing enough to meet the emotional needs of children and that the development of SEL was critical to school readiness and academic success. In particular, the authors recommended that legislators

> Require, through legislation, that the Illinois State Board of Education (ISBE) develop and implement a plan, to be submitted to the Governor by December 31, 2004, to incorporate social and emotional standards as

> part of the Illinois Learning Standards for the purpose of enhancing and measuring children's school readiness and ability to achieve academic success.[13]

Given the current educational policy context's emphasis on accountability and standards, the report was taken very seriously and ultimately led to the passage of the 2004 Illinois Mental Health Act (Public Act 93-0495). As per the report's recommendation, one section of the Act mandated for the development and implementation of a plan to incorporate SEL standards as part of the Illinois Learning Standards. Following this legislative directive a group of educators and administrators determined three broad SEL goals:

Goal 1: Develop self-awareness and self-management skills to achieve school and life success.
Goal 2: Use social awareness and interpersonal skills to establish and maintain positive relationships.
Goal 3: Demonstrate decision-making skills and responsible behaviors in personal, school, and community contexts.[14]

The group also included a rationale as to why each goal was important and necessary for schools to implement and assess. For example, their justification for Goal 1 stated:

> Several key sets of skills and attitudes provide a strong foundation for achieving school and life success. One involves knowing your emotions, how to manage them, and ways to express them constructively. This enables one to handle stress, control impulses, and motivate oneself to persevere in overcoming obstacles to goal achievement. A related set of skills involves accurately assessing your abilities and interests, building strengths, and making effective use of family, school, and community resources. Finally, it is critical for students to be able to establish and monitor their progress toward achieving academic and personal goals.

Each of the three SEL goals is linked to one of ten learning standards. These ten standards are specific statements about the knowledge and skills students need in order to successfully achieve the goal. For example, Goal 1 is linked to the following three learning standards:

Standard 1A: Identify and manage one's emotions and behaviors.
Standard 1B: Recognize personal qualities and supports.
Standard 1C: Demonstrate skills related to achieving personal and academic goals.[15]

Each of the ten standards are then further linked to more specific benchmarks that are individually determined for children in five grade-level clusters: early elementary (grades K–3), late elementary (grades 4-5), junior high (grades 6-8), early high school (grades 9-10), and late high school

(grades 11-12). At the early elementary level, identifying and managing one's emotions and behaviors (Standard 1A) is associated with two benchmarks:

1A.1a. Recognize and accurately label emotions and how they are linked to behaviors.
1A.1b. Demonstrate control of impulsive behavior.

By the time students reach late high school, identifying and managing emotions and behaviors (Standard 1A) involves a student's ability to:

1A.5a. Evaluate how expressing one's emotions in different situations affects others.
1A.5b. Evaluate how expressing more positive attitudes influences others.[16]

Benchmarks are then related to particular performance indicators, which are again specific for each age cluster of students. Returning to the Standard 1A, teachers at the early elementary level are asked to assess achievement of this goal though their students' ability to:

1. Identify emotions (e.g., happy, surprised, sad, angry, proud, afraid) expressed in "feeling faces" or photographs.
2. Name the emotions felt by characters in stories.
3. Identify ways to calm yourself.
4. Describe a time you felt the same way a story character felt.
5. Discuss classroom and school rules.
6. Share feelings (e.g., through speaking, writing, drawing) in a range of contexts.[17]

At the late high school level, the performance indictors students must demonstrate in order to meet Standard 1A include their ability to:

1. Identify factors that cause stress both positive and negative.
2. Identify physical reactions to stress (e.g., increased energy and alertness, increased heart rate and respiration, sweaty palms, red face, etc.).
3. Recognize emotional reactions to stress.
4. Describe strategies for dealing with upsetting situations (e.g., disappointment, loss, separation).
5. Reflect on the possible consequences before expressing an emotion.
6. Use "I-statements" to describe how you feel, why you feel that way, and what you might like to change.
7. Practice strategies to reduce stress (e.g., talking to a friend or trusted adult, considering what led to these feelings, physical exercise).[18]

Even if we could be sure that this highly structured, prescriptive, and bureaucratic approach was, in principle, the right way to improve young

people's emotional lives, teachers would still be faced with navigating these new goals, standards, benchmarks, and indicators. Taking all the grade level clusters together, this SEL initiative represents literally hundreds of new directives which apparently need to be added to the many others that apply in most other subject areas.

Unfortunately, though, the question of efficacy cannot be ignored. The merits of SEL are currently debated in the literature, as is the general notion of "emotional intelligence" on which SEL rests. And while one might therefore be inclined to suspend judgment about its merits, the more salient point is that SEL has *already* been implemented in Illinois before any empirical agreement about its effectiveness or even conceptual robustness has been established. As so often happens with school health initiatives, questions of efficacy seem, at best, an afterthought, or, at worst, an irrelevance.

More broadly, it appears that concern for the social and emotional health of young people is linked to pervasive ideas about youth, risk, the importance of self-regulation, personal responsibility, and the breakdown of traditional family structure and the inadequacies of parents. In fact, it is remarkable how often initiatives like SEL are framed by statements that assert that families are now no longer capable in preparing children for the life that awaits them. So, rather than the families, advocates propose a specific set of allegedly assessable performance indicators, reflecting a highly instrumentalist understanding of emotions.

SEL also appears to assume that managing emotions in a cognitive and instrumental fashion is preferable to considering the personality of individual children or that there might be better, different, or other culturally appropriate ways of expressing or managing emotion. It also seems to claim that we all experience sadness and happiness in similar ways and that these can be captured in a set of performance indicators. As Diane Hoffman points out, emotional health is presented as a means to academic and personal success as opposed to being something valuable in and of itself.[19]

Hoffman also argues that SEL emphasizes the regulation of disruptive emotions, that children must learn to self-regulate, and that their emotional life is as something that is disconnected from others and community. She writes:

> What is essentially happening is that when it comes to describing and recommending actual practices of classroom management, the language of caring ideals often devolves to a discourse about control, rules, contracts, choices, activities, and organizational structures. In effect, substance is replaced by structure; feeling is replaced by form. Most tellingly, caring and community are conceptualized as things teachers teach *children* to do by getting them to behave in appropriate ways.[20]

Although virtually no research into the claims of mental hygiene took place, its advocates claimed that it was rigorously scientific.[21] And like Mary Hanchett Hunt's Scientific Temperance Instruction that we explored in chapter 4, its advocates appear to claim scientific credibility for SEL via a haphazard selection of buzzwords and debatable scientific claims.

However, what seems most remarkable about an educational enterprise like SEL is that, despite the quagmire of terminology and indicators that accompanies it, it appears to sanction virtually any kind of educational intervention imaginable, no matter how apparently tangential. Consider, for example, the average Illinois school teacher or administrator juggling community expectations in literacy, numeracy, science, and the dozens of other things schools are expected to do, all under increasingly straightened economic circumstances. How then to cope with the extra demands created by mandatory SEL? Into this scenario steps an educational entrepreneur offering to run programs in, say, origami or meditation or "mindfulness" or chess or positive psychology or glass blowing. To avoid misinterpretation, all of these sound to us like potentially interesting pursuits that at least some young people might find diverting or fun. Could there be any doubt that all of them at least have the potential to affect the emotional lives of some participants? And could we blame busy school officials for choosing to hand their SEL responsibilities to an enthusiastic salesperson or corporation with a simple, cost-effective solution? In other words, rather than criticizing these activities, our point here is that by turning emotion into an area of school study, SEL exposes schools and children to even greater commercialization pressures without any grounds for confidence in the educational worth of the product. By expanding the reach of school health so far as to include emotional education, SEL appears to be the quintessential expression of school health's conceptual elasticity. On the other hand, perhaps what is more likely is that teachers will simply resort to using the language of SEL to describe teaching practices they have always used.

From our perspective writing at the end of 2013, the push to make schools more responsible for the mental health of children appears, if anything, to be gathering pace. Despite the concerns of those who have written about the rise of "therapeutic culture" and its impact on schools,[22] for the foreseeable future schools, teachers, parents, and students will be required to speak in psychological terms, whether they understand them or not. In 2012, the Australian government announced its intention to screen the country's three-year-olds for signs of mental illness.[23] Whatever else ensues from measures like this, it is clear that, for now, the attention of psychologists will be something that children all over the world will find increasingly difficult to avoid.

WHITHER EFFICACY?

At the end of our survey of school health interventions over the last 200 years an obviously pessimistic conclusion presents itself. Perhaps it is the way of the world that when it comes to public policy, it is the loudest and most persistent voice that is mostly likely to be heard. Perhaps it is just naïve to prefer that school health achieved what it is purported to achieve and that, instead, we need to accept that it will usually be the tireless zealot who will determine what school health is. Timing obviously helps also, as well as the ability to tell a good bad-news story. In fact, the most successful advocates for school health have usually displayed particularly febrile imaginations concerning the catastrophes that await us, along with a certain mastery of crisis rhetoric.

On the other hand, we would have to concede that, at least in more recent times, the bar does not seem to have been set particularly high. The proliferation of health-related curricula, school resources and programs, and the sheer breadth of health issues that schools are asked to address, suggest that there are few, if any, limits, checks, or balances. And as the Australian researcher Katie Wright has argued, there are signs that school health has been joined, perhaps even eclipsed, by the even more nebulous concept of "well-being," a term that appears to widen the floodgates still further, especially for interventions with a mental health flavor.[24]

To name only a very small sample, schools are now regularly called upon to fight childhood obesity, reduce teenage suicide, prevent skin cancer, discourage schoolyard bullying, teach cooking skills, address a range of online behaviors deemed problematic (such as cyber-bullying, stalking, and "sexting") alongside the perennials of sex, smoking, drugs, alcohol, and road safety. In our work as teacher educators it is now commonplace to visit schools that teach programs designed to increase students' skill in using screen-based technologies while also running anti-obesity interventions explicitly predicated on reducing the time students spend in front of screens!

Whatever else we might say about the situation, two things are clear. First, it is not a criticism of teachers to point out that most school health interventions do not work. Given what we know about how difficult, expensive, and time consuming effective health interventions tend to be, it is patently unreasonable to expect schools to successfully address a wide variety of health concerns. Again, returning to our own experience, what we often see is schools targeting a range of different health matters in a one-off or haphazard way. Given the range of concerns that school health now covers, it is difficult to see how the situation could be much different. Moreover, teachers do this because they sincerely want to feel like they are playing their part in improving the lives of their students. In a research project one of us is involved in, teachers generally justified this

approach to school health by saying "something is better than nothing." But is it?

In many Western countries elementary or primary school children receive once a year instruction, often as little as an hour or two, in drug or sex education. Usually, these courses are run by businesses that make their money traveling from school to school delivering programs with no robust history of efficacy and for which parents often to have to pay extra. We should keep in mind also that, in the case of complex matters like sex and drug education, almost all school-based interventions, regardless of their duration or the expertise of the people running them, have an appallingly bad record of achieving the goals that are claimed for them. At least the one-off approach has the advantage of not taking up too much time.

Second, school health in America is quickly becoming simply another form of mundane commerce. This is happening in two main ways. First, schools are outsourcing health programs because they simply have no way of coping with the demands being placed on them. Second, as we saw in chapters 8 and 9, the word "health" is being used to camouflage the economic exploitation of public education. While there is nothing inherently wrong with school health turning into a commodity to be bought and sold, the issue we have drawn attention to here is that there are very few signs that this process is likely to improve anyone's health.

In fact, a constant throughout the history of school health is that efficacy is rarely a matter that appears to interest anyone very much. For the most part, advocates have made up their mind long ago and have little interest in inconvenient alternative points of view. Busy politicians rarely have time for the messy business of weighing up the evidence, and instead need to appear to be acting expeditiously before moving on to the next problem. As for schools, they are busy places where most people understand that health promotion will always be a lower priority than the academic curriculum for which schools are being held increasingly and more punitively accountable.

One of the reluctant conclusions we reached during the process of writing this book is that there is an element of cynicism to the practice of school health in that few people really expect it to work. For a range of different reasons, people seem to need the comfort of knowing that it happens but would prefer to be spared the discomfort of looking at the evidence or contemplating the lessons of history. And while some will be inclined to accuse us of cynicism, we would simply point to the history we have discussed in this book. What this history tells us is that society asks schools to solve the problems we do not understand. In part, this is why schools exist; to be the "black box" into which our anxieties and the problems we refuse to deal with in a more direct way can be pushed. And while the particular anxieties and problems may change a little over time, it is remarkable how often they come back to questions of social disad-

vantage and the pain that people inflict on each other. Although any number of examples could be chosen, the resurgent school-based mental health movement seems emblematic of this. It is a soothing, perhaps even noble thought to imagine that schools could insulate young people from emotional pain or turn them all into calm and rational masters of their own souls. The trouble is that this is a dream that has been dreamed many times over. The only difference this time around is the sheer size and influence of the commercial interests that stand to profit if people can be made to believe in the dream.

AN ARGUMENT FOR SCHOOL HEALTH

While we started the previous section by saying that there is *a* pessimistic conclusion that presents itself, this does not mean that this is the *only* conclusion that we might draw. Before exploring other conclusions, though, we need to make the admittedly self-evident point that our method in this book has been far from scientific. We have used the term "school health" as a necessary catchall for many different types of school-based activity and this has inevitably meant glossing over a great deal of complex specificity. We have also stayed mostly well clear of trying to distinguish between "good" and "bad" examples of school health. Nothing in the material we have presented here has been sufficiently precise to warrant us giving advice about the best way to do school health. Instead, our focus has been on the relationship between schools and public health; that is, schools as a taken-for-granted location for population-wide health interventions. In short, this book has been concerned with an unhelpful habit of mind.

The significance of this distinction is that it would be a serious mistake to interpret our position as criticizing all forms of school health. We fully accept that schools have a health role to play. A school may, for example, employ a particular counselor who is well known and respected for the quality of the work he or she does. Many schools offer popular extracurricular programs which may engage students who are generally not engaged by school life. Some schools feed children who have been insufficiently fed at home, provide protection for children who have been the victims of abuse, and perform countless other concrete health-enhancing actions. In other words, we think teachers and school leaders should, within limits, always be free to adopt courses of action which make sense to them and in which they truly believe. It would be unreasonable, of course, to ask each of these thousands of small actions to empirically demonstrate their effectiveness, which is just another way of saying that any educational system worth having needs to place a degree of trust in the intelligence and professionalism of its teachers. This is certainly not to suggest that the actions of teachers should be beyond scrutiny or criti-

cism, but rather that health needs to be thought about in the same way that, at least in theory, we think about other areas of the curriculum: as an educational enterprise in which teachers have an important intellectual, ethical, and pastoral role to play. The central problem that we have tried to highlight throughout this book is not that schools are asked to contribute to the health of young people, but that they are automatically assumed to be instruments of public health policy.

The problems associated with using schools in this way, at least to us, seem obvious. Not only are schools busy, complex places, they also vary in their aspirations, ethos, and student population. As a result, assuming that it is implemented exactly as it was intended to work, a situation that is extremely rare, any intervention faces one of two problems. If the program is faithfully delivered it may fail because students vary so much; no program can have the same effect on millions of different students. On the other hand, if programs are altered to suit the circumstances in which they need to be taught they cease being the intervention they were originally intended to be. This is the so-called "fidelity" problem that has preoccupied health educators for some time, a problem that becomes all the more insurmountable once the intervention attempts to have an impact on complex social behaviors. Contrary to Sallis and McKenzie's logic about using schools to fight obesity, schools are mostly *not* an ideal site for public health intervention.

We are also not making a libertarian argument that governments and other authorities should have no role in schools whatsoever. There have been and will continue to be many cases in which broad interventions are justified. This is particularly the case in developing countries where, for example, information programs about AIDS and contraception have proved valuable. What these initiatives share is that they solve the crucial problem of gaining access to students and schools. In countries like the United States there are still many school health problems of this nature; the physical condition of school premises, the amount and quality of food that children have access to, and the physical safety of students while at school. These are all examples where schools either have a responsibility to act or are at least very well placed to do so. By contrast, for so much of what is currently done in the name of school health, access to children is not the primary hurdle to overcome. Running courses on the harmful effects of illegal drug use, no matter how well attended, are usually not enough to prevent illegal drug use.

This brings us to questions about the role of health education. In line with the arguments we have made throughout this book, health education does not appear to be a generally effective form of public health policy or health promotion. But this does not mean that there is nothing for students to learn about health. For example, some scholars propose treating health as a subject of critical social scientific study; a space in which students learn how to understand health as a concept and the

ways in which it is used in society for good and ill.[25] On the one hand, were this a course of action that was seriously pursued, it would represent a challenge to the idea of schools as part of the transhistorical public health project that René Sand and George Rosen imagined. In fact, understood this way, health education would cease to be an instrument of public health at all.

On the other hand though, treated as a critical social science, the study of health potentially regains some of the political content that George Rosen saw as so important. After all, part of the problem of turning school health into public health, rather than a field of study, is that it may become utterly depoliticized. This is a particular risk as schools are commercialized and school health interventions begin to attract corporate sponsorship or are created for purely commercial purposes. As a recent study shows, the marriage of public health and commercialized schools often results in highly neoliberal educational programs that demand that children take full moral responsibility for their own health.[26] Whatever the future holds, it is to be hoped we can do better than this.

Above all, though, it seems obvious to us that the most pressing issue generated by the public health's long-standing but accelerating colonization of schools is the apparent disregard for school teachers and their work. We saw at the beginning of this book that there was a time when school health initiatives could be and were vigorously resisted by school community members, including teachers. We do not presume to talk for teachers or to assume they share our views, but there does seem an urgent need to consult with and involve them in decisions about the health agendas schools are obliged to pursue. We are not in position to suggest how this might be done, but it is patently obvious that many who work in the field of public health see schools as passive institutions with no choice in whether or not they are intervened upon. In contrast, it is high time that a far higher burden of justification should rest on those who want to use public schools for public health purposes. This would seem a reasonable suggestion given that so many school health interventions do not achieve the benefits that are claimed for them.

To borrow from the educational historian Michael Katz, we do not think it unreasonable to "ask that a little skepticism and realism temper the messianic tendencies" of school health.[27] In fact while he is talking here about educational reformers of the past, Katz's point applies equally to contemporary reformers who want to remake the mission of schools in their own image. In particular, he writes that the proliferation of "utopian and essentially unrealistic ideology" that committed education to a program of social salvation created a "smokescreen that actually obscured the depth of the social problems it proposed to blow away."[28] He goes on:

> when education reform becomes too bound up with personal and group interests, it loses the capacity for self-criticism. It can be a dazzling diversionary activity turning heads away from the real nature of social problems. It can become a vested interest in its own right, so pious and powerful that it can direct public scorn to anyone who doubts. But the doubters are essential; for someone must try to keep the claims of education in proper perspective, to loose the hold of interest upon the cause of reform.[29]

Katz's use of the term "smokescreen" is apt here, if a little conspiratorial for our purposes. Yes, we *do* need to keep an eye on the self-interest of advocates of school health programs, particularly in a commercializing educational landscape. But the more fundamental issue is whether we can imagine school health as anything more than a series of short-term reactions to the latest health panic. As we said earlier, schools tend to be saddled with health problems we do not understand, and this makes it all the more necessary that we use health in schools to foster a skeptical spirit of mind rather than pretending that we have the answers.

NOTES

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8. Michael W. Sedlak, "The Uneasy Alliance of Mental Health Services and the Schools: An Historical Perspective," *American Journal of Orthopsychiatry* 67, no. 3 (1997): 350.
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10. Cohen, "The Mental Hygiene Movement," 130.
11. For a brief historical account see Sedlak, "The Uneasy Alliance of Mental Health Services and the Schools: An Historical Perspective."
12. Jennifer S. Braden, Eleanor DiMarino-Linnen, and Thomas L. Good, "Schools, Society, and School Psychologists: History and Future Directions," *Journal of School Psychology* 39, no. 2 (2001): 203.
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21. Cohen, "The Mental Hygiene Movement, the Development of Personality and the School," 142.
22. Such as Kathryn Ecclestone and Dennis Hayes, *The Dangerous Rise of Therapeutic Education* (Milton Park: Routledge, 2008).
23. Jill Stark, "Preschool Mental Health Checks," *Sydney Morning Herald*, June 10, 2012, accessed December 10, 2013, http://www.smh.com.au/national/health/preschool-mental-health-checks-20120609-202qd.html.
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