TESTIMONY OF LESTER BRESLOW, MD, MPH PROFESSOR AND DEAN EMERITUS, UCLA SCHOOL OF PUBLIC HEALTH, AND FORMER DIRECTOR, CALIFORNIA STATE DEPARTMENT OF PUBLIC HEALTH TO LITTLE HOOVER COMMISSION.

As a participant in California's public health activities since 1946 I appreciate this opportunity to submit testimony in connection with the Little Hoover Commission's current consideration of public health in the State. Unfortunately I cannot appear personally at your June 27 hearing, being obligated as a member of the Los Angeles County Public Health Commission that day.

Your consideration of public health is timely, not only because of the present burgeoning interest in bioterrorism and how public health may help deal with that threat, but also because of the long public neglect of public health and the very real hazards which that imposes on the people of California every day.

Since it is my understanding that you will be hearing from people well qualified to discuss the nature of public health, its structure in California and some of its major problems in the State, I will confine these brief remarks to two topics: 1) the scope of your consideration, and 2) State governance of public health.

No doubt the current bioterrorism threat constitutes an important element stimulating your interest in public health. That certainly deserves attention which should include preparations to deal with it such as their relationship to present emergency services and communicable disease control.

However, at least equally important is the long decline in support of public health in California which has removed the promise of activities undertaken decades ago to

protect against the every day damage to health among the State's residents. This damage takes the form not only of the occurrence of preventable communicable diseases but also of preventable chronic diseases such as heart disease, cancer and diabetes. Too few people realize that the heart disease death rate has dropped to about one-third of what it was in 1950; and that although the cancer death rate was rising steadily until 1990, since that time it has declined remarkably to less than it was in 1950. This progress against the two leading causes of death, which still account for half of all mortality, has been due largely to public health activity. That progress could be considerably enhanced if public health were adequately supported and organized. (Perhaps you would like to examine these statements and, if so, I'd be glad to assist.)

My entry to California public health started in 1946, after military service, upon joining the State's then Department of Public Health and continuing through 1967 when I was serving as Director. In those days, while Earl Warren and Goodwin Knight (both Republicans) and Pat Brown (Democrat) were Governors, the Department was widely regarded as a national leader in the field, evidenced among other ways by the election of its three Directors (and there were only three during those 22 and three prior years) to the Presidency of the American Public Health Association. One could cite many significant Departmental contributions during those years, for example, tuberculosis control, re-use of waste water, early studies of smoking and lung cancer, and training of medical students in public health.

However, I want to stress the differences in governance of public health during those 25 years and the subsequent 35 years.

1. In the early period public health activity was integrated in one Department, not scattered through several Departments as in more recent decades. The latter situation makes for independent functions that are pertinent to various aspects of public health but are not being coordinated for protection of public health as a whole.
2. In the early period a State Board of Health guided the work of the Department. It also had considerable autonomy in adopting regulations for health protection; for example, the Board adopted the first standards for modern air pollution and its automobile exhaust source. Imagine how such a first decision would be made now, without such a Board of Health. Since 1968 no such body has existed.
3. In the early period the appointment of a Public Health Director was for a four-year term which overlapped one year of an in-coming Governor's term, a device which Governor Earl Warren (who then went on to serve as Chief Justice of the US Supreme Court) originated in order to enhance the likelihood that the appointment would be based on competence, and Departmental stability thus maintained. Again, that arrangement was terminated in 1968.

These differences have largely resulted in both fragmentation and politicization of public health. In effect it has thus been reduced to pieces over which independent decisions too often reflect relatively narrow other political interests. There is little view of public health as a whole and decisions affecting it are considerably influenced by interests other than those of public health.

I therefore recommend:

I. A State Board of Health with responsibility for viewing and guiding public health work in the State and with authority for adopting regulations regarding public health.

I propose for the State Board of Health:

1. A body of 5, 7, or 9 persons appointed by the Governor and the Legislature to a four year term with representation of health expertise and the general public, and no more than a bare majority from any one political party.
2. The duties of:
    a. Actively monitoring the State's health problems and progress, and the Department of Health Service's operations.
    b. Guiding the State Director of Public Health and advising the Governor on health matters.
    c. Exercising authority to adopt regulations pertaining to public health.

II. A term of office for the State Director of Public Health, overlapping by one year an in-coming Governor's term.

I propose for the State Director of Public Health:

1. Knowledge of health, how to assess it in the State's population and how to protect and improve it by environmental control measures, personal health services and promoting healthful behavior.
2. Significant experience at State, Federal or local levels of public health involving their interrelationships, and with a record of accomplishment.
3. Leadership manifested by demonstrating insight into health problems, ability to analyze them and propose solutions; personal presence and competence in communicating such analyses and proposed solutions to significant bodies including the general public; and effectively advocating their appropriate action.
4. Appointment by the Governor to a four year power term overlapping by one year the next Governor's term.
5. Being a physician, or other health professional with competence to supervise physicians engaged in public health medical services, and graduating from a School of Public Health may be helpful preparation, but these are not sufficient. Probably the commonest mistake in selecting a health officer has long been simply to choose a physician with political views agreeable to the appointing power.