OREGON PUBLIC HEALTH LAW- REVIEW AND RECOMMENDATIONS

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Table of Contents

Preface and Acknowledgments

Lawrence O. Gostin

The public health law improvement process is the product of many talented and dedicated persons in Oregon. I had the privilege of listening to and learning from a wide variety of people in law, public health, medicine, nursing, environmental health, epidemiology, and many other disciplines. I was educated by legislators, public health officials, tribal representatives, municipal officials, public health professionals, and volunteers.

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This report, in many senses, does not contain original ideas. My job was to listen and to reflect on the advice and counsel I received from all of these experienced and dedicated professionals and volunteers.

It will be evident that for at least part of the report the purpose was to broadly educate readers about the field of public health law. Public health leaders, workers, and volunteers in Oregon were uniformly intrigued with public health law, and demonstrated enthusiasm for the subject. For those readers seeking more information on public health law, see LAWRENCE GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT (University of California Press and Milbank Memorial Fund, Forthcoming 2000).

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The mission of public health is fulfilling society's interest in assuring the conditions in which people can be healthy.[1]

Introduction

Preserving the public health is among the most important goals of government. As such, law is an essential tool of public health practice. Public health law contemplates the responsibilities of individuals and the duties of government to act for the health of society. Laws define the jurisdiction of public health officials and specify the manner in which they may exercise their authority. Laws can also establish norms for healthy behavior and create the social conditions in which people can be healthy. Legislatures, courts, and administrative agencies serve as conduits for social debates on important public health issues within the legal language of rights, duties, and justice. Within this context, we define public health law as the study of the legal powers and duties of the state to assure the conditions for people to be healthy, as well as the limitations on the power of the state to constrain legally-protected interests of individuals to promote community health.

In its foundational 1988 text, THE FUTURE OF PUBLIC HEALTH, the Institute of Medicine (IOM) agreed that law was essential to good public health, but questioned the soundness of public health law in the United States. The IOM concluded that the United States "has lost sight of its public health goals and has allowed the system of public health activities to fall into disarray,"[2] due partly to obsolete and inadequate state laws and regulations. Though its bleak view is not universally accepted,[3] the IOM further recommended that:

states review their public health statutes and make revisions necessary to

> accomplish the following two objectives: [i] clearly delineate the basic authority and responsibility entrusted to public health agencies, boards, and officials at the state and local levels and the relationships between them; and [ii] support a set of modern disease control measures that address contemporary health problems . . ., and incorporate due process safeguards (notice, hearings, administrative review, right to counsel, standards of evidence).[4]

More recently, the United States Department of Health and Human Services recommended public health law reform as part of its *Healthy People 2010* initiative. In response to these challenges, some states have updated and revised their public health laws since 1988. Most, however, have not. Public health law in many states remains ripe for reform. Pursuant to a comprehensive survey of communicable disease law in the fifty states, we (and others) have suggested that existing state statutes are ineffective in responding to contemporary health threats for many reasons.[5] These statutes often (1) pre-date modern scientific and constitutional developments; (2) fail to equip public health officials with a range of flexible powers needed to control infectious disease; (3) lack adequate standards of privacy, due process, and risk assessment; and (4) are based on arbitrary disease classification schemes that no longer relate to modern disease threats or epidemiologic methods of infection control.[6] Although the need for public health law reform is well-stated by the IOM and others, uncertainty concerning the framework for public health law has confounded meaningful proposals for reform by public health officials, state legislators, and the general public in many states.

This report reviews the state constitutional and statutory laws supporting the public health system in the State of Oregon and identifies potential areas for statutory and policy reform. The report is part of Oregon's Turning Point Initiative, *Collaborating For A New Century in Public Health*. This initiative provides technical support for state and community public health

partnerships. Through its Coordinator, **Jan Wallinder**, at the Oregon Health Division's Department of Human Services, the Oregon Turning Point Steering Committee asked the Georgetown/Johns Hopkins Program on Law and Public Health to assist with an assessment of the State's public health laws. Particularly, the Project seeks greater understanding of the current constitutional and legal structure of public health powers in Oregon, with a view toward improving the legal infrastructure at the state and local levels of government.

The Project is conducted in three primary stages. **Stage I** involves expert consultation between a high-level panel of governmental officials, public health experts in the public and private sectors in Oregon, state legislators, academics, and members of the Oregon Turning Point Steering Committee and one of the report's authors [**Professor Lawrence O. Gostin**]. **Stage II** involves a summary analysis of state public health laws toward the preparation of this report which thoroughly examines public health law in Oregon.

The report first provides a framework for examining the concept and definition of public health law, including legal issues of separation of powers, individual rights, and federalism, to provide some context for a discussion of Oregon public health law. Second, it provides both a general and sometimes specific review and analysis of constitutional, statutory, administrative, and case-based public health law in Oregon. The substance of the report is not intended to be exhaustive, but rather demonstrative of various facts of Oregon public health law. Third, the report discusses the benefits of a public health law improvement process, and provides specific guidelines for public health law reform in Oregon.

After the report is completed, Professor Gostin will present the findings to Oregon

Turning Point and public health officials and other interested individuals during **Stage III**. This consultation will focus on proposed changes concerning Oregon public health law which may be needed to facilitate Turning Point recommendations.

Public health law is that branch of jurisprudence which [applies] common and statutory law to the principles of hygiene and sanitary science.[7]

II. A Framework for Public Health Law

Conceptualizing public health law is not easy. Lawmakers, judges, health officials, scholars, and others have often viewed public health law at the intersection of other fields or disciplines including health law, health care law, law and medicine, forensic medicine, environmental law, and bioethics. While public health law is conceptually linked to the fields of law and medicine or health care law, it is itself a distinct discipline which is susceptible to theoretical and practical differentiation from other disciplines at the nexus of law and health.[8] In this section, we briefly define public health law within a constitutional framework and demonstrate the various governmental responsibilities and powers relating to public health consistent with our definition.

A. Defining Public Health Law

At the crux of the field of public health law is the definition of public health. Public health has historically been associated with the control of communicable diseases and the improvement of unsanitary or unsafe conditions in the community. Public health is actually more encompassing. Modern definitions of public health vary widely, ranging from the utopian conception of the World Health Organization of an ideal state of physical and mental health[9] to definitions which merely list common public health practices.[10] The Institute of Medicine has proposed one of the most influential contemporary definitions of public health which, though simply stated, is quite accurate: "Public health is what we, as a society, do collectively to assure the conditions for

people to be healthy."[11]

Building on this definition of public health, we define *public health law* as:

> the study of the legal powers and duties of the state to assure the conditions for people to be healthy (e.g., to identify, prevent, and ameliorate risks to health in the population), and the limitations on the power of the state to constrain the autonomy, privacy, liberty, or other legally protected interests of individuals for protection or promotion of community health.

From this definition five essential characteristics distinguish public health law from the fields of medicine and the law:

(1) *Government*: Public health activities are the primary responsibility of government, rather than the private sector;

(2) *Populations*: Public health focuses on the health of populations, rather than the clinical improvement of individual patients;

(3) *Relationships*: Public health contemplates the relationship between the state and the population (or between the state and individuals who place themselves or the community at risk), rather than the relationship between the physician and patient;

(4) *Services*: Public health deals with the provision of public health services, rather than personal medical services; and

(5) *Coercion*: Public health possesses the power to coerce the individual for the protection of the community, and thus does not rely on a near universal ethic of voluntarism.

Although these broad parameters help distinguish public health law from other fields, it is necessary to further examine the concept of public health law through our constitutional system of government.

B. Constitutional Authority for Public Health Powers

The United States Constitution is the starting point for any analysis concerning the distribution of governmental powers. Though the Constitution is said to impose no affirmative obligation on governments to act, to provide services, or to protect individuals and populations, it does serve three primary functions: it (1) divides power among the three branches of government (separation of powers), (2) limits government power (to protect individual liberties), and (3) allocates power among the federal government and the states (federalism).[12] In the realm of public health, then, the Constitution acts as both a fountain and a levee; it originates the flow of power – to preserve the public health, and it curbs that power – to protect individual freedoms.[13]

1. Separation of Powers

The Constitution separates governmental powers into three branches: (1) the legislative branch (which has the power to create laws); (2) the executive branch (which has the power to enforce the laws); and (3) the judicial branch (which has the power to interpret the laws). States have similar schemes of governance pursuant to their own constitutions. By separating the powers of government, the Constitution provides a system of checks and balances which is thought to reduce the possibility of government oppression.

The separation of powers doctrine is essential to public health, for each branch of government possesses a unique constitutional authority to create, enforce, or interpret health policy. The legislature creates health policy and allocates the necessary resources to effectuate it, although some contend that legislatures are unable to balance and make complex public health decisions. Legislators may (1) respond too quickly without sufficient fact-finding or consideration

of all the implications, (2) lack expertise in the health sciences, and (3) be influenced by popular beliefs that may be inconsistent with public health objectives. Yet, legislators remain politically accountable for their actions which the public must understand are balanced with competing claims.

While the executive branch enforces health policy, its role in setting policy is enormous. Executive agencies at the federal and state levels are legislatively charged not only with implementing legislation, but with establishing complex health regulations. Executive branch agencies are uniquely positioned to effectively govern public health. They are created for the very purpose of advancing public health, can focus on public health problems for extended periods, and may possess significant expertise and resources to address these problems. Conversely, however, agency officials focus too narrowly on single topics and may serve for long durations, thus lending to stagnant policies and procedures and complicity with the subjects of regulation.

The judiciary's task of in interpreting the law toward resolving legal disputes makes the courts' role in public health deceptively broad. Courts exert substantial control over public health policy by determining the boundaries of legislative and executive government power. Courts decide whether a public health statute is constitutional; whether agency action is authorized by legislation; whether agency officials have gathered sufficient evidence to support their actions; and whether government officials and private parties have acted negligently. The judicial branch has the independence and legal training to make thoughtful decisions about constitutional claims regarding, for example, individual rights or federalism. Courts, however, may be less equipped to review critically the substance of health policy choices. Judges are politically unaccountable (at

least federal judges -- some state judges are elected), are bound by the facts of a particular case; may be influenced by *avant garde* expert opinions; and may focus too intently on individual rights at the expense of communal claims to public health protection.

2. Limited Powers

A second constitutional function is to limit government power to protect individual liberties. Government actions to promote the communal good often infringe on individual freedoms. Public health regulation and individual rights may directly conflict. Resolving the tension between population-based regulations and individual rights requires a trade-off. Thus while the Constitution grants extensive powers to governments, it also addresses this trade-off through the declaration of individual rights which government cannot infringe without some level of justification. The Bill of Rights (the first ten amendments to the Constitution), together with other constitutional provisions,[14] creates a zone of individual liberty, autonomy, privacy, and economic freedom that exists beyond the reach of the government. Public health law struggles to determine the point at which government authority to promote the population's health must yield to individual rights claims.

These observations are clearly demonstrated in the United States Supreme Court Opinion, *Jacobson v. Massachusetts*[15] in 1905. In *Jacobson*, the Supreme Court considered a constitutional challenge to a general vaccination requirement for smallpox. Massachusetts enacted a law at the turn of the twentieth century empowering municipal boards of health to require the vaccination of inhabitants if necessary for the public health or safety. The Cambridge Board of Health, under authority of this statute, adopted a vaccination requirement for smallpox.

Jacobson refused the vaccination, was convicted by the trial court, and was sentenced to pay a fine of five dollars. The Massachusetts Supreme Judicial Court upheld the conviction,[16] and the case was appealed to the United States Supreme Court in 1905. Jacobson's argued that "a compulsory vaccination law is unreasonable, arbitrary and oppressive, and, therefore, hostile to the inherent right of every freeman to care for his own body and health in such way as to him seems best."[17] His claim was grounded in constitutional liberty interests which, he asserted, supported natural rights of persons to bodily integrity and decisional privacy.

Rejecting Jacobson's appeal, the Supreme Court adopted a narrower view of individual liberty while emphasizing a more community-oriented philosophy in which citizens have duties to one another and to society as a whole. Justice Harlan, writing for the Court, stated:

> [T]he liberty secured by the Constitution of the United States . . . does not import an absolute right in each person to be, at all times and in all circumstances, wholly freed from restraint. There are manifold restraints to which every person is necessarily subject for the common good. On any other basis organized society could not exist with safety to its members. . . . .'"[18]

Under a social compact theory, then, "a community has the right to protect itself against an epidemic of disease which threatens the safety of its members"[19] consistent with a state's traditional police powers which authorize an array of governmental action in the interests of public health, among other priorities.[20] The legacy of *Jacobson* surely is its defense of social welfare philosophy and unstinting support of police power regulation.

However, the Court also recognized the limits of these broad powers. Utilizing state police powers in support of vaccination requirements or other public health initiatives are constitutionally permissible only if they are exercised in conformity with the principles of:

(a) *public health necessity* - Justice Harlan, in *Jacobson*, insisted that police powers must be based on the "necessity of the case" and could not be exercised in "an arbitrary, unreasonable manner" or go "beyond what was reasonably required for the safety of the public;"[21]

(b) *reasonable means* - The *Jacobson* Court introduced a means/ends test that required a reasonable relationship between the public health intervention and the achievement of a legitimate public health objective.[22] Even though the objective of the legislature may be valid and beneficent, the methods adopted must have a "real or substantial relation" to protection of the public health, and cannot be "a plain, palpable invasion of rights;"[23]

(c) *proportionality* - "[T]he police power of a State," said Justice Harlan, "may be exerted in such circumstances or by regulations so arbitrary and oppressive in particular cases as to justify the interference of the courts to prevent wrong, . . . injustice, oppression or absurd consequence."[24] Thus, a public health regulation may be unconstitutional if the intervention is gratuitously onerous or unfair; and

(d) *harm avoidance* - While those who pose a risk to the community can be required to submit to compulsory measures, including vaccination, for the common good, the measure itself should not pose a health risk to its subject. Jacobson presented no medical evidence that he was not a "fit person" for smallpox vaccination. However, requiring a person to be immunized despite knowing harm would be "cruel and inhuman in the last degree."[25]

Thus, while *Jacobson* stands firmly for the proposition that police powers authorize states to compel vaccination for the public good, government power must be exercised reasonably to avoid constitutional scrutiny. The acts of a board of health, it has been held, are limited to those

which are essential to protect the public health.[26]

3. Federalism

Finally, the Constitution attempts to allocate powers among the levels of government, federal and state. Federalism, as a principle of law and governmental design,[27] distinguishes between the powers among the levels of American governments.[28] The federal government has those limited powers granted pursuant to the Constitution, including the power to enact laws in areas which the federal government has jurisdiction. To preserve the powers of the federal government from intrusion by the states, the Supremacy Clause[29] provides that federal laws and regulations override conflicting state laws via the doctrine of preemption.

Likewise, with the passage of the Tenth Amendment, states reserved their sovereign power over "all the objects, which, in the ordinary course of affairs, concern the lives, liberties and properties of the people; and the internal order, improvement, and prosperity of the State."[30] These powers, collectively known as police powers, give states broad jurisdiction to regulate matters affecting the health, safety, and general welfare of the public.[31]

Though a consequence of federalism, the distinction between federal and state powers is not always predictable in application. Federalism represents neither a bright line nor visible boundary between state and federal powers.[32] Federal and state government powers approach each other on a regular basis. It is precisely at the point when these powers collide that federalism takes on many shades and "almost imperceptible gradations."[33]

Federalism-based issues can be classified into two broad categories: (1) *state*

intrusions into the federal sphere. These include instances where states seek to intrude on the constitutional authority of the federal government (e.g., enacting laws which interfere with Congress' regulation of interstate commerce)[34] or fail to recognize federal supremacy or authority (e.g., attempting to impose taxes on federal goods).[35] Such examples proliferated during the early history of the nation as states tested the limits of their sovereign powers; and (2) *federal intrusions into traditional state duties*. Originally federal exercises which interfered with traditional state powers were virtually inconceivable in light of the considerable weight of state police powers.[36] In theory, federal legislation which touched areas traditionally left to the states was beyond Congress' jurisdiction, and therefore did not reign supreme over state law. However, the expansion of the federal government during the New Deal relaxed such traditional notions of federalism.[37] Arguments stemming from federal intrusion over states typify, though not exclusively, modern federalism debates.

Despite the accepted ability of the federal government to enter the field of public health, the American political and judicial process has placed enforceable limits on Congress' powers[38] in an era of *new federalism.*[39] Increasingly, federalism has been the focal point of political[40] and judicial issues. New federalism cases before the United States Supreme Court have resulted in the Court's (1) adoption of a super-strong rule against federal invasion of "core state functions;"[41] (2) presumption against application of federal statutes to state and local political processes;[42] (3) disdain for federal action that "commandeers" state governments into the service of federal regulatory purposes;[43] (4) rejection of federal claims brought by private parties against states;[44] and (5) adoption of the "plain statement rule" that Congress must ". . .

make its intention unmistakably clear in the language of the statute,[45]" that state law is preempted where such may alter the balance of federalism.[46]

The Supreme Court's decision in *United States v. Lopez*[47] is reflective of the judicial trend.[48] In *Lopez*, the Court held that Congress exceeded its Commerce powers by making gun possession within a school zone a federal criminal offense.[49] Concluding that possessing a gun within a school zone did not "substantially affect" interstate commerce, the Court declared the statute unconstitutional.

By any account, new federalism has mobilized the Tenth Amendment as a vehicle for challenging federal statutes that compel state legislative or administrative action. As a result, some federal public health laws may be vulnerable to state challenges on Tenth Amendment grounds — for example, environmental regulations that direct states to adopt or enforce a federal regulatory scheme[50] or loosely preemptive federal laws[51] which invade core state concerns in public health.

C. Governmental Public Health Powers

In the following sections, the authority and exercise of public health powers federal, state, and local governments within the constitutional framework are explored.

1. Federal Powers

The federal government must draw its authority to act from specific, enumerated powers. Before an act of Congress is deemed constitutional, two questions must be asked: (1) does the Constitution affirmatively authorize Congress to act, and (2) does the exercise of that power improperly interfere with any constitutionally protected interest?

In theory, the United States is a government of limited, defined powers. In reality,

political and judicial expansion of federal powers through the doctrine of implied powers allows the federal government considerable authority to act in the interests of public health and safety. The federal government may employ all means reasonably appropriate to achieve the objectives of constitutionally enumerated national powers.[52] For public health purposes, the chief powers are the power to tax, to spend, and to regulate interstate commerce. These powers provide Congress with independent authority to raise revenue for public health services and to regulate, both directly and indirectly, private activities that endanger human health.

2. State Police Powers

Despite the broad federal presence in modern public health regulation, states have historically and contemporaneously had a predominate role in providing population-based health services. States still account for the majority of traditional spending for public health services (not including personal medical services or the environment).[53] The Tenth Amendment of the federal Constitution reserves to the states all those powers not otherwise given to the federal government nor prohibited to the states by the Constitution.

The police power represents the state's authority to further a primary goal of all government, to promote the general welfare of society. Police powers can be generally defined as the inherent authority of the state (and, through delegation, local government) to enact laws and promulgate regulations to protect, preserve and promote the health, safety, morals, and general welfare of the people. To achieve these communal benefits, the state retains the power to restrict, within federal and state constitutional limits, private interests — personal interests in liberty, autonomy, privacy, and association, as well as economic interests in freedom to contract and uses

of property.

Police powers in the context of public health include all laws and regulations directly or indirectly intended to improve morbidity and mortality in the population. The police powers enable state and local governments to promote and preserve the public health in areas ranging from injury and disease prevention[54] to sanitation and water and air pollution.[55] Police powers exercised by the states include laws authorizing vaccination,[56] isolation and quarantine,[57] inspection of commercial and residential premises,[58] abatement of unsanitary conditions or other health nuisances,[59] regulation of air and surface water contaminants as well as restriction on the public's access to polluted areas,[60] standards for pure food and drinking water,[61] extermination of vermin,[62] fluoridization of municipal water supplies,[63] and licensure of physicians and other health care professionals.[64]

3. Local Powers

In addition to the significant roles which federal, state, and tribal governments have concerning public health law in the constitutional system, local governments also have important public health interests. Public health officials in local governments, including counties, municipalities, and special districts, are often on the front line of public health dilemmas. They may be directly responsible for assembling public health surveillance data, implementing federal and state programs, administering federal or state public health laws, operating public health clinics, and setting public health policies for their specific populations.

To the degree local governments set local public health priorities, they do so pursuant to specific delegations of state police powers. Local governments in the constitutional system are

recognized as subsidiaries of their state sovereigns. As a result, any powers which local governments have to enact public health law or policies must be delegated from the state. Such delegations of power, which may be narrow or broad, provide local governments with a limited realm of authority, or "home rule,"over public health matters of local concern within their jurisdiction. These delegations of power may be protected against withdrawal or infringement by state constitutions or statutes. Absent constitutionally-protected delegations of power to local governments, however, states may modify, clarify, preempt, or remove "home rule" powers of local government at will.

Exercises of local authority in the interests of public health cannot extend beyond limited jurisdictional boundaries or conflict with or impair federal or state law. As a result, the role of local governments in public health law is largely limited by federal and state laws and regulations to which local governments must adhere in setting or implementing public health policies.

4. Tribal Powers

Oregon's tribal governments are unlike state executive agencies and local governments which have been established and vested with public health powers via the state constitution and statutory laws. Tribal governments are not "established" pursuant to state law. Rather, their legal existence and many of their public health powers derive from the federal government.

The federal government's relationship with the American Indians is the product of compromise. In the mid 1800's American Indians executed treaties with the United States that turned over vast quantities of Indian land to federal control. In return, American Indians were granted limited set-asides of land (reservations), were allowed to form sovereign tribal

governments, and were to receive direct federal assistance. As sovereigns, tribal governments retained the traditional powers of government which are associated with state governments. This includes the power to act in the interest of public health. However, protecting the health of the community among tribal populations has traditionally been a shared venture between federal, state, and tribal governments.

Pursuant to the Snyder Act of 1921,[65] Congress directly assumed responsibility for the provision of health care to tribal governments. Such federal assistance continues today through long-term commitments for comprehensive health services administered by the Indian Health Service (IHS) of the federal Department of Health and Human Services (DHHS), and to a lesser extent, the Bureau of Indian Affairs (BIA). Congress has legislatively strengthened its commitment to provide health care benefits to American Indians through the Indian Self-Determination and Education Assistance Act of 1975[66] and the Indian Health Care Improvement Act of 1976.[67] Together these Acts clarified federal objectives for the provision of health-related services and encouraged the direct involvement of tribal governments in planning and operating health programs.

In 1991, Congress began the IHS Tribal Self-Governance Demonstration Project.[68] This Project, which is scheduled to continue until 2006, specifically authorizes IHS and BIA to execute agreements (or compacts) with American Indians for the purpose of providing federal funds for health programs and facilities without significant federal oversight. Under this law, general management and supervision of such programs and facilities are left to the tribal governments. As a result, the setting of public health goals and objectives are increasingly the responsibility of tribal

governments. This movement toward self-governance was further solidified with the Congressional enactment of the Tribal Self-Governance Act of 1994.[69]

American Indians on reservations in Oregon may receive their funds directly from IHS. They can use the funds for specific heath programs within their discretion, provided the spending is consistent with the general conditions for federal funding. This flexibility allows local tribal governments to target and respond to differing health needs across their populations.

"[E]ach citizen of this state is entitled to basic public health services which promote and preserve the health of the people of Oregon."[70]

II. Public Health Law in Oregon

In many states, public health law creates a highly-centralized structure for the regulation, delivery, and enforcement of various public health responsibilities at the state level. General and specific public health responsibilities are often legislatively assigned to two primary state agencies, a comprehensive department of health and a distinct department of environmental protection. Occasionally traditional public health duties and functions (e.g., epidemiology, communicable disease control, public health laboratories) are coupled with environmental duties (e.g., water, ground, and air pollution and contamination) in one comprehensive state agency. In most states, other, smaller agencies may also have public health missions. Together, these state agencies either perform directly or regulate the level and extent of public health services provided at the local county or city levels. Thus, these agencies are legislatively granted broad authority which they exercise in a top-down fashion in the interests of public health. Local public health agencies at the county or city levels carry out public health responsibilities consistent with significant state oversight and subject to state control.

Oregon's public health laws, however, suggest a variation of this common structure for the provision and delivery of many public health services in the state. Oregon has seemingly adopted a bottom-up approach in relation to core public health responsibilities (besides environmental protection). Each of the state's thirty-six counties is statutorily authorized to regulate in the interests of public health at the local level.[71] Oregon's cities are prohibited from

organizing public health departments.[72] County departments of health may align to form district health departments.[73] These county or district health departments work together as partners with state public health agencies. State agencies serve a supervisory role, but do not generally provide public health services directly. Through this relationship, the authority and direct responsibility for public health in Oregon largely lies at the local, county level of government.

This unique public health structure has advantages and disadvantages over different models employed in other states. In this section, we describe the public health laws in Oregon beginning with a brief overview of relevant state constitutional law. We then proceed to examine the structure, duties, and relationship of state and local public health agencies in Oregon, as well as some of the benefits, disadvantages, and challenges underlying this system. Interestingly, while Oregon's public health system is configured on a bottom-up approach, its public health laws do not absolutely require it. Rather, Oregon public health laws reflect a degree of flexibility among state and local powers which could allow for fundamental changes in the existing structure (if such is desired) without significant legislative action.

A. The Oregon Constitution

Like the federal Constitution, the Oregon Constitution sets limits on the powers of the state while providing affirmative grants of governmental powers. The State of Oregon's constitution explicitly provides many of the same or similar guarantees of individual rights set forth in the federal Constitution. These rights include due process rights to life,[74] equal protection,[75] freedom of religion[76] and speech,[77] and a prohibition against unreasonable searches and seizures.[78] Unlike some states, however, the Oregon Constitution does not explicitly provide

for additional protections such as an individual's right to privacy.

While the State constitution does not explicitly grant the Oregon Legislature the power to promote or protect public health or to provide for public welfare, the Legislature is given broad authority to act in areas not otherwise restricted.[79] The omission of specific grants of authority shall not be construed to deprive the legislature of such authority. Oregon public health law and regulations are thus largely defined by the Legislature through statutory laws and delegated rule-making, which courts are required to liberally construe.[80]

The Oregon constitution also authorizes the legislature to create political subdivisions, subject to few limits. Pursuant to this concentration of lawmaking power, the State has been organized into thirty-six counties, 240 cities, and over 800 special service districts. The Oregon constitution, unlike some states' constitutions, expressly empowers local governments, including counties,[81] cities,[82] and districts,[83] with limited "home rule" powers. County governments and their boards of health are empowered to create ordinances or other laws in the interest of public health. Occasionally, local enactments pursuant to these delegations of public health powers may interfere or overlap with state law. When this occurs, the authority of the state to act prevails,[84] though Oregon courts try to reconcile such conflicts wherever possible.

B. Public Health at the State Level

There are, at least, three main issues that are important to understand in thinking about public health in Oregon at the state level. First, it is important to see how agencies providing public health services are organized administratively and politically. This helps to explain the priority and visibility of the public health agency. Second, it is important to examine the mission,

functions, and powers of the state public health agency. This helps explain how well the agency can, and does, operate. Thirdly, it is important to examine the funding of the agency. Although this is closely related to the previous two issues, it is important in its own right. State funding for public health is influenced not only by priorities but by the amount of revenues generated by the state.

1. Public Health Organization and Structure

Unlike some states,[85] Oregon has statutorily enacted a basic statement regarding the protection of the health and safety of its citizens:

> The Legislative Assembly of the State of Oregon finds that each citizen of this state is entitled to basic public health services which promote and preserve the health of the people of Oregon. To provide for basic public health services the state, in partnership with county governments, shall maintain and improve public health services through county or district administered public health programs.[86]

Pursuant to this declaration, the Oregon Legislative Assembly has declared public health to be a fundamental, governmental responsibility and has subsequently enacted an array of statutes creating and authorizing various state and local governmental agencies and departments to regulate and carry out public health functions.

Many of these agencies are overseen in the executive branch by the Assistant Director for Health.[87] The Oregon Public Health Advisory Board serves as an advisory body to the Assistant Director, making recommendations for reform and public health policy development, although the degree to which the Board is utilized varies with the discretion of the Assistant Director.[88] Numerous state agencies are legislatively assigned responsibility and oversight functions for a variety of public health objectives including, for example: the ***Agriculture Department***

(whose Animal Health Division regulates animal diseases, including those transmissible to humans (e.g., rabies[89]), and whose Food Safety Division conducts inspections of various food handling and preparation facilities (other than restaurants)); the ***Department of Education*** (which administers child nutrition programs); the ***Bureau of Labor and Industries*** (which enforces state antidiscrimination laws and protects workers and children in the workplace); the ***Disability Commission*** (which advocates on behalf of persons with health-related disabilities); and the ***Department of Business and Consumer Services*** (whose Occupational Safety and Health Division works to improve the safety and health of individuals at their workplace).

Most traditional public health functions in Oregon, however, are centrally regulated by one of two state agencies: the ***Oregon Department of Human Services*** (DHS)[90] [previously known as the Department of Human Resources] (www.hr.state.or.us) and the ***Department of Environmental Quality*** (DEQ)[91] (www.deq.state.or.us). As summarized below, the respective duties and functions of these state agencies, though at times overlapping, are distinguished by the general legislative intent underlying the agency's establishment. DEQ is delegated the authority to regulate environmental threats to health, which it shares with the Health Division (OHD) at DHS. DHS is primarily responsible for regulating public health matters related to the control of communicable diseases, administration of public health care, and issues of public safety.

2. The Oregon Department of Human Services (DHS)

The Oregon Department of Human Services is the principal administrative agency at the state level which provides services to assure the conditions for health and safety of Oregonians. DHS is statutorily assigned broad responsibility for public programs relating to need-based

assistance, children and family support services, health-related affairs, mental health and developmental disabilities, vocational rehabilitation, elderly persons, disabled persons (including persons with traumatic brain injuries), and alcohol and drug abuse.[92]

DHS Director, **Gary K. Weeks**, and Deputy Director, **Bob Mink**, report directly to the Governor and supervise the following divisions and agencies responsible for providing human services: (1) the ***Adult and Family Services Division***; (2) the ***State Office for Services to Children and Families***; (3) the ***Mental Health and Developmental Disability Services Division***; (4) the ***Vocational Rehabilitation Division***; (5) the ***Senior and Disabled Services Division***; (6) the ***Office of Alcohol and Drug Abuse Programs***; (7) the ***Office of Medical Assistance Programs***; and (8) the ***Health Division***.[93]

Pursuant to this organizational structure, the ***Health Division (OHD)*** (www.ohd.hr.state.or.us) is primarily responsible for coordinating, overseeing, and providing state public health services. OHD is organized into five centers through which it operates over a hundred public health programs. ***The Center for Child and Family Health*** (CCFH) (www.ohd.hr.state.or.us/ccfh) addresses health issues concerning at-risk women, children, and families. Its services include immunization, prenatal care, nutrition and health screening, reproductive health care, and other services for high-risk children. ***The Center for Disease Prevention and Epidemiology*** (CDPE) (www.ohd.hr.state.or.us/cdpe) is responsible for the identification, investigation, and prevention of diseases and injuries caused by infectious agents, physical trauma, toxic chemicals, and unhealthy behaviors. CDPE conducts surveillance activities, gathers and analyzes epidemiologic information, and collects vital statistics for the state.

The Center for Environment and Health Systems (CEHS) (www.ohd.hr.state.or.us/cehs) serves two distinctive roles: (1) it protects against environmental hazards through its safe drinking water, radiation protection, and sanitation programs; and (2) it regulates hospitals, emergency and medical technicians, ambulance services, and trauma systems. ***The Public Health Laboratory*** (PHL) (www.ohd.hr.state.or.us/phl) provides statewide lab testing and consultation for state and local health departments, and assesses other clinical laboratories throughout the state. Finally, the ***Office of the Administrator and Program Services*** (OA-PS) (www.ohd.hr.state.or.us/oaps) is a conglomerate of agency-wide support services and special programs that supplies public health policy and direction to OHD.

a. Mission, Duties, Functions, and Powers

The Health Division has statutorily been assigned multiple powers and duties through broadly-worded legislation. The OHD shall (1) directly supervise "all matters relating to the preservation of life and health of the people of the state." Though broadly stated, the Oregon Attorney General has opined that this provision should be not interpreted to confer sweeping public health authority to the OHD;[94] (2) keep health-related statistics; (3) perform surveys, investigations, and inquiries respecting the causes and prevention of diseases, (especially epidemics like HIV,[95] and specifically cases of sudden infant death syndrome[96]); (4) issue findings related to alleviation of public health hazards, usually impure water or inadequate sewage treatment, by city annexation of unincorporated areas;[97] and (5) have "full power in the control of all communicable diseases."[98]

Concerning this latter responsibility, OHD is empowered to promulgate rules to guide the

reporting of infectious diseases to local public health administrators,[99] the investigation of disease threats,[100] the testing of various individuals for HIV,[101] the implementation of newborn screening programs,[102] the exposure of workers to infectious diseases,[103] and the restriction of children with communicable diseases from schools.[104] OHD must assist local public health administrators with the quarantine of appropriate individuals[105] and provide laboratory services to facilitate the diagnoses and investigation of various diseases.[106] These administrative regulations are regarded by courts as having the same authority as state legislation.[107]

Furthermore, the OHD is statutorily entrusted with responsibility for developing a child immunization registry,[108]coordinating statewide rabies vaccine clinics,[109] and establishing public health education programs on a variety of health measures (e.g., indoor air pollutants[110] [including tobacco smoke[111]], and the need for bone marrow donors).[112]

While the organization of public health services in Oregon conveys a great degree of power to local county boards of health (discussed below), Oregon statutory law allows for some degree of interpretation of the extent of state public health power. The Oregon Legislature has broadly granted OHD the power to "[e]nforce state health policies and rules,"[113] and furthermore, to thoroughly and efficiently execute ". . . the public health laws of [Oregon] in every part of the state. . . ."[114] OHD can instruct local public health administrators[115] and deploy OHD representatives to any part of the state when deemed necessary in its discretion.[116] It can also proscribe and enforce performance standards which have the "force and effect of law."[117] Local public health administrators must adhere to and enforce the laws and regulations implemented by the Legislature or OHD.[118] While these provisions, read together with other statutes, do not

support a centrally-powered public health authority in Oregon, they do suggest that OHD may be positioned to assume greater public health responsibility in the State if such is desired.

b. State Funding

The Health Division's funding presents a significant barrier to achieving its missions. Virtually all public health agencies believe they are under-funded. Relative to the enormous sums allocated to health care services, public health is very poorly funded. **William Roper**, who has served in several major federal posts including head of the Centers for Disease Control and of the Health Care Financing Administration, described his own experiences with under-funding for public health services:

> From my perspective, as a White House official watching the budgetary process, and subsequently as head first of a health care financing agency and then of a public health agency, I was continually amazed to watch as billions of dollars were allocated to financing medical care with little discussion, whereas endless arguments ensued over a few millions for community prevention programs. The sums that were the basis for prolonged, and often futile, budget fights in public health were treated as rounding errors in the Medicare budget.[119]

However, the funding problems in Oregon are particularly acute. First, public health has not been given priority in funding and visibility within the DHS. While this is changing, the Division still has relatively low funding levels. Even if the Governor's office and DHS wanted to significantly increase state funding for public health, Oregon has severe fiscal limitations. At the moment, most states are experiencing budget surpluses and also have unexpected funds from the tobacco settlement. However, in Oregon, initiatives have severely restricted revenue services, both at the state and local level. At the state level, there is no sales tax and there are limits on income tax and possible restrictions on the use of tobacco settlement resources.[120] The State has

also made an important, but expensive, commitment to achieving near universal access to health care through the Oregon Health Plan.

The Health Division not only has limited funds for its own work, but has almost no general funding that it can allocate to counties or tribal governments. As a result, the main state-level funding of counties are "pass-through" funds. The State, therefore, merely channels federal program funds to the counties which gives OHD less ability to provide leadership and standards for counties.

3. The Department of Environmental Quality (DEQ)

The Oregon Department of Environmental Quality(DEQ) is a regulatory agency whose job is to protect the quality of Oregon's environment. DEQ is responsible for protecting and enhancing Oregon's water and air quality, for cleaning up spills and releases of hazardous materials, and for managing the proper disposal of hazardous and solid wastes. DEQ staff use a combination of technical assistance and inspections to help public and private facilities and citizens understand and comply with state and federal environmental quality regulations. Other responsibilities that directly involve individual citizens include the residential on-site sewage program, and the vehicle inspection program, which protects air quality in the Portland and Medford areas.

In addition to local programs, DEQ has delegated authority from the Environmental Protection Agency (EPA) to operate federal environmental programs within the state such as the Federal Clean Air, Clean Water, and Resource Conservation and Recovery Acts.

The Director of DEQ, **Langdon Marsh**, reports to the Environmental Quality

Commission. The Environmental Quality Commission (EQC) is a five-member citizen panel appointed by the governor and confirmed by the Oregon Senate for four-year terms to serve as DEQ's policy and rule-making board. In addition to adopting rules, the EQC also establishes policies, issues orders, judges appeals of fines or other department actions, and appoints the DEQ director.

DEQ has developed a clear mission, vision, values, and goals. Its mission is to be an active leader in restoring, enhancing, and maintaining the quality of Oregon's air, water, and land. Its vision is to work cooperatively with all Oregonians for a healthy, sustainable environment. Its values are (1) to achieve favorable environmental outcomes; (2) serve customers (e.g. public fora and open participation); (3) partner with other agencies, the private sector, and the community; and (4) promote excellence, integrity, employer growth, teamwork, and diversity. And it has set goals for air quality, water quality, and waste management and cleanup.

a. Coordination of Functions

DEQ's mission and functions suggest that the demarcation line between DEQ and other public health agencies (e.g. the Health Division) is reasonable. In particular, the environmental functions of DEQ (e.g. clean air and water, and waste management) are common among the states and began with the environmental movement of the late 1960's. There are a number of areas relevant to public health and the environment where DEQ does *not* take primary responsibility: radiation (Health Division), noise (counties), pesticides (Department of Agriculture), and safe drinking water (Health Division).

Despite the relatively clear demarcation of responsibilities between DEQ and the Health

Division, there are important areas of overlap. For example, decisions to remove effluents from streams may save fish but create human dangers; decisions to introduce waste materials as fertilizers may help farmers but cause pulmonary problems in the adjoining human populations.

As a result of these, and many other, common interests, it is important for DEQ and the Health Division to have structured, systematic relationships and coordination. Particularly since the Turning Point initiative, officials at middle management at these two agencies have begun to meet. Yet, staff at both agencies acknowledge that regular and structured relationships would be valuable.

It is interesting to observe that the heads of these two agencies seldom meet. This may be due partly to differences in leadership. However, one clear reason for this is that the DEQ Director is a cabinet official and meets other agency heads at cabinet meetings. Since the Administrator of the Health Division is not at this level of management, it impedes ongoing discussions. This, of course, does not prevent these two agency heads from scheduling meetings together, which they have regularly in the past.

b. Agency Organization

There are critical differences in the organizational structures of DEQ and the Health Division. As mentioned above, the Director of DEQ reports directly to the Governor while the Administrator of the Health Division reports to the Oregon Department of Human Services. Additionally, the Environmental Quality Commission supervises some of DEQ's work, while there is no equivalent citizen commission supervising the Health Division's work and acting as an advocate for public health.

The DEQ has direct responsibility for most state services and regulation. Consequently, it can exercise strong leadership. The Health Division, on the other hand, has a role that is principally supervisory without direct service and regulatory functions. Thus, DEQ has a "top-down" approach while the Health Division has a "bottom-up" approach. The reasons for these differences are partly historical and partly functional. Public health in Oregon has a history of strong county-level service provision, while counties have not taken similar responsibilities in the area of the environment. From a functional perspective, the environment has national and state-wide implications. Air and water pollution are seldom localized. Rather, pollution at the local level soon affects the state and the region. Public health is more traditionally regarded as a local issue. Yet, it is certainly possible to see the state-wide implications. For example, an outbreak of communicable or sexually transmitted disease can soon cross county borders.

c. Public Support and Outreach

From the interviews conducted, there appears to be greater support among policy makers and the public in Oregon for the environment than for public health. Issues of fish, toxic waste, timber, and clean water and air are very important to Oregonians. Yet, policy makers and the public have exhibited greater concern for access to medical care (the Oregon Health Plan) than for public health.

The reasons for these differences are complex and not completely clear. Nevertheless, DEQ has been aggressively engaged in efforts to garner political and public support. Among these efforts, DEQ has published highly accessible "*Citizen's Guides*" to the environment and the work of the agency; engaged in personal and high-level "outreach" with the community (e.g.

rotary clubs), the private sector, legislators, and municipal officials; and has sought community-level support for this work by involving citizens in policy, planning, and "good" environmental practices. The Health Division is currently seeking to improve its outreach in these and other areas. As we discuss later (see Part V), these outreach activities are very important to the agency's future success.

C. Public Health at the Local (County) Level

As we have discussed, Oregon has a highly decentralized structure for public health (beyond core environmental protections under DEQ's jurisdiction). As in the case of state public health agencies, it is important to examine local public health agencies according to their powers, organization and structure, functions, and funding.

1. Power, Organization, and Structure of Public Health at the Local Level

County governments have statutorily been assigned primary responsibility for providing public health services in Oregon. "Local public health administrators are charged with the strict and thorough enforcement of the public health laws of this state in their districts, under the supervision and direction of the Health Division."[121] Counties carry out public health functions through local or district boards of health.[122] They may employ private agencies to perform these functions, or choose not to perform them at all. Only one county (i.e. Gilliam County) has decided against assuming public health authority. In this case, the State may take over the county's inherent authority.[123]

Alternatively, two or more contiguous counties may combine to form a district health unit pursuant to county resolutions.[124] This has occurred in only one case— the combined

Wasco/Sherman County Health Department. A district health unit can designate a district board of health that subsequently replaces and assumes all the powers of the pre-existing county boards. Participating counties may appoint a separate public health advisory board to advise the district board of health on public health matters.

County commissioners, who are elected by local citizens, appoint a public health administrator who is the chief health official at the local level. The public health administrator serves as the executive secretary of the county health board and administrator of the county health department. They may appoint, with board approval, various administrators, medical officers, public health nurses, and other employees as needed. Public health administrators inform the board about the activities of the department and submit an annual budget for the approval by the county government(s). As well, they act as "the agent of the Health Division" in enforcing state public health laws and rules.[125] If the administrator is also a physician, he or she may serve as the local health officer. Local health officers may be part- or full-time, appointed or hired, although all such officers must be physicians.[126] Though their degree of public health expertise varies widely, they are each generally responsible for medical aspects underlying public health services within the county.[127]

Tillamook County employs a full-time health officer who is also engaged in some clinical work. Baker County employs a full-time physician who serves as health officer and administrator. At present, however, Multnomah County (which includes the Portland area) is the only county that employs a full-time health officer who is devoted exclusively to public health. Multnomah County is by far the largest county. Its public health agency is larger than the Oregon Health

Division and its relationship with the state is different than most other counties. Much of the discussion below about capacity-building, therefore, does not apply to Multnomah County in the same way as it does to the other counties in Oregon. With limited budgets and smaller populations, the remaining counties in Oregon employ part-time physicians to perform the role of health officer.

2. Local Public Health Functions

The laws which broadly set out the public health responsibilities of Oregon local health departments are general and somewhat antiquated (thirty-nine years old). Apart from the requirements to meet State standards and follow state laws and regulations, counties have a great deal of autonomy that allows them to exercise their powers in ways that meet local needs. OHD is statutorily required to concur with local health departments concerning, for example, the minimum standards which dictate the operation and organization of the departments.[128]

District or county boards of health have the power to adopt rules necessary to carry out its duties and responsibilities, provided no rule conflicts with or is less strict than any public health law of the Health Division.[129] Specifically, local public health authorities shall administer and enforce local and states rules and laws concerning public health. They must assure activities necessary for the preservation of health or prevention of disease as provided in the annual plan including (a) epidemiology and control of preventable diseases and disorders; (b) parent and child health services, including family planning clinics; (c) collection and reporting of health statistics; (d) health information and referral services; and (e) environmental health services.[130]

These legal requirements pose several problems for public health in Oregon. First, they

express the counties' obligations in terms of programmatic activities rather than essential services. Consequently, the statute does not conform with modern public health approaches. Public health experts now believe that state public health agencies should perform a defined set of "essential public health services." National public health authorities have listed ten such essential services:

1. Monitor health status to identify health problems;
2. Diagnose and investigate health problems and hazards;
3. Inform, educate, and empower people about health issues;
4. Mobilize partnerships to identify and solve health problems;
5. Develop policies and plans that support individual and statewide health efforts;
6. Enforce laws and regulations that protect health and ensure safety;
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable;
8. Assure a competent public and personal health care workforce;
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services; and
10. Research for new insights and innovative solutions to health problems.[131]

The Oregon Turning Point Initiative is also considering identifying a defined set of services, perhaps utilizing national sets as a framework. Ideally, public health law should conform to these modern approaches.

The second problem is that there is considerable variability in the ability of counties to perform these essential services. Some counties have a great deal of funding and expertise, while others have much less capacity. Some county public health agencies have as little as four staff members which makes it virtually impossible to perform all essential public health services for their citizens. Consequently, there is considerable variability in the capacity of counties to assure the conditions for the community's health.

3. County Funding

Most of the money for public health services at the county level comes from two sources. The federal government provides funds for specific programs. Counties receive these federal funds after they are distributed to the state.[132] This categorical funding can make public health functions difficult to perform. Counties may have to create programs they may not need and discontinue programs they do need. By creating "silos" of programmatic funding, counties lose the flexibility of needs-based assessments that are important to local governance.

The second source of funds are from county revenues which can be used for general purposes. Counties, however, are quickly losing their main sources of revenue. In particular, state-wide ballot initiatives have set limits on property taxes. In addition, revenues from timber have fallen dramatically in recent years. Counties, therefore, are not always in a strong financial position to assure all essential public health services. As a result, they may decide to reduce the level of public health services consistent with their fiscal limitations. An Oregon court has agreed that counties have the authority under statutory law to reduce the level of services where needed given fiscal constraints.[133]

4. Holding Counties Accountable for Meeting State Standards

There is wide-ranging discussion in Oregon about the desirability of holding counties responsible for meeting minimum state standards. While counties seek continued autonomy and properly demand local flexibility, many public experts believe that some minimum levels of service and quality are important. At present, there exist three ways in which the state may hold counties accountable: minimum standards, assurances, and periodic reviews (every three years). In addition, the state has several options for enforcing these standards and assurances through

withholding of funds and taking over local functions and services.

a. Minimum Standards

The Health Division in conjunction with the Conference of Local Health Officials Standards Committee have developed a set of minimum standards for county public health agencies. These standards are thoughtful, detailed, and widely respected at the state and local level. However, while they are entitled "standards," there is no credible system for enforcing them or ensuring their adoption and implementation at the local level.

Many interviewees commented that the state does not do enough to monitor and enforce these minimum standards. There is a certain amount of frustration with this lack of enforcement. Yet, again, the state is in a dilemma. While many counties would welcome accountability, others resent the state setting and policing standards at the local level. A certain amount of leadership would be required to overcome this perennial problem.

b. Assurances

The Health Division, as a condition of dispersal of federal or state funds, requires counties to give "assurances" that certain standards will be met and programmatic activities will be performed. This is in the nature of a contract so, legally, the state could withhold funds for local failures to comply with the assurances. Despite this legal power, the state rarely follows up with rigorous enforcement of assurances. One possible reason is that assurances rarely contain tangible mechanisms to evaluate the quantity and quality of local services performed.

c. Periodic Reviews

Every three years, the Health Division undertakes a review of public health activities in

each county. While most interviewees felt that theses reviews were thorough and comprehensive, they widely question the value of these periodic reviews.

One reason for the dissatisfaction was the lack of consequences for ongoing problems at the local level. One county health administrator remarked that every triennial report would make the same points about local failures to meet minimum standards. Each report would be ignored, and the next report would point to the same problems. "Nothing happened— there were no consequences." At the same time, this administrator explained, the state would send a complementary letter to his or her county commissioners stating what a good job had been done for public health in the county.

d. Enforcement

The foregoing discussion suggests there exists a lack of implementation of state standards. In part, this is because the state has few adequate enforcement tools. If counties fail to meet standards, the state has two choices. It can withhold funds or it can take over local powers and services. Neither prospect is attractive. The state is reluctant to withhold funds because public health services are so essential. The state also does not wish to take over local powers and functions because it is not well equipped to do so. In addition, the state properly respects local autonomy.

This suggests that the state should develop new tools to enforce its standards. This will not be easy, either from a management or political perspective. Rigorous discussion between high-ranking state and local officials will be important in resolving this dilemma. As another county administrator noted: "There needs to be basic expectations of service and qualifications

wherever you live. This requires accountability."

e. Budgets

Adding to the problem of state/county relations is the method for budgeting. As required by statute,[134] all money given by the state to counties must be determined according to funding formulas set by the Health Division with the concurrence of the Conference of Local Health Officials. To some observers this is a useful statutory provision because it requires state and localities to negotiate. To others, this law presents a management problem because it is unclear which entity has final authority.

D. Public Health at the Tribal Level

The population of American Indians living on tribal lands in Oregon is relatively small (9,000 - 10,000), although many additional Native Americans reside in Oregon, particularly in the Portland area. There are over a dozen formally-recognized Indian tribal governments in Oregon, although the extent of their organization and recognition by the state varies. Depending on the governmental structure of the tribes in Oregon, various public health services may be directly or indirectly provided to Native Americans in Oregon.

Some tribal governments (e.g., the Confederate Tribes of Warm Springs-- the largest tribal population in Oregon at approximately 4,000 persons) exist as sovereign governments within Oregon consistent with their federally-recognized status. These tribal governments contract directly with various entities for the provision of health and mental care to their populations. They increasingly have the delegated responsibility from the federal government to implement and provide individual and public health services as needed. Given their sovereign status under federal

law, they may receive very little (if any) direct state support, although their citizens may utilize state public health services outside the reservation.

Others (e.g., the Confederate Tribes of Grand Ronde) are not formally organized as sovereign governments, and are largely viewed as residents of the Oregon counties. Native Americans in these tribes receive public health services directly from the counties which they reside. Still others (e.g., the Confederate Tribes of Umatilla) represent a patchwork between these two governmental structures.

Clearly the provision of public health services by tribal governments depends greatly on their organizational structure. However, state and tribal governmental authorities tend to agree that greater recognition of tribal governments within the state public health system is desired. Extensive variation of public health services available to Native Americans suggest the need to equalize public health functions and support for tribal governments. Perhaps tribal governments should be formally recognized by the state as having similar public health status as counties, although this recognition would likely have to derive from the State Legislature.

The field of public health is firmly grounded in law and could not exist in the manner in which we know it today except for its sound legal basis.[135]

III. The Benefits of a Public Health Law Improvement Process

Public health law contemplates the responsibilities of individuals and the duties of government to act for the health of society. As such, public health law serves as a foundation and a framework for public health activity. Public health law should assure that public health agencies are fully capable of responding to current and coming public health threats. Unfortunately, existing public health laws too often fail to support health departments in carrying out their essential services and accomplishing their goals. Reform of the law can promote more effective decision-making and protect individual rights.

Before explaining why public health law improvement can yield many benefits, it is important to be candid about the limitations of the legislative approach. We recognize the law as merely one tool toward the improvement of public health. Many of the problems observable in public health are remedied not primarily though law reform but, rather, through better leadership and training, improved infrastructure for surveillance and epidemiological investigations, comprehensive counseling and health education, and innovative prevention strategies. In making policy, public health authorities will have to consider prevailing social values and respect multiple constituencies, including scientists, politicians, and community leaders.

A. The Role of Public Health Law

There are at least four possible roles for the law in advancing public health. Law can define the objectives of public health and influence its policy agenda, authorize and limit public

health actions, serve as a tool of prevention, and facilitate planning and coordination of governmental and non-governmental health activities.

Public health statutes should establish the purposes, goals, and core functions of public health, the personnel and infrastructure realistically needed to perform these functions, and budgeting mechanisms that will provide reliable levels of support. By doing so, the law can inform and influence the activities of government and the expectations of society about the scope and fundamental importance of public health. Courts give deference to statements of legislative intent and may permit a broad range of activities that are consistent with legislative objectives. No government program can be assured full funding during budgetary crises. However, structuring public health law to embrace defined functions, minimum infrastructure and personnel needs, and funding mechanisms can provide a yardstick for health departments and policy makers in the future.

Public health law must provide broad authority for the exercise of public health powers and coextensively limit that authority where necessary for the protection of individual rights. In considering law reform, it is important to distinguish between duties and powers in public health. The legislature should impose duties on health departments[136] to initiate a broad range of activities relating, for example, to surveillance, communicable disease control, environmental protection, sanitation, and injury prevention. It is important that health officials retain *flexibility* in the powers used to achieve public health purposes.

While providing for a flexible range of public health powers, the law must also place appropriate limits on those powers to protect human rights. This is best accomplished by

adhering to certain strategies:

- Establishing clear criteria for the exercise of compulsory powers by requiring health authorities to use scientific evidence of a significant risk to the public health;
- Providing procedural due process for all individuals who face serious constraints on their liberty; and
- Safeguarding the privacy of individuals and preventing or punishing unlawful discrimination.

Public health law is, and should remain, a tool of prevention. Public health law should use a wide variety of legal means to prevent injury and disease by creating the conditions for people to be healthy.

The following benefits could be achieved through a public health law improvement process.[137]

B. Update Antiquated Laws

Most public health laws in the United States have been passed piecemeal in response to specific disease threats such as tuberculosis, sexually-transmitted diseases, and HIV/AIDS. The law has thus developed, layer-upon-layer, from one time period to another. Certainly, older laws are not necessarily bad laws. A well-written statute may remain useful, efficacious, and constitutional for many decades. However, older laws are often outmoded in ways that directly reduce their efficacy and conformity to modern legal standards. Older laws may not reflect contemporary scientific understanding of disease, current medical treatments of choice, or constitutional limits on the state's authority to restrict individual liberties. They may fail to allow public health agencies the discretion to modernize such enactments through administrative regulation.

C. Comply with Modern Constitutional and Other Legal Requirements

Some public health laws predate contemporary developments in constitutional law, disability discrimination law, health information privacy, and other modern legal requirements. As a result, state law may not meet evolving standards enunciated by state and federal courts and legislatures.

At the constitutional level, the United States Supreme Court now has more exacting standards for equal protection of the laws, substantive due process, and procedural due process. Public health powers that affect liberty (e.g., quarantine and directly observed therapy), privacy (e.g., reporting and partner notification), and autonomy (e.g., compulsory testing, immunization, or treatment) may undergo more careful scrutiny under the federal Constitution. At the same time, the Constitution may require more rigorous procedural safeguards before exercising compulsory powers.

Federal disability law prohibits discrimination against persons based on their health status, such as an infectious disease. This may require health officials to adopt a standard of "significant risk" before resorting to compulsion. A significant risk may be defined as a direct threat to the health or safety of others that cannot be eliminated by modification of policies, practices, or procedures. Thus, under this standard, adverse treatment, such as a decision to use compulsory powers, would only be permitted if the person posed a significant risk to the health or safety of others. A significant risk regarding communicable diseases would be determined through an individualized assessment of the mode of transmission, probability of transmission, severity of harm, and the duration of infectiousness.[138]

D. Clarify the Law

General or overlapping provisions concerning public health duties and responsibilities sometime result in confusion about who has what public health powers and when to exercise those powers. This confusion is understandable. Given the multiplicity and layer-upon-layer approach of public health law, even the most expert lawyers have difficulty providing clear answers to public health officials about their authority to act. One major benefit of public health law reform would be to provide greater clarity about legal powers and duties.

E. Improving Relationships

Improving the working relationships in public health is an important goal. Public health practice involves complex relationships between governmental and non-governmental entities and actors. These relationships are of several kinds.

1. Legislative and Public Health Authorities

Legislators and public health officials may sometimes have markedly different understandings about public health and the role of government. Public health authorities frequently seek greater freedom to exercise their discretion in matters concerning the health of the community. Legal requirements and the political process can be viewed as impediments to a well-functioning health department. Concerns exist over how legislators approach issues of public health law, funding, and development of an adequate public health infrastructure. Coextensively, legislators may see a need for clear criteria and procedures under which public health officials can operate.

Legislators and public health authorities must listen to one another through discussions which are motivated on the sole issue of improving Oregon's public health system. Such

communications should not occur mainly in response to the latest public health issue. Rather, a primary benefit of public health law reform would be the coming together of public health authorities and legislators for the common good.

2. Federal and State

As with every state, the federal government is intricately involved in public health in Oregon, and thus, there remains a need for strong relationships among federal and state public health officials.

3. State, Tribal, and Local

State, tribal, and local dialogue on public health is critical in Oregon given the size and diversity of the State and its urban, suburban, and rural populations. Maintaining channels of communication between state, tribal, and local public health authorities is important. A lack of regular communication between these authorities could carry serious implications for the public health. If the State, for example, had to discontinue a public health service because of budgetary constraints or otherwise, local governments should be made aware of the decision in order to prepare for their potential responsibility to provide these services. Otherwise there may be temporary, serious gaps in public health services. Clearly local governments may not be able to assume public health functions previously funded or provided by the state, but early communication may facilitate local resource allocation and perhaps avoid public health repercussions from sudden discontinuances of programs.

4. City and Rural

Closely related to State and local relationships are the different perspectives of city and

rural dwellers. State legislators from urban areas have distinctly different visions of public health and financial responsibilities than persons from rural communities. Each constituency may lack some trust in the other. A constructive and systematic dialogue process may improve relationships.

5. Public Health Authorities and the Private Sector

Increasingly government public health authorities have aligned with private sector health care providers, insurers, managed care companies, and nonprofit and religious organizations to provide, directly or indirectly, various public health services. The private sector can play a valuable role in public health, especially where government funding for public health programs remains static, if not in decline. Establishing and nurturing these relationships between public and private sectors may serve to improve the public health.

V. Guidelines for Reforming Oregon Public Health Law

Many of the public health laws we reviewed may perhaps be seen as outdated given their age or generalized approach to public health duties, structure, and organization. However, it is notable that the Oregon State Legislature has remained active in amending and, on occasion, repealing public health laws. Entire chapters of dated public health law (e.g., venereal disease) have been repealed or amended by the State Legislature with guidance from public health authorities. Through active, ongoing reform over the past several decades, Oregon has refined its public health laws at the state and local levels, updated its statutory code in many instances, and aggressively implemented effective state administrative regulations. As a result, many ill-advised public health laws which might linger among the statutory codes in other states have been addressed and remedied in Oregon. This is not to say that Oregon public health law is not obsolete in some ways and that improvements through statutory reform are possible.

Most public health experts in Oregon suggest that the state's public health system is well-designed, thorough, and functioning. The public health system is well-regarded for its ability to attend to most traditional public health functions, including communicable disease control, health prevention activities, licensing and inspection, public health education, and environmental issues. For these reasons, Oregon is ahead of other states which may struggle to provide even basic public health services to their entire populations because of a fundamental lack of organizational structure and deficient public health laws. Despite these observations, however, Oregon's public health laws can be improved.

Whether Oregon should reform its public health law remains open. Law reform is not the

inevitable result of the public health law improvement process pursuant to the Turning Point Initiative (although it certainly could be). While this report discusses many of the benefits of law reform, there are also risks. Bills introduced into state legislatures can become politicized, sometimes polarizing or skewing the original goals or interests underlying the bill. Even if a bill is enacted as proposed, laws tend to bind future decisions and authority. Revising laws, though possible, is complicated and contingent on legislative agendas. Where laws tend to affix public health responsibilities, many public health professionals emphasize the need for flexibility. As well, when the law attempts to refine or model relationships among public health officials at the state, tribal, and local levels, or redistribute public health powers, some distrust may arise. Despite these risks, it is important to see the benefits of public health law improvement (see discussion in Part IV). We propose the following substantive, structural, and procedural guidelines for public health law improvement in Oregon.

A. Mission Statement: Essential Public Health Services

Many public health experts agree that most state public health laws contain inadequate mission statements: they fail to clarify or authorize the essential public health services recommended by the Institute of Medicine and the federal Department of Health and Human Services.[139] Although Oregon's Legislature has declared the government's responsibility for public health,[140] Oregon, like other states, does not articulate a mission for public health or spell out core or essential public health services necessary for serving the State. As a result, Oregon law reform should express a clear vision for public health. This vision should articulate the best theory and practice in public health and make a symbolic statement about assuring the conditions necessary

for the health of the people. This does not just include personal medical services, but a rich array of services for disease and injury prevention and health promotion.

Oregon health officials recognize the need for a comprehensive mission statement. They have recently proposed adding a new, introductory section (§ 431.031) to **Title 36: Public Health and Safety** of the OREGON REVISED STATUTES. This new section, entitled "*Public Health Services, Generally,*" assimilates many of the public health responsibilities currently spread over numerous statutory sections into a comprehensive statement about the roles and responsibilities in public health. It specifically incorporates the ten essential public health services (discussed above) into three categories (assessment, policy development, and assurance) as primary functions of public health. Furthermore, it recognizes a role for the private sector (e.g., health care providers, community organizations, and businesses).

While the proposed mission statement, as worded, may require some additional revision and clarification, its passage would mark an important event in public health law reform in Oregon. Its breadth would begin to craft a new image for public health in the state, set affirmative new goals for public health programs, and clarify the sorts of duties and responsibilities which state, local, and tribal governments share in the interests of protecting the health of populations.

B. Changing the Profile of the Oregon Health Division

Protecting the public health is among the most important responsibilities of government. If citizens and communities do not have their health they cannot participate in family, social, economic, and political life to the fullest. Consequently, health and safety is a foundational

responsibility of government that deserves attention at the highest level of government.

Clarifying the mission for public health in Oregon is an important step toward upgrading and standardizing public health responsibilities. However, reworking the image of public health in Oregon will take additional effort beyond statutory reform. The Turning Point Initiative has recommended that the Oregon Health Division (OHD) become more visible and gain greater priority among the state's programs. The OHD is one of many sub-cabinet level agencies competing for priority, visibility, and funding within the Department of Human Services and, for that matter, the state. Seeking greater visibility and priority for OHD as an important component of the Department is critical toward improving the health and safety of Oregon communities where OHD is legislatively assigned a large portion of public health responsibility. There are many ways to improve the visibility of OHD.

1. Centralizing Public Health Responsibilities

Some states have actively sought to centralize public health responsibilities in a single agency equipped with broad public health powers. While a super-agency may be in the best interests of the public health, such entities are politically difficult to create where public health functions are traditionally delegated to multifarious state and local agencies.

Oregon has made a political commitment to having the health division remain a sub-cabinet level agency. The State sees public health as a broad responsibility requiring the services of many agencies. To assure coordination among these agencies, they are under the jurisdiction of a single, cabinet-level director.

2. Internal Changes at the OHD

Given the State's justifiable decision to maintain its current organizational structure, the State should find other ways to raise the OHD's profile and political status. Indeed, there are ongoing discussions at senior levels to improve the organizational, public, and political position of the Health Division. Within DHS, Director **Gary K. Weeks** and Deputy Director **Bob Mink** are engaged in a process of raising the priority of the OHD and using its expertise more efficiently. First, the Director is seeking to make public health a higher priority within the agency. This greater attention could involve giving public health more visibility, requiring the Health Division to demonstrate its cost effectiveness through outcome evaluations, and by having regular on-going and high-level discussions among DHS and OHD officials. Second, the Director is considering methods of using the Health Division's expertise to assist other agencies to accomplish their mission more efficiently. Third, they are committed to continuing consultation and coordination with the Acting Administrator, **Jono Hildner**, and the Health Officer, **Grant Higginson**.

The Governor's Office is also engaged in discussions to improve the visibility and importance of the Health Division. The Governor's senior staff director on health matters, **Mark Gibson**, has been engaged in a dialogue with **Mr. Hildner** and **Dr. Higginson**. **Mr. Gibson** clarified that the Governor is committed not only to the Oregon Health Plan, ensuring access to health care for all Oregonians, but also to public health in general. However, to secure greater funding and priority for public health, OHD will have to demonstrate its preparedness to lead and its ability to render cost-effective services with demonstrably favorable outcomes.

3. Outreach Programs

OHD can take its own steps to improve its own visibility and importance. In addition to the Division's commitment to internal re-structuring and engaging in rigorous outcome and program evaluations, OHD could engage in outreach efforts to inform the public and political community about its work and the importance of public health. The Division is already free to conduct discussions within its own branch of government and with the State legislature. Regular, ongoing meetings and joint planning with the Governor, DHS, and legislators are critically important in gaining the status and priority that OHD seeks and deserves.

Furthermore, outreach to the public is very important. There is widespread under-appreciation of the role and importance of public health among communities. The need to educate the public about the importance of public health and the work of the Department of Human Services and its Health Division among the three branches of government, communities at risk, the private sector, and the general public is clear. This kind of effective dialogue, joint planning, and education will improve the status and visibility of the Division within DHS.

C. Improving Existing Services and Accountability

While various stake holders in Oregon may differ on how public health functions should be performed, most agree that the State has a responsibility to ensure statutorily-mandated minimum functions. Yet, there also appears to be agreement that the State does not always ensure these functions as well as it could. In particular, the assurances the Health Division requires of counties are sometimes not sufficiently rigorous or enforceable. This results in significant inequalities in the public health services available in different counties.

The Health Division is not solely at fault for the lack of consistency of services. As we

have suggested, there is a strong (and understandable) culture of local autonomy in Oregon. Counties are the primary public health authority and have statutory duties to provide programs and quality services. While the law requires counties to provide a range of services and assure their quality, in practice, this does not always happen.

Counties sometimes do not feel obliged to conform with state standards since they receive very little general state funding. They also may lack the capacity to provide all statutorily required services because they have little general funding of their own and small populations. In particular, counties may not be able to attract highly qualified and experienced public health professionals. Given the limited finances for salaries and compensation, the rural locations, the part-time nature of employment opportunities, and insufficient budgets, recruitment and retention of public health professionals becomes very difficult. At the same time, the State does not (and cannot) pay for most local services so it is not in a strong position to expect conformance with State standards.

As the State's primary public health agency, the OHD arguably has considerable credibility and trust within government and in the public. However, this can be a double-edged sword. At the moment, the Division has been asked to handle two highly visible and politically difficult problems in Oregon— death with dignity and medicinal marijuana. While these are undoubtedly important issues, they can drain the human resources and attention of senior public health officials. As a result, there may be less time and attention that can be directed to functions and services that affect the health and safety of large populations.

These observations clearly suggest that there are multifarious problems which confront the

Oregon public health system. These problems center on the uncertainty of authority (*see* Part D below), insufficient measures to make public health authorities at the state, tribal, and local levels accountable (*see* Part E below), and an occasional lack of commitment to statutory and administrative public health goals. At least concerning the latter of these dilemmas, the solution may be found in attending to resolving the first two of these three problem areas. Thus, resolving uncertainty over public health duties and improving accountability among public health officials will inevitably increase the commitment of state and local public health officials to their respective, defined missions. Accomplishing these other objectives is the subject of our next two sections.

D. Clarifying State and Local Authority

According to Oregon law, the primary holders of public health responsibility and power are counties. At the same time, from a constitutional perspective, states have primary control over localities and have been given liberal statutory powers to enact and enforce administrative regulations on a variety of public health issues. Local government, for the most part, gains its authority from powers delegated by the state— either in the state constitution or by state statute. In Oregon, nine counties have asserted "home rule" and a degree of local autonomy in their governance.[141] These home rule counties, as well as most other counties, have a large degree of independence concerning local issues.

As we have suggested, Oregon's significant commitment to a de-centralized public health structure is justifiable. Counties are closer to the people and better understand the community's needs and how to deliver services. Nevertheless, there is also a desire among many at the state and local levels for greater accountability and uniformity in the provision of quality public health

services. There exist significant inconsistency and variability in assuring the conditions for public health throughout the state. Certainly, there should not be an expectation of rigid uniformity as this would defeat the manifest advantages of local autonomy. Nevertheless, principles of justice suggests that Oregonians, wherever they live, should rightfully expect high levels of public health services.

This being the case, OHD must conceptualize its appropriate role and function in the realm of public health. On one hand, by its constitutional stature and by statutory duty, the Health Division possesses overall responsibility to assure the health and safety of Oregonians. It may desire (and in fact possess some) statutory authorization to exercise its public health powers over counties in such ways as to improve the equality of distribution of public health services across the population. On the other hand, the OHD does not have the primary power or funding to directly provide all necessary services and regulatory authority to achieve its mission. For these reasons, it must rely upon counties and tribal governments to provide public health services at levels which they deem sufficient, even where the OHD may determine that minimal levels of services are defeating public health goals and objectives.

In some ways, these observations are a symptom of inadequate funding at the state and local levels. Yet, some of the resulting problems in public health service distribution in Oregon stem directly from the State's current organizational structure that attempts to draw fine lines between state and local authority, responsibility, oversight, and powers. This is particularly true concerning traditional public health services (e.g., communicable disease control, surveillance), although less so concerning environmental programs under the jurisdiction of DEQ. Clarifying the

roles of state, local, and tribal public health authorities through statutory reform may benefit the State's diverse population through improved and consistent delivery of public health services across the State.

Despite some of the current structural limits of the Oregon public health system (i.e. a desire to retain a strong aura of local public health authority and a subordinate state public health authority), greater accountability may still occur through statutory reform. State public health systems which seem to generate stronger accountability are often statutorily organized from the top-down. In these states, state public health agencies are granted broad statutory authorization, power, and funding which they use to distribute public health benefits to local governmental units in uniform fashion. Local health officials are either state employees working at the local level, or mere "agents" of the state by statutory definition. While accountability is an asset of such systems, they often suffer from inattentiveness to the actual needs of the local populations. Public health programs may be doled out and administered without specific consideration of local problems and customs, thus engendering resentment among county and city residents.

For Oregon to retain its bottom-up approach while improving state and local accountability, statutory law must, however, incorporate the strengths of a top-down approach, namely a stated and defined set of responsibilities administered by state and local authorities. Public health officials in Oregon need to determine those responsibilities which they consider to be primarily state functions (even if they are less significant than those responsibilities of state public health agencies in a top-down state) and those which are primarily local functions. Clear, statutory lines need to be drawn between these responsibilities. Appropriate state or local officials

need to assume their respective duties. In those areas of public health regulation which overlap, state and local authorities must work together, although one group versus another must be statutorily bound to ensure compliance.

Ultimately, Oregon public health officials need to consider abandoning the existing legal fiction underlying its current system. Public health law and practice in Oregon suggests that there are a number of important public health objectives which, subsequently, local authorities are responsible for administering under some layer of state oversight (which does not include strong penalties for failures to administer, or incentives to compel compliance). A bottom-up system of public health cannot work efficiently on the premise that a multitude of local health officers will provide these services where state oversight is so limited. Collaboration between state and local officials is a wonderful feature of the Oregon system for many reasons, but it also seems to be an source for excuses (at both levels) concerning responsibility for public health duties. Such excuses can be statutorily eliminated provided these authorities can agree to accept primary responsibility for public health functions which logically belong at the state or local level.

Where local authorities fail to fulfill their duties, state authorities must have the statutory recourse to (1) require compliance; (2) perform the services directly; or (3) contract for the services within the private sector. Curiously some of these options are already embodied in state law, but are rarely utilized because of the aura of local autonomy. This is precisely why greater delineation between those duties which are state versus local is needed. As well, it hardly needs to be repeated that the Oregon legislature should strongly consider making public health funding a greater priority for the upcoming fiscal years.

E. Improving Relationships and Resolving Disputes

Regular and meaningful exchange of information between state, tribal, and local public health agencies is critical. As discussed above (see *Benefits of a Public Health Improvement Process*), the relationships between federal, state, tribal, and local public health authorities are important. A lack of communication between the state's two primary public health agencies, OHD and DEQ (see Part II.B.3.a), as well as some distrust of state government among local and tribal governments provide ample reasons for sustained communication in the future.

Where Oregon public health relies on core relationships between state public health agencies and local health departments, ongoing communication is statutorily mandated. As we discussed (see Part II.C.4), the OHD assesses county performance through the joint setting of minimum standards, contracting to guarantee assurances, and by performing public health reviews every three years. While these and other tools may serve as good conduits for state and local communication, some public health authorities in Oregon suggest that the OHD and local public health administrators do not effectively utilize these statutory methods of communication.

Through increased adherence and improved administration of these formal, statutory requirements, state and local public health authorities could realize several beneficial effects. First, effective communication helps to plan in advance to avoid conflicts. Second, it provides a mechanism for responding to crises when they arrive. Third, it enhances familiarity and trust among different groups in the public health infrastructure.

However, legal reform may be unable to dramatically improve the complex inter-relationships among public health authorities in Oregon. Other techniques may be utilized to

improve these relationships especially in circumstances (such as dispute resolution) where improvements may be needed most. The following options for improving relationships are not meant to be mutually exclusive. Rather, it is possible that each could be considered at different times and circumstances.

1. Case-by-Case Resolution

State and local authorities may disagree about who has public health authority in a given circumstance. This is partly a symptom of a statutory failure to clearly delineate these responsibilities (*see* Part D above). One option, which is often exercised, is to resolve disputes on a case-by-case/issue-by-issue basis.

This option has its values. Significant disputes are uncommon. When they do arise, this approach allows state and local authorities to meet, determine the facts, discuss the law, and negotiate resolutions. Through such a process, each side learns more about public health law and practice in Oregon.

However, this approach also lends toward inconsistencies over time and geographic regions. Decisions may not be formalized through written, circulated memos or papers. The decisions themselves may be legally questionable. And a degree of distrust among officials may arise based on heavy-handed negotiations or unfavorable resolutions. For these reasons, other options may need to be considered to supplement or replace this approach.

2. Structured Discussions

Resolving disputes on a case-by-case basis may be improved when accomplished within a structure such as a planned forum for discussion. Rather than waiting for a crisis to arise, this

option would engage major public health officials in meaningful and ongoing discussions with community leaders.

Oregon's public health system already features statutory mechanisms for these planned discussions, but some public health officials express concerns that ideas exchanged through these fora are not always respected or received. This consequence is regrettable, although it does not defeat the value of systemized, ongoing communication as a vehicle to address disputes. Resolving these issues does require that individuals at the source of the conflict act consistent with the agreed plans of conduct determined through planned discussions.

3. Conflict Resolution

A third option is to determine in advanced an administrative means for resolving disputes or raising objections. Alternative dispute resolution (ADR), which utilizes impartial, expert fact-finders to facilitate decision-making, is a popular option for resolving legal disputes outside a courtroom setting. This is not to say that formal ADR is recommended for handling inter-agency or inter-level disputes among public health officials. Rather, it is the essence of ADR as a method of mediating disputes which perhaps should be considered.

Perhaps the OHD or CLHO may form a joint panel to help mediate disputes. It could consist of retired officials at the state and local levels who are committed to public health and its improvement. Published decisions of the panel could be influential, although not likely fully authoritative.

4. Formalize Relationships

A final option is to try to formalize relationships. Rather than leaving the structure of

relationships unspoken, this method would try to clarify them. This could be accomplished, for example, through circulated memoranda or even in law or regulation. In Oregon, as in many states, public health officials may seek to formalize relationships or resolve disputes through requested opinions of the Attorney General. The determination of minimum standards which guide local public health responsibilities is another primary example of how relationships are formalized.

F. Avoid Separate Disease Classifications and Disease Specific Laws

The primary epidemiologic rationale for classifying diseases and treating them differently is to distinguish between modes of disease transmission. However, the origins of this differential treatment may be better explained by historical and political influences than by reasoned distinctions or thoughtful strategies. The result often creates different standards and procedures for different diseases. Thus, the legal environment for controlling health risks depends on how the disease is classified.

A strong argument exists that public health law should be based on uniform provisions that apply equally to all health threats. Public health interventions should be based on the degree of risk, the cost and efficacy of the response, and the burdens on human rights. These considerations cut across disease classifications. Oregon public health law largely reflects these observations in its attempt to classify communicable diseases under limited headings (e.g. HIV/AIDS, tuberculosis). The elimination of some existing laws which apply differing standards to certain diseases or conditions will contribute toward the implementation of a single set of standards and procedures, clarify legal regulations, and may diminish future politically-motivated

disputes about existing and newly-emergent diseases.

G. Base Public Health Decisions on the Best Scientific Evidence of Significant Risk

In combating public health threats, health officials need both clear authority and flexibility to exercise powers and sufficient guidance. Consequently, effective and constitutionally-sound public health law should include a rational and reliable way to assess risk and establish fair procedures.

Oregon public health law should give public health authorities the power to make decisions based upon the best available scientific evidence. Public health officials should examine scientific evidence in the following areas: (1) what is the nature of the risk (e.g., the mode of transmission)? (2) what is the probability that the risk will result in harm? (3) what is the severity of harm should the risk ensue? and (4) what is the duration of the health risk? Provided health officials act with a good foundation in science, they should be supported by public health law. And where scientific evidence may not provide suitable public health responses, public health authorities should have a flexible range of powers to address such instances.

H. Provide Fair Procedures

Public health officials need ample and flexible powers to protect the common welfare. Coextensively, the community needs to have confidence in the fairness of public health practice. At times, Oregon public health law may generally delineate the powers of public health authorities without suggesting the manner in which they may be exercised.

Public health law should ensure fair procedures. The nature and extent of the process required depends upon several factors including: (1) the nature of the interests affected; (2) the

risk of an erroneous decision; (3) the value of additional safeguards; and (4) the administrative burdens of additional procedures. Except in an emergency when rapid response is critical, public health law should assure a fair and open process for resolving disputes about the exercise of powers and authority.

I. Private Sector and the Public Health

Public health has always envisioned the cooperative efforts of the public and private sectors. Increasingly states are turning to the private sector (e.g. medical providers, hospitals, health insurers, managed care companies, nonprofit organizations) for assistance with public health goals. While government must remain primarily responsible for the public health, the private sector may serve important roles (e.g., population-based disease screening, provision of indigent care, surveillance assistance). Some state public health authorities encourage managed care entities to perform free mammograms or provide free vaccinations. Health providers clearly have a critical role in disease surveillance through the accurate reporting of disease.

Like the relationships between governmental public health agencies, the relationships between public and private sectors can be formalized through state law. As the potential collaboration between public and private sectors becomes a core facet of public health planning, these formal relationships may work overall to strengthen the public health system. While public health officials in Oregon support collaboration between the public and private sectors, there exists relatively little statutory law supporting or requiring these joint pursuits.

Conclusion

The public health system in Oregon is commendable for many reasons, several of which we have noted in this report. Yet, public health in Oregon faces many challenges, some of which are reflective of the challenges facing the Oregon Health Division. The OHD has assumed a relatively low level of power on the organizational chart of executive branch sub-agencies (although its parent, the Department of Human Services, shares prominence with other state agencies); elected officials and the public do not have a clear appreciation of the OHD's work and importance; it has no clear set of responsibilities and powers from a legal perspective; and it has significant constraints on its funding.

These are indeed major challenges not only for the OHD and DHS, but for the public health improvement process in Oregon. Though formidable, these challenges are surmountable. The Health Division has impressive strengths and expertise. Its vision of public health in Oregon is one of the most thoughtful and nuanced in the country. The Turning Point Initiative has allowed it the opportunity to think systematically about its goals and mission. It has done so exceptionally well and is poised to make impressive strides in public health. The OHD also has some of the best known and respected public health officials in the country. Its capacity, for example, in epidemiology and laboratory work is the equal of any state in the country. The future of public health in Oregon, therefore, is bright. But it will take vision, hard work, and cooperation among state, tribal, and local partners to achieve the goals.

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16. Commonwealth v. Pear, 66 N.E. 719 (Ma Sup. Jud. Ct. 1903).

17. 197 U.S. at 15–16, 26.

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21.197 U.S. at 28.

22. *See, e.g.*, JAMES A. TOBEY, PUBLIC HEALTH LAW 90 (1926).

23. 197 U.S. at 31. *See also* Nebbia v. People of State of New York, 291 U.S. 502, 510–511 (1933) (public welfare regulation must not be "unreasonable, arbitrary, or capricious, and the means selected must have a real and substantial relation to the object sought to be obtained.").

24. 197 U.S. at 38–39.

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27. *See* Texas v. White, 7 Wall. 700, 725 (1869) *quoting* Lane County v. Oregon, 7 Wall. 71, 76 (1869) ("The Constitution, in all its provisions, looks to an indestructible Union, composed of indestructible States"); *see also* A REPORT OF THE WORKING GROUP ON FEDERALISM OF THE DOMESTIC POLICY COUNCIL, THE STATUS OF FEDERALISM IN AMERICA 5 (1986) ("federalism is a constitutionally based, structural theory of government designed to ensure political freedom. . . . ").

28. *See, e.g.*, Editorial, *The Court and Federalism*, WASH. POST, Jan. 14, 2000, at A26 ("The proper question [of federalism] is whether . . . policy issues [should] be addressed by the appropriate level of government, rather than which level is likely to deliver a particular favored outcome.").

29. U.S. CONST. art. VI, par. 2 (". . . [t]his Constitution, and the Laws of the United States which shall be made in Pursuance thereof; . . . shall be the supreme Law of the Land; . . . ").

30. JAMES MADISON, THE FEDERALIST PAPERS, NO. 45, at 292-293 (C. Rossiter ed. 1961), as quoted in Gregory v. Ashcroft, 501 U.S. 452 (1991).

31. *See, e.g.*, ERNST FREUND, THE POLICE POWER: PUBLIC POLICY AND CONSTITUTIONAL RIGHTS 3-4 (1904); James G. Hodge, Jr., *The Role of New Federalism and Public Health Law*, 12 J. L. & HEALTH 309, 318-320 (1998).

32. *See* New York v. United States, 505 U.S. 144, 112 S. Ct. 2408, 2417 (1992) (". . . the task of ascertaining the constitutional line between federal and state power has given rise to many of the Court's most difficult and celebrated cases").

33. *See* 16 AM. JUR.2D *Constitutional Law* § 277 (1979); Alan R. Arkin, *Inconsistencies in*

Modern Federalism Jurisprudence, 70 TUL. L. REV. 1569 (1996).

34. *See, e.g.*, South Carolina Highway Dep't v. Barnwell Brothers, 303 U.S. 177 (1938) (finding constitutional a South Carolina law that prohibited trucks over 90 inches wide or weighing over 20,000 gross pounds on state highways despite infringement on interstate commerce).

35. *See* McCulloch v. Maryland, 17 U.S. (4 Wheat) 316 (1819) (invalidating the attempt by Maryland to tax the issuance of bank notes by the newly created national bank).

36. States were considered essential to the functioning of government because they retained the majority of powers. *See* A REPORT OF THE WORKING GROUP ON FEDERALISM, *supra* note 67, at 10. So powerful were the states under the original balance of power among the national and state governments that Alexander Hamilton commented "there is greater probability of encroachments by the [states] upon the federal [government] than by the federal [government] upon the [states]. *Id.* at 9 *citing* THE FEDERALIST PAPERS, No. 31, at 197. *See also* New York v. United States, 505 U.S. 144 (1992) ("The Federal Government undertakes activities today that would have been unimaginable to the Framers in two senses; first, because the Framers would not have conceived that *any* government would conduct such activities; and second, because the Framers would not have believed that the *Federal* Government, rather than the States, would assume such responsibilities").

37. *See, e.g.*, Daniel S. Herzfeld, *Accountability and the Nondelegation of Unfunded Mandates: A Public Choice Analysis of the Supreme Court's Tenth Amendment Federalism Jurisprudence*, 7 GEO. MASON L. REV. 419 (1999).

38. Richard C. Reuben, *The New Federalism*, ABA J., Apr. 1995, at 76-77 (the resurgence of federalism is partially the result of increased political efforts of the states to move toward greater autonomy from the federal government and the effects of such efforts on the political processes on Capitol Hill); s*ee also* Juliet Eilperin, *House GOP's Impact: Transforming an Institution*, WASH. POST, Jan. 4, 2000, at A4 (chronicling the failures of former House of Representatives Speaker, Newt Gingrich, Eilperin comments that ". . . while Gingrich had once hoped to lead the country from the speaker's chair, some of the changes he set in motion may well diminish the legislative's branch's power in the years to come by transferring powers to state and local governments. . . "). *Id.*

39. The term "new federalism" may have first been used by Donald E. Wilkes, Jr. in his article, *The New Federalism in Criminal Procedure: State Court Evasion of the Burger Court*, 62 KY. L.J. 421 (1974).

40. Although several state governors failed in their 1994 effort to organize a "Conference of States" to draft federal constitutional amendments in support of greater state rights (*see* William Claiborne, *Supreme Court Rulings Fuel Fervor of Federalists*, WASH. POST, June 28, 1999, at A2.), Congress has recently introduced several bills which would require it to consider federalism issues prior to the passage of legislation. Ron Eckstein, *Federalism Bills Unify Usual Foes*, LEGAL TIMES, Oct. 18, 1999, at 1. In August, 1999, President Clinton signed the second draft of his executive order concerning federalism. This initial draft of the order was roundly rejected by state and local government associations for its failure to appropriately reflect new federalism

principles. David S. Broder, *Federalism's New Framework*, WASH. POST, Aug. 5, 1999, at A21. The revised order disfavors federal preemptive laws or policies, requires executive officials to defer to states whenever possible in setting national standards, and features an enforcement mechanism against implementation of federal executive policies that lack a federalism "impact statement" (i.e. a written assessment of the potential impacts of a national executive policy or plan on state-based functions or powers). *Id.*

41. *See* City of Boerne v. Flores, 521 U.S. 507 (1997) (pursuant to a challenge based on the decision of a local zoning authority to deny a church a building permit, the Court invalidated the Religious Freedom Restoration Act of 1993 as beyond Congress authority under § 5 of the Fourteenth Amendment); United States v. Lopez, 514 U.S. 549 (1995) (Congress lacked the commerce power under U.S. Const. art. I, § 8 to enact the Gun-Free School Zones Act of 1990, making criminal the knowing possession of a gun by a student while at school).

42. *See* City of Columbia v. Omni Outdoor Advertising, Inc., 499 U.S. 365, 373 (1991).

43. *See* Printz v. United States, 521 U.S. 898 (1997) (1997) (declaring unconstitutional the federal requirement under the Brady Handgun Violence Prevention Act that state chief law enforcement officers temporarily conduct background checks on prospective handgun purchasers); New York v. United States, 505 U.S. 144 (1992) ("take title" incentive provisions of the federal Low-Level Radioactive Waste Policy Amendments Act of 1985 are constitutionally invalidated); Hodel v. Virginia Surface Mining and Reclamation Association, Inc., 452 U.S. 264 (1981) (Congress may not commandeer the state legislative processes by directly compelling them to enact and enforce a federal regulatory program).

44. *See, e.g.*, Joan Biskupic, *Justices, 5-4, Strengthen State Rights*, WASH. POST, June 24, 1999, at A1.

45. *See* Atascadero State Hospital v. Scanlon, 473 U.S. 234 (1985).

46. *See* Gregory v. Aschroft, 501 U.S. 452 (1991).

47. United States v. Lopez, 514 U.S. 549 (1995).

48. *See, e.g.*, Printz v. United States, 117 S.Ct. 2365 (1997); Seminole Tribe v. Florida, 517 U.S. 44 (1996); New York v. United States, 505 U.S. 144 (1992).

49. Lopez, 514 U.S. 549 (1995).

50. New York v. United States, 505 U.S. 144 (1992).

51. Gregory v. Ashcroft, 501 U.S. 452 (1991).

52. McCulloch v. Maryland, 17 U.S. (4 Wheat.) 316 (1819).

53. INSTITUTE OF MEDICINE, *supra* note 1, at 178-183.

54. TOM CHRISTOFFEL & STEPHEN P. TERET, PROTECTING THE PUBLIC: LEGAL ISSUES IN INJURY PREVENTION 25-28 (1993).

55. 39 AM. JUR.2d Health §§ 22, *et seq.* (1968) (state citations omitted).

56. Zucht v. King, 260 U.S. 174 (1922).

57. Leisy v. Hardin, 135 U.S. 100 (1890).

58. Givner v. State, 124 A.2d 764, 774 (Ct. App. Md. 1956); See v. Seattle, 387 U.S. 541, 550-52 (listing historical examples of state inspection) (Clark, J., dissenting) (1967).

59. Jones v. Ind. Livestock Sanitary Bd., 163 N.E.2d 605, 606 (Ind. 1960); Francis v. La. St. Livestock Sanitary Bd., 184 So.2d 247, 253 (La. 1st Cir. 1966).

60. Oklahoma ex rel. Corp Comm'n v. Texas County Irrigation & Water Res. Ass'n, Inc., 818 P.2d 441 (Okla. 1991).

61. Strandwitz v. Board of Dietetics, 614 N.E.2d 817, 824 (Ct. App. Oh. 1992).

62. Kaul v. Chehalis, 277 P.2d 352, 354 (Wash. 1955) (en banc).

63. Safe Water Ass'n, Inc. v. Fond Du Lac, 516 N.W.2d 13, 15 (Ct. App. Wis. 1994); Douglas A. Balog, *Note, Fluoridation of Public Water Systems: Valid Exercise of State Police Power or Constitutional Violation?*, 14 PACE ENVTL. L. REV. 645 (1997).

64. State v. Otterholt, 15 N.W.2d 529, 531 (Iowa 1944); Adams v. Dept. of Health & Human Resources, 458 So.2d 1295,1298-99 (La. 1985).

65. 25 U.S.C. § 13 (1997).

66. P.L. 93-638.

67. 25 U.S.C. §§ 1601-1683 (Supp. 1998).

68. 25 U.S.C. § 450f (Supp. 1998).

69. 25 U.S.C. § 450 (Supp. 1988).

70. OR. REV. STAT. § 431.375(2) (Michie 1997).

71. OR. REV. STAT. § 431.375(2) (Michie 1997).

72. OR. REV. STAT. § 431.480 (Michie 1997).

73. OR. REV. STAT. § 431.414 (Michie 1997).

74. OR. CONST. Art. I, § 10.

75. OR. CONST. Art. I, §§ 1, 20.

76. OR. CONST. Art. I, §§ 2-6.

77. OR. CONST. Art. I, § 8.

78. OR. CONST. Art. I, § 9.

79. OR. CONST. Art. IV, § 1.

80. Gardner v. First Escrow, 732 Or. Ap 715 (1985), *rev. den* 299 Or 314; *rev. den*. 299 Or 314.

81. OR. CONST. Art. VI, § 10.

82. OR. CONST. Art. IV, § 1; Art. XI, § 2.

83. OR. CONST. Art. IV, § 1.

84. OR. REV. STAT. § 431.415(2) (Michie 1997).

85. Kristine M. Gebbie & Inseon Huang, *Identification of Health Paradigm in Use in State Public Health Agencies*, Columbia Univ. School of Nursing, Center for Health Policy and Health Services Research (Oct. 28, 1997).

86. OR. REV. STAT. § 431.375(1) (Michie 1997).

87. OR. REV. STAT. § 431.035 (Michie 1997).

88. OR. REV. STAT. § 431.195 (Michie 1997).

89. OR. REV. STAT. § 433.360 (Michie 1997).

90. OR. REV. STAT. § 409.010 (Michie 1997).

91. OR. REV. STAT. § 468.030 (Michie 1997).

92. OR. REV. STAT. § 409.010(2) (Michie 1997).

93. OR. REV. STAT. § 409.010(3) (Michie 1997).

94. 36 OP. OR. ATT'Y GEN. 1089 (1974).

95. OR. REV. STAT. 433.055 (Michie 1997).

96. OR. REV. STAT. § 431.120(5) (Michie 1997).

97. OR. REV. STAT. §§ 222.840 -- 222.915 (Michie 1997).

98. OR. REV. STAT. § 431.110 (Michie 1997).

99. OR. REV. STAT. § 433.004 (Michie 1997).

100. OR. REV. STAT. § 433.006 (Michie 1997).

101. OR. REV. STAT. § 433.065 (Michie 1997).

102. OR. REV. STAT. § 433.285(2) (Michie 1997).

103. OR. REV. STAT. § 433.423 (Michie 1997).

104. OR. REV. STAT. § 433.273 (Michie 1997).

105. OR. REV. STAT. § 433.156 (Michie 1997).

106. OR. REV. STAT. § 433.012 (Michie 1997).

107. Bronson v. Moonen, 270 Or. 469, 528 P.2d 82 (1974).

108. OR. REV. STAT. § 433.094 (Michie 1997).

109. OR. REV. STAT. § 433.367 (Michie 1997).

110. OR. REV. STAT. § 433.511 (Michie 1997).

111. OR. REV. STAT. § 433.850 (Michie 1997).

112. OR. REV. STAT. § 431.270 (Michie 1997).

113. OR. REV. STAT. § 431.120(1) (Michie 1997).

114. OR. REV. STAT. § 431.150(2) (Michie 1997).

115. OR. REV. STAT. § 431.120(3) (Michie 1997).

116. OR. REV. STAT. § 431.110(f) (Michie 1997).

117. OR. REV. STAT. § 431.140 (Michie 1997).

118. OR. REV. STAT. § 431.150(1) (Michie 1997).

119. William Roper, Why the Problem of Leadership in Public Health? In: LEADERSHIP IN PUBLIC HEALTH 20, 21 (1994).

120. OR. REV. STAT. § 431.832 (Michie 1997).

121. OR. REV. STAT. § 431.150 (Michie 1997).

122. OR. REV. STAT. §§ 431.370(2), 431.410 (Michie 1997).

123. OR. REV. STAT. § 431.370(2) (Michie 1997).

124. OR. REV. STAT. § 431.414 (Michie 1997).

125. OR. REV. STAT. § 431.418 (Michie 1997).

126. OR. REV. STAT. § 431.418 (Michie 1997).

127. OR. REV. STAT. § 431.418 (Michie 1997).

128. OR. REV. STAT. §§ 431.330 - 431.350 (Michie 1997).

129. OR. REV. STAT. § 431.415(2) (Michie 1997).

130. OR. REV. STAT. § 431.416 (Michie 1997).

131. Centers for Disease Control and Prevention, *State Public Health System Performance Assessment Instrument* [draft as of Sept. 16, 1999] (http://www.phppo.cdc.gov/dphs/nphpsp/state_tool_7_5.pdf).

132. OR. REV. STAT. §§ 431.210 *et seq.* (Michie 1997).

133. Burks v Lane County, 72 Or. App 257 (1985).

134. OR. REV. STAT. § 431.380 (Michie 1997).

135. FRANK P. GRAD, PUBLIC HEALTH LAW MANUAL (2d ed. 1990).

136. The term “health” department is used in the generic sense to include all public health functions carried out by the Commonwealth.

137. *See, e.g.*, Lawrence O. Gostin, Scott Burris, and Zita Lazzarini, *The Law and the Public’s Health: A Study of Infectious Disease Law in the United States*, 99 COLUMBIA L. REV. 59 (1999).

138. *See* Lawrence O. Gostin, Chai Feldblum, & David W. Webber, *Disability Discrimination in America*, 281 JAMA 745, 746 (1999).

139. Kristine M. Gebbie & Inseon Huang, *Identification of Health Paradigm in Use in State Public Health Agencies*, Columbia Univ. School of Nursing, Center for Health Policy and Health Services Research (Oct. 28, 1997).

140. *See, supra*, text accompanying note 86.

141. These counties are as follows: Benton, Lane, Clatsop, Hood River, Multnomah, Jackson, Josephine, Washington, and Umatilla.