



THE Probe

Quarterly Newsletter of the Oregon Public Health Association

Winter 2004

Oregon Food Bank network reports

Hunger stretches charity resources

by Terry Hammond

Survey results announced in October by the U.S. Department of Agriculture placed Oregon first in the nation for hunger (see related story, page 3). According to statistics from the Oregon Food Bank, also released in October, an estimated 780,000 people in the state ate meals from emergency food boxes at least once last year – up 10 percent from the year before. The growing number served dismays OFB Executive Director Rachel Bristol. The figure represents one of every five persons in Oregon, or 22% of the population.

“I still can’t believe that,” Bristol said. “We may be about to tip the scales in the recognition of need for a safety net, a living wage, education ... Frankly, it’s very scary.”

Charity resources across the state are stretched thin, government support is dwindling, and need appears to be increasing. The definition of charity as support for catastrophic events is being gradually molded into a private channel to address a “chronic emergency” for a large share of the population on an ongoing basis.

Located in Northeast Portland in an impressive new warehouse facility, OFB is the hub of a network of 18 independent food banks state-wide, serving 832 food distribution agencies in Oregon and Clark County, Wash. About 70 percent of the relief agencies are churches.

For over 10 years, OFB has received a state grant of \$750,000 per biennium, mostly devoted to food acquisition and transportation. About \$200,000 is given to the regional food banks, primarily for informational services. A food bank is

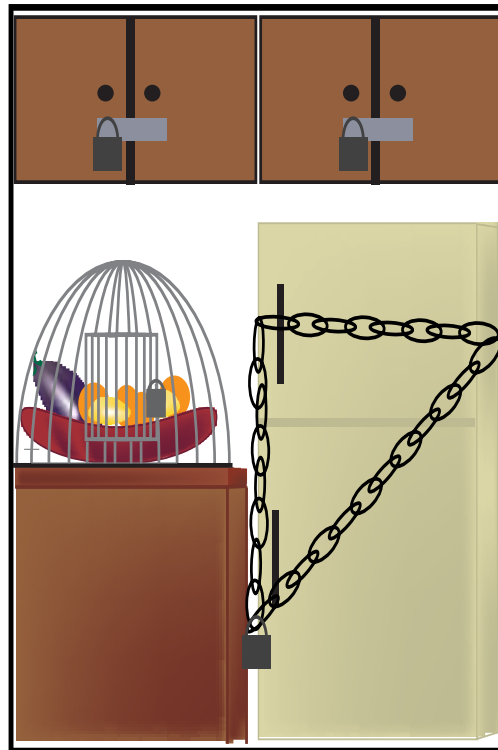
likely to be a person's first point of entry into the state system of social assistance. Counties provide various levels of additional support. Passing through federal emergency management funds is a popular option.

The federal share of revenues has steadily declined since the late 1980s. Direct donations of USDA food fell from 22 percent in fiscal year 2002, to 14 percent in 2003, putting an increasing responsibility on private sources. OFB sponsors over one thousand food drives from October through December, making a monumental,

"crazy-making" schedule. Food drives are the most expensive way to acquire food, according to Bristol, but they help get the word out; and a food drive is often a volunteer's first action to help solve hunger in Oregon.

Once the holiday season of giving is over – Remember! Bristol warned – the

(continued on page 3)



"Food Security" by Eva Rippeteau

INSIDE: WOMEN'S CRISIS LINE,
NEW TAXES WITH MEASURE 30,
NEW OPHA REGIONS,
EMERGENCE OF SARS, & MORE ...

OPHA Mission

- *Protect and promote the health of all Oregon residents*
- *Educate and support public health workers*
- *Advocate for just and equitable health policies*

Uniformed corps supports Oregon health

by Lesley Rush

With health and safety risks such as bioterrorism on the minds of the federal government, and the importance of homeland security following terrorist attacks and the heightened alert that comes with war, how is our government dealing with these threats? One way that the government is participating in nationwide public health concerns is by providing services from a uniformed, rapid response health force, the Public Health Service Commissioned Corps.

The U.S. government supports the Public Health Service Commissioned Corps, a team of health professionals with specializations in Indian health services, emergency medicine, environmental health, mental health, engineering – just to name a few – providing auxiliary public health services in local areas when needed. These officers strive “to provide highly-trained and mobile health professionals who carry our programs to promote the health of the Nation, understand and prevent disease and injury, assure safe and effective drugs and medical devices, deliver health service to federal beneficiaries and furnish health expertise in time of war or other national or international emergencies.”

The corps consists of 6,000 commissioned officers across the country. In April 2003, the corps added 30 positions to fill needs in the area of food safety and inspection. The service is divided into ten regions. Region 10 includes Oregon, Washington, Idaho, and Alaska, with the central headquarters in Seattle, under the leadership of Dr. Patrick O’Carroll. Under his leadership, officers live, work and hold regular jobs, but serve in readiness as trained resources when areas in the region need them.

The Commissioned Corps operates under the surgeon general. Assistant Surgeon General Rear Adm. John Babb coordinates the overall operation. He explained the purpose of the corps is to provide the nation with a mobile unit of health professionals for additional aid to the state public health systems.

U.S. Public Health Service Commissioned Corps

The Public Health Service, under the U.S. Department of Health and Human Services (HHS), is one of the seven uniformed services of the federal government, along with the Army, Navy, Marine Corps, Air Force, Coast Guard, and National Oceanic and Atmospheric Administration. The health officers below wear the corps uniform.



CAPT Janet Wildeboor, RN, MS
Regional Program Consultant for
Family Planning
HHS Region 10



CAPT David Kerschner
Branch Manager, Survey Quality
and Standards Branch, CMS
HHS Region 10

Oregon received help from the corps during the 2002 wildfires. Many state health professionals were involved in the protection and repair efforts following the fires, but Oregon had other pressing health needs at the same time. The Commissioned Corps came in and conducted much-needed inspections of 30 water systems within the state. Environmental health specialists from around the country joined them.

Babb explained that the corps has been deployable since 1994. In the last four years, officers have been deployed to provide services 75 times. The purpose of the federal corps is not to replace local health services, but to back-up the resources of the states. When states need assistance, within approximately 24 hours, additional service workers, in uniform, can be there to help. [See website at www.usphs.gov/]

Photos courtesy of Jenny Holladay, intergovernmental affairs specialist, HHS Region 10. Contact 206-615-2772 or jenny.holladay@hhs.gov – also, thanks to the Washington State Public Health Association for the photo of Bev Clarno, which appeared in its fall newsletter. Contact: 425-377-1477.

Bev Clarno still watches over Oregon from post in Seattle

HHS already announced it in August, but here is a second notice that Bev Clarno did not simply go home to Bend after the end of the 2003 legislative session, but moved to Seattle to accept an appointment as the new regional director for HHS, Region 10. The job began August 11.

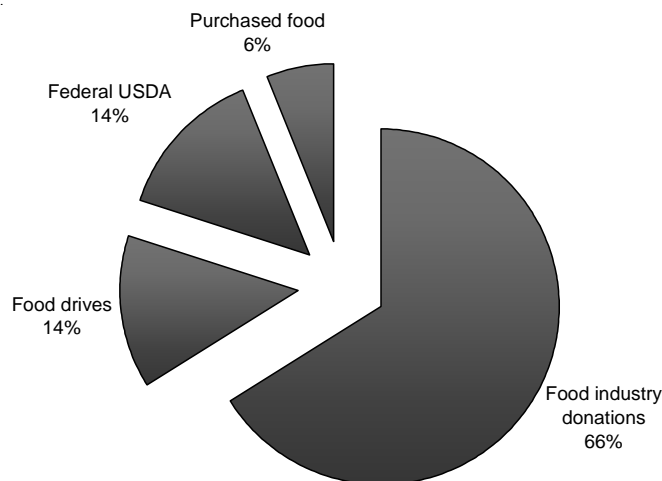
Clarno has a long career serving Oregon, elected to the state house of representatives in 1988, raised to speaker in 1995, and elected to the state senate in 2000.



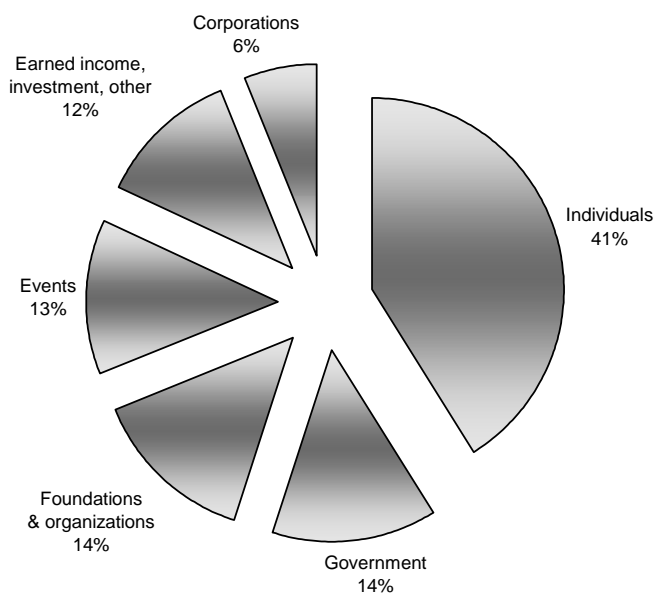
Republican Bev Clarno has distinguished herself in Oregon public service.

Oregon Food Bank, July 2002-June 2003

Sources of food



Sources of revenue



Food crisis represents a chronic emergency

(from page 1)

need is constant throughout the year. Presently, resources from private charities are stretched "paper thin."

Last year, OFB hired a lobbyist to bring its issues to Salem, involving housing, health care, a living wage, tax justice, and education. In all, income insecurity is Bristol's foremost concern, at the root of the persistent need for emergency relief.

"People should not have to beg for food," she said. She believes people should be allowed to make their own food choices, rather than rely on charity. In her view, if everyone would be guaranteed an adequate basic income for survival, the food-bank infrastructure statewide could then get back to concentrating on emergency relief rather than chronic care.

The principal reasons for Oregon's high hunger rate, as reported by the Oregon Center for Public Policy, are (a) the widening income gap, growing faster in Oregon through the 1990s than anywhere in the country (except Connecticut), and four times faster than the national average, (b) soaring housing costs, (c) employment skewed toward low-wage service jobs, and (d) seasonal employment in rural areas.

Along with her concern for income security, Bristol repeatedly mentioned education. Current studies are confirming that good nutrition makes a difference in educational achievement. Supporting universal school breakfast and lunch programs, she told a story of an initially skeptical local administrator who found the school food program made an amazing difference once it began. "It's a no brainer," Bristol concluded. "Feed your kids so your kids can learn."

With a fine kitchen at its Portland facility, OFB regularly hosts nutrition education classes, segmented into groups for small children, teen-agers, and adults. The classes are held in English, Spanish and Russian, according to demand. For more information about classes, or to help as a volunteer chef, contact Beth Gergick at 503-282-0555, ext. 258.

Food and Health: A review of major issues

by Kim Hoffman

Food security is a privilege most Americans enjoy. However, about 11 percent of the U.S. population lacks the availability of nutritionally adequate and safe food. The rate of food insecurity in Oregon is 13.7 percent, including about one of every seven people.

Concern over the large number of Oregonian's experiencing food insecurity and hunger was reinforced by the publication in October 2003 of the USDA's newest report on *Measuring Food Security in the United States* – with Oregon again scoring worst in the nation. Despite criticism over design, method, and margin of error in the surveys, successive reports reveal a

distressing trend that is difficult to brush aside.

The rate of hunger declined somewhat in recent years, but Oregon remains one of the hungriest states in the nation, and rates higher than the national average in both food insecurity and hunger by a statistically significant amount.

In the single year from 2001 to 2002, the prevalence of food insecurity rose from 10.7 percent to 11.1 percent, and the prevalence of food insecurity with hunger rose from 3.3 percent to 3.5 percent. Households with children reported food insecurity at more than double the rate for households without children (16.5 percent vs. 8 percent). Single-mother families

(continued on page 4)

Food insecurity and hunger in USA and Oregon, 1996-2002

Years	Food Insecurity			Hunger		
	USA	Oregon	Oregon rank	USA	Oregon	Oregon rank
1996-1998	9.7	12.6	7	3.5	5.8	1
1997-1999	9.2	12.3	3	3.1	5.7	1
1998-2000	10.8	14.2	3	3.3	6.2	1
1999-2001	10.7	13.7	4	3.3	5.8	1
2000-2002	10.8	13.7	7	3.3	5.0	2

Hunger threat common for children

(from page 3)

have been found to be particularly vulnerable.

TANF

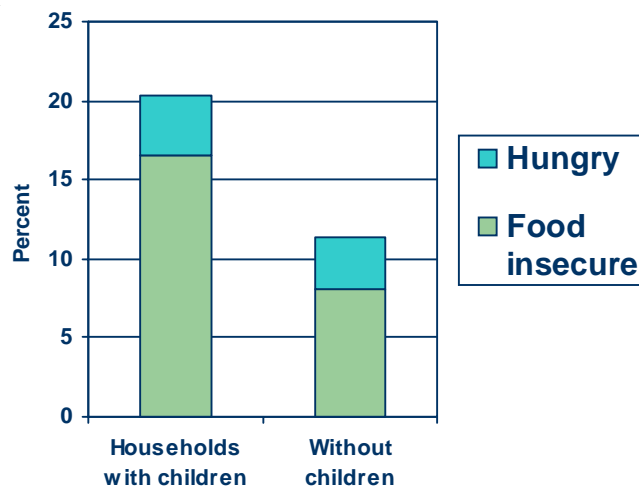
Temporary Assistance for Needy Families (TANF), commonly known as welfare, is the monthly cash assistance program for families with no- or low-income, and at least one child under age 18. Pregnant women also qualify.

As defined by the Department of Health and Human Services, TANF's goals are to provide assistance to needy families so that children can be cared for in their own homes; to reduce dependency by promoting job preparation, work and marriage; to prevent out-of-wedlock pregnancies; and to encourage the formation and maintenance of two-parent families. In 1996, Congress reformed welfare by creating TANF, through the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA). The act replaced the former Aid to Families with Dependent Children (AFDC), and Job Opportunities and Basic Skills Training (JOBS) program. As a result, federal funds are provided to states in the form of block grants, which total \$16.5 billion annually. The amount each state receives is based on federal welfare funding levels the state received in the mid-1990s. Under the prior welfare law,

states received federal funds as an entitlement, ensuring assistance for every eligible family. When changed to a block grant program, families in need were no longer guaranteed assistance. The enactment of PRWORA has heightened concerns about increasing food insecurity and hunger among poor women and children.

In June 2003, about two million families (nearly five million individuals) were receiving TANF cash benefits nationally. In Oregon, 18,943 families (43,237 individuals) were receiving TANF benefits. The average value of cash assistance annually in 2002 was \$2,990 per family. About one-fourth of adult TANF recipients were employed.

The racial composition of welfare families has changed over the past ten years. In 1990, 38 percent were white, 40 percent black, and 17 percent Hispanic. By 2000, 25 percent were Hispanic. The average age of adult TANF recipients is 31. About 90 percent are women.



Food Insecurity and Obesity

Inadequate food intake can directly compromise physical health. Growing evidence shows food insecurity is linked to poor health and physical limitations. An additional connection is now being recognized between food insecurity and obesity. With an obesity rate (defined as a body-mass index of 30 kg/m² or more) of about 21 percent among adults, Oregon ranks highest among all 13 Western states.

The notion of a relationship between food insecurity and obesity was first suggested in 1994 by William H. Dietz, in relation to children. Since then, a limited but growing body of evidence suggests that individuals experiencing food insecurity are more likely to be overweight or even morbidly obese (though many have questioned this claim due to its paradoxical nature). The connection between food insecurity and obesity was supported by national data from the 1988-94 National Health and Nutrition Examination Survey (NHANES III). Researchers were only able to speculate about the possible reasons for the relationship.

One factor that may contribute to the relationship between food insecurity and obesity is the physiologic changes that can occur to assist the body in conserving energy during dietary shortages. The result is greater efficiency at storing energy as fat, regardless of the adequacy of the diet. A related theory suggests that an uneven distribution of food availability induces overeating at times when food becomes available. This corresponds to the "food-stamp cycle," where households experience abundant supplies of food during the first three weeks of each month, followed by a period of "involuntary restriction" after (purposely inadequate) food-stamp funds have been depleted. Over time, the pattern of feast and famine can alter the body's metabolic rate.

Another theory suggests that low-income families feel compelled to supplement their diets with lower-cost, higher-calorie food. Households without money to buy enough food change their

(continued on page 5)

Measuring Food Insecurity

In 1994, a joint effort between researchers, the National Center for Health Statistics (NCHS), the USDA and the Census Bureau resulted in the development of the survey instrument currently used to assess the prevalence of hunger and food insecurity. Although food security data has been collected nationally since 1977, the USDA's Food Security Core Module (FSCM) is the first official household measure of food insecurity and hunger to capture respondents' anxiety about food insufficiency, the impact of budget or consumption decisions, and the presence of hunger.

Since 1995, the survey has been administered annually to over 50,000 citizens nationwide, including about 600 Oregonians, through the Current Population Survey by the U.S. Census Bureau.

The module's 18 questions have been carefully designed to avoid identifying anyone as food insecure who may be fasting or dieting to lose weight. Each household is classified into one of four food security status categories: (a) food secure, (b) food insecure without hunger, (c) food insecure with moderate hunger, and (d) food insecure with severe hunger. NCHS also developed an abbreviated 6-item scale. Both food-security scales have been criticized, as they are based on the perceptions of respondents, and are therefore considered less reliable than more objective measures of food sufficiency.

Key Concepts

Food insecurity occurs whenever the availability of nutritionally adequate and safe food, or the ability to acquire acceptable foods in socially acceptable ways, is limited or uncertain.

Hunger is defined as the uneasy or painful sensation caused by a recurrent or involuntary lack of food, and is a potential though not necessary consequence of food insecurity. Over time, hunger may result in malnutrition.

(from page 4)

purchasing and eating habits, cutting back on more expensive, nutrient-rich foods, before cutting back on the amount of food. In their effort to avoid hunger, families try to maximize caloric intake for each dollar spent, which can lead to overconsumption of calories and a less healthful diet. The stress of a low-income lifestyle may lend itself to neglecting a balanced diet and physical activity. According to the Center on Hunger and Poverty and Food Research and Action Center, poor diet combined with erratic eating patterns and stress, contributes to both malnutrition and obesity.

Mental Well-being

Worry over inadequate food supplies can also lead to emotional distress. Some research has shown that food-insecure respondents are over three times as likely to experience distress or a major depressive episode. Preoccupation with access to food, and lack of control over their situation and the need to hide it, may lead

individuals to feel powerlessness, guilty, ashamed, mistreated, and excluded from society.

A separate body of research concentrates on the effects of hunger in the classroom. There is growing evidence that hunger contributes to cognitive deficits. According to reports from the American Dietetic Association, "breakfast is essential" for optimal development and growth, attention and performance, though the finding is not supported by a 1993 interim evaluation of a universal-free school breakfast program, which failed to find a significant effect on selected student outcome measures. A more recent study of the universal-free school breakfast program, however, in *Annals of Nutrition & Metabolism* (46, Suppl 1:24-30; 2002), showed significant improvements in student academic performance and psychosocial functioning. Before the school breakfast program, the study classified one-third of the students from 97 inner-city schools at nutritional risk.



The Oregon Environmental Council announces upcoming forum events, jointly sponsored by Oregon Health and Science University. Continuing education credits are available for physicians, nurses, and naturopaths.

JANUARY 28 [PORTLAND] & 29 [EUGENE]

A New View on Toxic Chemicals: How They Impact Our Health

Recent science indicates even low-level exposure to toxins, particularly in the development of a fetus or small child, can cause subtle yet serious health impacts.

John Peterson Myers PhD will highlight cutting-edge science, conceptual shifts, and implications for clinical practice.

FEBRUARY 19 [PORTLAND]

Pollution Gets Personal: Tracking Toxic Chemicals in Our Bodies

Research institutions are beginning to "bio-monitor" people as a way to measure the "body burden" of synthetic chemicals.

Jane Houlihan MS will share recent findings.

MARCH 11 [PORTLAND]

Breast Cancer: Are Environmental Toxins a Major Factor?

Recent studies suggest that exposures to certain environmental chemicals are linked to breast cancer. **Devra Davis PhD MPH** will identify known and suspected environmental risk factors.

MARCH 23 [BEND]

Urban Sprawl: What's Health Got to Do With It?

Smarter built environments could help to reduce the severity and frequency of many chronic diseases. **Andrew L. Dannenberg MD MPH** will discuss ways the built environment shapes health.

For reservations (\$25/event, \$75/all) or more information, call (503) 222-1963 or check online at www.orcouncil.org Nonprofits and OEC members are eligible for a discount.

Afraid to go home?

Crisis line coordinates response to violence

Are you safe right now? This is the typical opening for calls answered at the Portland Women's Crisis Line, operating now for 30 years. The service started as a rape-relief hotline – the first of its kind in the state, and one of the first in the nation. Gradually, the view was expanded to also respond to domestic violence.

In the USA, about 1.5 million women are raped or physically assaulted by an intimate partner each year, according to a summary of evidence by Lynne Stevens in November 2003 ("Improving Screening of Women for Violence," available online at www.medscape.com/viewprogram/27777). Possibly, over 40 percent of women aged 18-64 have experienced one or more forms of violence, including childhood sexual abuse (18%), physical assault (19%), rape (20%) and intimate partner violence (35%). Further estimates suggest only one-third of the women have discussed the violence with a physician. Fewer than 10 percent of physicians routinely screen for domestic violence during regular office visits.

With a staff of 18, some part time, and many volunteers, the Women's Crisis Line takes about 2,000 calls per month, according to Executive Director Barbara Ballou. Operating statewide, the phone numbers – 503-235-5333 in Portland, or 1-888-235-5333 elsewhere in the state – are widely distributed. Many calls are forwarded from other agencies.

Located at a house with an undisclosed location, the crisis line operates two phones 24 hours a day, every day. The ATT language bank allows the crisis-line advocates to communicate in about 140 languages through teleinterpreters.

In situations of violence at home, staff have learned to probe for additional underlying problems with food, housing, and other family hardships. About one-third of the calls begin with issues of food and housing. The crisis line prescreens for eligibility, and makes referrals for counseling, shelters and other resources, including ethnic-based service agencies. Probing and talking awhile is important

for matching referrals to the true needs of the person calling.

By phone, callers are advised of available options in their area. Staff make the necessary emergency calls. Counselors can be brought on-line directly for a "warm hand-off." Taxi vouchers are available for transportation. In cases of sexual assault, additional direct service is available at any time of day through an on-call advocate, ready to meet the person at an emergency room or wherever is most

About one-third of the calls

begin with issues of food and housing

comfortable. The advocate provides personal attention and support, help with hospital or police forms, and information about gathering and preserving evidence.

"These people are traumatized," Ballou said, grimly. She worked six years on domestic violence with the Gresham Police Department. For the person involved, the immediate situation is made more bearable by a compassionate stranger willing to help.

One critical concern is to distance the woman from the offender. Whereas men are much more likely to die from violence (see graph), women are more likely to be victims of persistent abuse from an intimate partner where escape is difficult. According to Ballou, violence most often

begins with verbal domination; and it appears in signs like obsessive phone calls and restriction of activities. Finally, Ballou offered, imagine the situation when you are afraid to go home.

2-1-1 Information & Referral

The Women's Crisis Line cooperates with the Multnomah County Sexual Assault Response Team, a national initiative to coordinate services and best practices, promoted by the state Office of the Attorney General. In addition, a coalition coordinated by United Way of the Columbia Willamette is bringing the national initiative of a three-digit social-services hotline to Oregon.

In 2000, the Federal Communications Commission reserved 2-1-1 as an easy-to-remember comprehensive health and human service information and referral number. About half the states have organized call centers using the number. Oregon was scheduled to go live in February, but the date has been postponed to July. The maze of logistics are difficult to navigate. (More information available at www.or211.org).

Ballou expects the volume of calls at the crisis line to increase once 2-1-1 is in operation. She is working on establishing a rudimentary prescreening protocol for 2-1-1 operators.

Volunteers are always welcome at the Portland Women's Crisis Line. Training is provided. For more information, call the business number for the crisis line at (503) 232-9751.

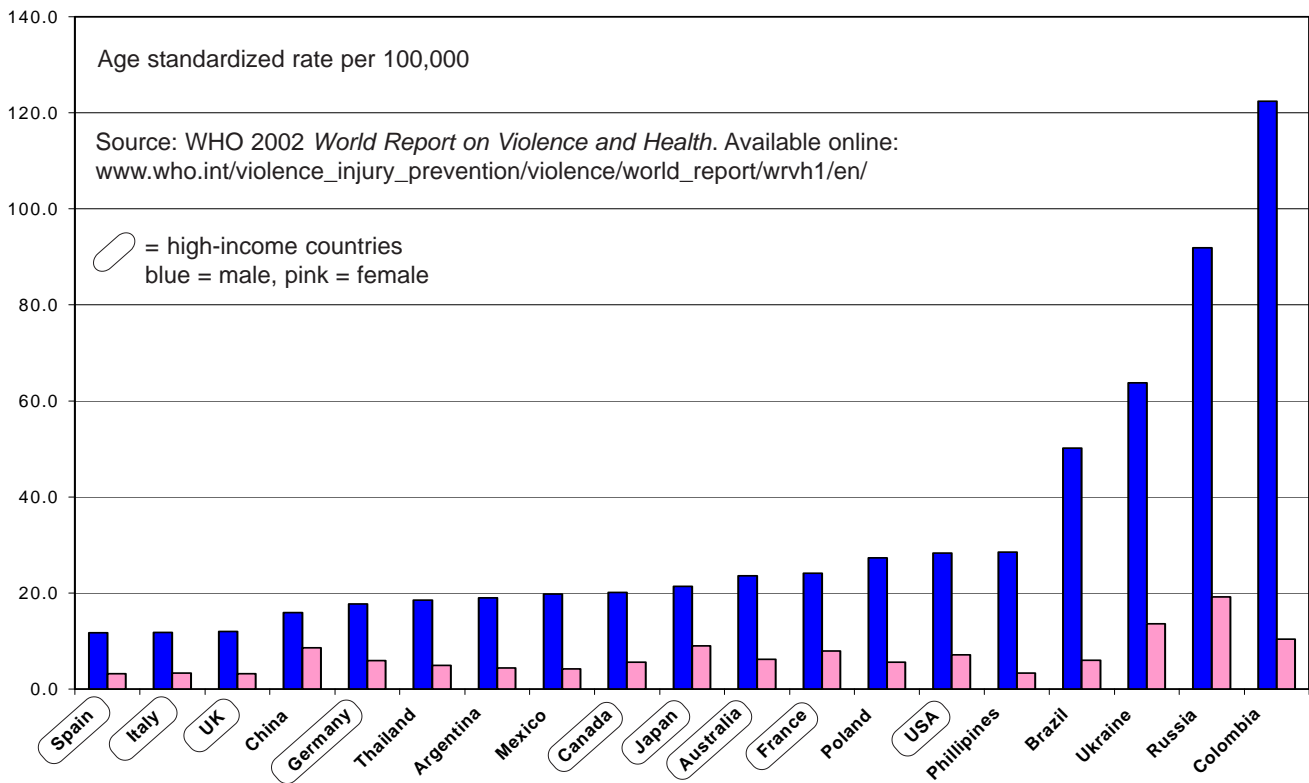
WHO data on world violence paints dark picture for USA

The World Health Organization's 2002 *World Report on Violence and Health*, responds to an international resolution declaring violence a major and growing public health problem around the world. The graphs on the opposite page illustrate the position of the USA in relation to other large nations. The USA stands in the range of other wealthy nations in terms of mortal violence, but within this cohort it ranks worst. For all nations, mortal violence is considerably

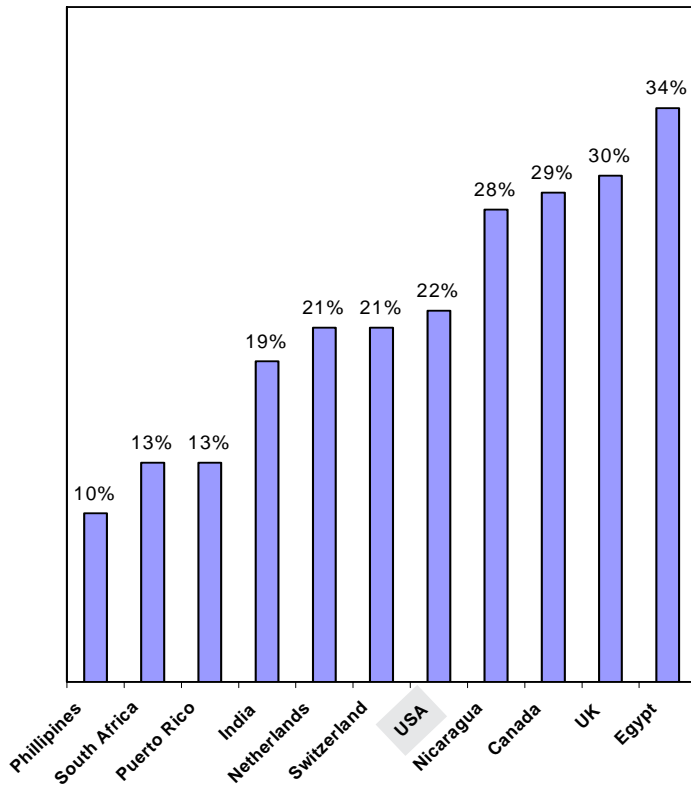
higher for men than women. Firearm-related mortality clearly accounts for a large portion of the problem. Changing this factor alone would move the USA closer to the bottom of the scale, next to the UK.

The comparison of "physical assault on women" offers data from independent and differently worded surveys that rely on self-report. The figures are probably understated, and not strictly comparable, but allow a general idea of prevalence.

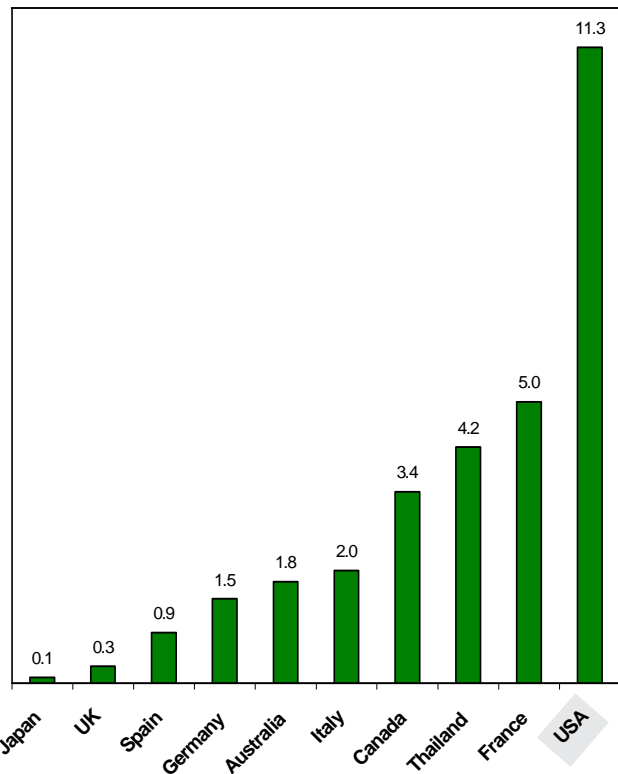
Mortality caused by intentional injury, world's largest countries (with data) all ages male and female, most recent year from 1990-2000



Physical assault on women by an intimate male partner, proportion ever assaulted, 1982-1999



Firearm-related mortality rate per 100,000



Further information on taxation available online

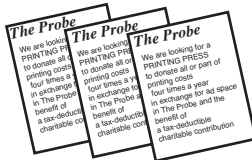
The Legislative Revenue Office published a 12-page description of tax provisions under Measure 30 in December 2003 (at www.leg.state.or.us/comm/lro/home.htm). Other helpful reports on a variety of topics related to taxation and public finance in Oregon are available online at the LRO website.

For a general view on citizen attitudes about taxation, a nice resource is the *National Survey of Americans' Views on Taxes*, published in April 2003 by National Public Radio/Kaiser Family Foundation/Kennedy School of Government (at www.kff.org). Most people appear to want government services rather than a cut in taxes (66%), but only about half want *more* services with accompanying taxes – a labyrinth of attitudes.

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Editor Terry Hammond at 503-282-1242 or at terryh@pdx.edu

OPHA endorses Measure 30 taxes

The Healthy Kids Learn Better Coalition is committed to adequate funding for schools and community-based groups to address physical, social and emotional barriers to learning.

Oregon's economic recovery depends on a stable education system and good schools. Measure 30 will provide stability to schools and support services.

The following members of the Healthy Kids Learn Better Coalition urge you to vote YES on Measure 30.

- CHILDREN FIRST FOR OREGON
- OREGON SCHOOL-BASED HEALTH CARE NETWORK
- OREGON SCHOOL NURSES ASSOCIATION
- COMMUNITY HEALTH PARTNERSHIP
- OREGON FOOD BANK
- OREGON NURSES ASSOCIATION
- OREGON PTA
- JULEEANNA ANDREONI, REGISTERED DIETICIAN/NUTRITIONIST
- MIKE PROGRAM - MULTICULTURAL INTEGRATED KIDNEY EDUCATION PROGRAM
- JACKIE ROSE, NURSE PRACTITIONER
- OREGON PUBLIC HEALTH ASSOCIATION
- OREGON ENVIRONMENTAL COUNCIL
- OREGON ALLIANCE FOR HEALTH, PHYSICAL EDUCATION, RECREATION AND DANCE
- OREGON SAFE SCHOOLS AND COMMUNITIES COALITION
- TOBACCO-FREE COALITION OF OREGON
- UPSTREAM PUBLIC HEALTH
- AMERICAN CANCER SOCIETY
- AMERICAN HEART ASSOCIATION
- AMERICAN LUNG ASSOCIATION OF OREGON

HEALTHY KIDS LEARN BETTER

Support Healthy Kids

Support Measure 30

Measure 30 gives voters tax opportunity

In an effort to overcome the state's crisis in public financing, a temporary tax measure will be presented to Oregon voters on Feb. 3, 2004. Calling it "A Small Price to Pay," the Oregon Center for Public Policy describes the components of Measure 30, and examines the proposed impact on taxpayers at various income levels. Excerpts from the report (available online at www.ocpp.org/2003/rpt031221_D.pdf) provide the following basic details.

In the closing days of the 2003 session, a "super-majority" of Oregon's Legislative Assembly agreed on a revenue package, House Bill 2152, to balance the state budget and avoid further cuts to education, public safety and human services programs. Opponents of the revenue package successfully petitioned to refer the measure to voters.

A temporary progressive income tax surcharge raises most of the additional revenue under Measure 30. Other Measure 30 provisions raise the minimum corporate income tax, reduce or eliminate some corporate tax breaks, extend an existing 10-cent cigarette tax, lower the depreciation for SUVs purchased for business use, and progressively phase out a special state medical deduction for seniors while also raising the deduction's age requirement. In addition, Measure 30 scales back the discount for early payment of local property taxes.

The income tax surcharge, in place from 2003 to 2005, is levied at rates from zero to nine percent of tax liability,

depending on the taxpayer's income. If tax collections rise higher than predicted, the surcharge will automatically be cancelled for 2005.⁴ Under the graduated rates of the income tax surcharge, household heads and married couples with incomes under \$20,000 pay nothing, while households with incomes of \$120,000 or more pay nine percent of their tax liability. Single individuals with incomes below \$10,000 would pay nothing.

The increased taxes under Measure 30 are small for most taxpayers. The net tax increase under Measure 30 for middle-income households will be \$81, or less than \$7 per month. The lowest income Oregonians will average just \$14 a year, or about \$1.17 a month, in increased taxes. The richest one-percent of Oregonians, with an average income of nearly \$710,000, will pay a net tax increase of \$4,084 under Measure 30. For all income levels, these increases are more than offset by recent federal tax cuts.

Tobacco tax sunsets if measure fails

by Dana Kaye

As public health professionals, it is clear that the defeat of Measure 30 will affect many of us and the populations we serve. What has not been well publicized is the fact that the renewal of part of Oregon's cigarette tax is tied up in the revenue package. This small portion of Measure 30 will affect many.

In 1993, Oregon increased the state cigarette tax by 10 cents, and allocated all of the revenue to the Oregon Health Plan. The tax included a sunset clause that requires the legislature to renew the tax every two years, which so far it has done. Currently, the tax provides approximately \$22 million per biennium to the Oregon Health Plan (OHP). If Measure 30 does not pass, the 10-cent cigarette tax will sunset at the end of 2003.

There are many reasons to retain the surtax. First, it is sound fiscal and health policy.

■ Each pack of cigarettes sold in Oregon costs the state an estimated \$7.58 in health care costs and lost productivity.

■ Over 40% of OHP participants use tobacco. OHP provides help to those who want to quit in order to decrease costs associated with tobacco-related illnesses.

■ Increasing cigarette prices is one of the most effective deterrents to youth smoking and one of the best methods to encourage adults to quit. Studies show that a 10% increase in price produces a decrease of 4% in overall demand for cigarettes.

Second, voters have repeatedly supported tobacco taxes.

■ Voters passed a 30-cent cigarette tax increase in 1996 by 56% to 44%, dedicating nearly all of the funds to health care and tobacco prevention.

■ In 2002, voters passed a 60-cent cigarette tax increase with 64% voting Yes, once again dedicating most of the revenue to low-income health care and tobacco prevention.

■ A May 2003 poll showed that voters continue to support increasing cigarette taxes that are dedicated to tobacco prevention and low-income health care, despite the fact that the tax was increased

Oregon Quit Line

The Oregon Quit Line provides high-quality services to those who want to quit using tobacco.

Numbers to call:

1-877-270-STOP (7867)

1-877-2NO FUME (Spanish)

1-877-777-6534 (TTY)

For information on additional services for OHP participants, contact Prevention Coordinator Judith Van Osdol at 503-945-6547 (judith.van-osdol@state.or.us).

only eight months prior to the poll. A 75-cent cigarette tax increase demonstrated large margins of support across party lines and throughout Oregon.

If Measure 30 is defeated Oregon will be the first state to decrease its cigarette tax in a decade, and legislative action would be needed to reinstate the surtax. From the perspective of the Oregon Public Health Association, and our fight to reach 100% access and 0 disparities in Oregon, this tax makes sense.

Federal bias in court endangers public welfare

Ed Rosenthal of Oakland, Calif., was arrested by federal drug enforcement agents two years ago for growing marijuana, sanctioned by license under the state of California's medical marijuana laws. Rosenthal was convicted in January 2003, by a jury kept wholly in the dark about the state laws supporting his activities. U.S. District Judge Charles Breyer restricted allowable evidence by the defense attorney, and controlled the case so tightly that he eventually barred the defense from questioning its own witnesses, and took over questioning himself. Demonstrators outside the courtroom were gagged.

Jurors revolted once they discovered the truth after the trial. Seven jurors held a press conference at the San Francisco Federal Courthouse, where they renounced their verdict, describing how they were manipulated and controlled, and presented Rosenthal with a letter of apology for the grief they had brought to him and his family.

This and other dramatic stories are reported in *The Marijuana Report* (Iss. 1, Vol. 1) currently circulating with a petition for a new ballot initiative to improve the 1998 Oregon Medical Marijuana Act (see www.VoterPower.org).

Medical marijuana is mostly a clinical issue for patients, but the drug war surrounding marijuana, especially a war like this in the courtroom, is a serious matter of public concern. Secrecy and false information are bad for our health (cf., *Secrecy* [1998], by Daniel Patrick Moynihan).

Oregon's congressional Reps. Earl Blumenauer and Peter DeFazio are sponsoring federal legislation to remove the conflict with Oregon's state law that allows the use of marijuana for medical purposes.

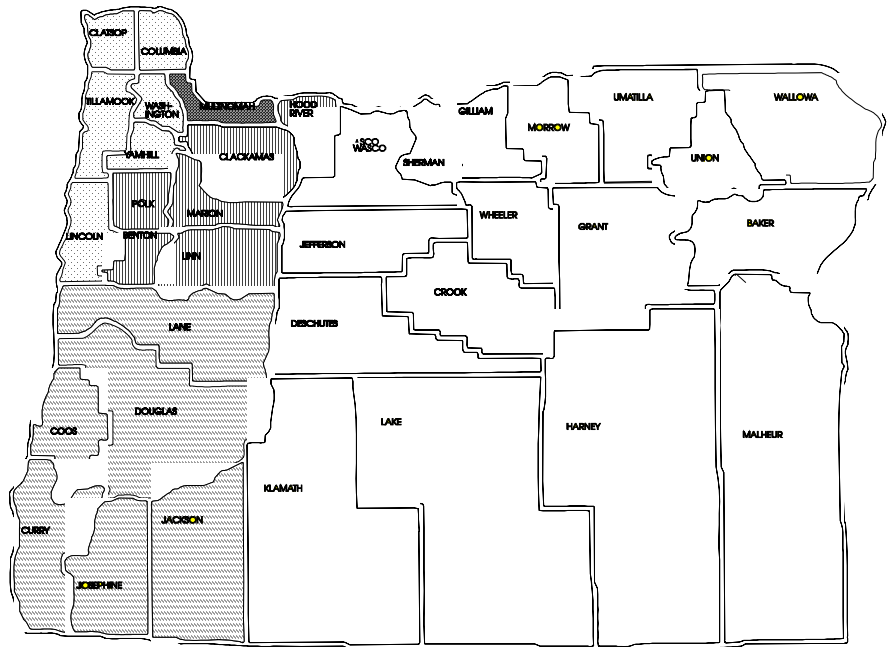
OPHA regions changed at annual meeting

At the 2003 OPHA annual meeting, members approved changes in the regional boundaries to redistribute membership. Region 1 membership will be reduced by about 30 members; and regions 3 and 5 will gain about 10 to 15 members each (based on September 2003 membership). Current board directors will serve out their respective terms. Future directors will be elected from persons who reside in each of the new region. See the map for more details.

One board member represents each of the regions. Each regional representative is elected by and from members who *reside* in that region, not by persons who

may *work* in the region. For example, a person who lives in Salem but works in Portland would vote for the Region 5 representative. This does not prohibit a member from identifying with or participating in activities in another region; it only defines who can vote for a particular regional director. Persons who live out of state vote only for the 10 director-at-large positions.

If you have any questions about the recent bylaw changes or suggestions for future amendments to the bylaws, contact Connie Guist, bylaws committee chair, at 503-988-3056, ext. 22972#; or at connie.l.guist@co.multnomah.or.us



New OPHA regional boundaries

Region 1: Multnomah County

Region 2 (Southwestern Oregon): Coos, Curry, Douglas, Jackson, Josephine and Lane counties.

Region 3 (Northwestern Oregon): Clatsop, Columbia, Lincoln, Tillamook, Washington and Yamhill counties.

Region 4 (Eastern Oregon): Baker, Crook, Deschutes, Gilliam, Grant, Harney, Jefferson, Klamath, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, Wasco and Wheeler counties.

Region 5 (Valley): Benton, Clackamas, Hood River, Linn, Marion and Polk counties.

Severe Acute Respiratory Syndrome (SARS)

Reviewing the emergence of an epidemic

by Maria Gilson Sistrom

As we sneeze and cough our way through this flu season, it's good to know that influenza surveillance works. Those of us who work with flu, already know this; but do we know that Severe Acute Respiratory Syndrome was identified through a unique form of influenza surveillance? It was.

On ProMed Mail (www.promedmail.org), on Feb. 10, 2003, a physician asked the question: "Have you heard of an epidemic in Guangzhou? An acquaintance of mine [...] reports that the hospitals there have been closed and people are dying." Immediately after that, on Feb. 14, in the Weekly Epidemiologic Record (www.who.int.wer), the World Health Organization released China's official report of 305 cases of the acute respiratory syndrome that soon became known as Severe Acute Respiratory Syndrome, or SARS.

The first case of the atypical pneumonia that became known as SARS occurred on Nov. 16, 2002, three months before the official announcement. On Nov. 27, the Canadian Global Public Health Intelligence Network, a health-news surveillance service, picked up an unofficial report of respiratory illness in Guangdong Province, China, as well as a recommendation for isolation of patients with symptoms. From a little-known local Chinese newspaper came the first knowledge of this frightening new epidemic. Notice how long it took for us to put the pieces of the epidemic together and call it an outbreak. As Kierkegaard said, "Life can only be understood backwards; but it must be lived forwards." It takes a confluence of a lot of information over a good long time, not only to understand life, but to recognize an outbreak.

We all know the rest of the story. Cases of SARS had occurred for several months in Guangdong, but through the miracle of modern travel and the still unexplained idiosyncracies of what are called "super-spreaders," the disease leapt to Hong Kong in a one-gentleman epidemic. On Feb. 21, the gentleman coming from Guangdong stayed at the now-famous Hotel M in Kowloon, and became the index patient for 249 further cases. One went to Hanoi, became the first known international case on Feb. 26, and made the epidemiologic link back to Hong Kong and Guangdong. Meanwhile, healthcare workers caring for other Hotel M cases in Hong Kong were getting sick and spreading the disease as well. Rather quickly, the cases linked to Hotel M made it to Ireland, Germany, Bangkok, the USA, and of course, Toronto – making this a truly international epidemic – although always one of relatively small scale.

The first in a series of case definitions, global alerts and travel advisories was released on March 12, throwing tourist economies, airports, hospitals, and public health departments into respective dithers, the world over. By July 2003, there were no more cases of SARS to be found. Perhaps as is the case for influenza, the weather and not overly zealous quarantine measures has saved us. A total of 8,995 cases of SARS occurred,

most of them in Asia. In the USA, 204 cases were suspected, only 8 with laboratory confirmation of SARS-Corona virus. The case-fatality rate averaged 9 percent, but for those afflicted over age 65, the case-fatality rate was 50 percent.

Although a few mysteries remain, SARS appears to be transmitted via close contact with respiratory droplets, has an incubation period of 3-10 days, and is not amenable to much in the way of treatment. Finally, in December 2003, we have come full circle into the modern age of emerging infections. There are now cases associated with our high-tech healthcare system – a laboratory-acquired case of SARS in Singapore (see WHO, ProMed or CNN). Stay tuned for further developments. Possibly via unknown local newspapers.

Maria Gilson Sistrom RN MSN, is an assistant professor at the OHSU School of Nursing (sistromm@ohsu.edu), and was formerly bioterrorism project manager at Oregon Health Services.

Be Prepared!

Reinforce public health in Oregon

The Oregon Public Health Association is chiefly supported by volunteers, and tax-deductible charitable contributions from individuals. Your efforts mean everything. Please consider joining us in 2004.

- **Facilitate continuing education and support for all our members in active sections of public health.**
- **Organize community forums on current public health issues.**
- **Advocate for just and equitable health policies.**

For more information
call OPHA President
Yolanda Russell
503.784.6711

Or contact us at
OPHA
818 SW 3rd Ave #1201
Portland OR 97204



NEWS BITES

Events focus on human rights

Planned Parenthood of the Columbia Willamette announces the following special events in January.

Bringing Human Rights Home

Nationally known speaker and activist **Loretta Ross** will discuss human rights, focusing on civil and political rights, as well as economic, social and cultural rights.

Jan. 15, 6-8 p.m.

Northstar Ballroom

635 N. Killingsworth Blvd., Portland

Jan. 16, Noon-1:30 p.m.

Portland State University

Multicultural Center

228 Smith Memorial Center

\$5-10 suggested donation.

For more info: 503-775-4931 ext. 234

Roe v Wade Anniversary Luncheon

Featured speaker **Arianna Huffington** is a nationally syndicated columnist, political commentator and author of nine books, named one of Washington, D.C.'s most influential commentators by both *Newsweek* and *People*.

Jan. 21, Noon

Portland Hilton

RSVP to 503-788-7277

Roe v Wade 31st Anniversary

Casual events sponsored with Pro-Choice Coalition of Oregon in Portland (contact Carmen at 503-775-4931 ext. 278) and

Bend (contact Barbara at 541-317-9388). The Portland event includes updates on the state of choice in Oregon by state Sen. Kate Brown and Rep. Mary Nolan, plus performances by poet Marie Fleishman and the band.

Jan. 22

Portland, 6:30 p.m.

Bridgeport Brew Pub

1313 NW Marshall

Bend, time TBA

PPCW Central Oregon Health Center

2330 NE Division, Ste 7

Public health website launched

On Oct. 16, 2003, Medscape and the American Public Health Association launched a website devoted to public

health and prevention, offering global access to the latest research findings (at www.medscape.com/publichealthhome).

Site targets consumer safety

At a new website, six federal agencies concentrate information about product recalls, involving toys, drugs, food, cosmetics, pesticides, cars and boats (at www.recalls.gov).

Government grants get site

A new website for government grants allows one-stop shopping for more than 800 available grant programs involving all 26 federal grant-making agencies, offering grants worth more than \$360 billion (at www.grants.gov).

Meet for social epidemiology

Beginning in November, an informal forum was initiated for the Portland-area public health community to discuss issues in social epidemiology. Participants are encouraged to discuss current work, brainstorm, and share ideas. For more information, please contact Rachel Gold (rachel.gold@kpchr.org) or Yvonne Michael (michaely@ohsu.edu).

THE
Probe


TERRY HAMMOND Editor
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KATE KARLSON Webmaster

The articles published in The Probe are to provide information. The views expressed in this newsletter do not necessarily represent the views of OPHA members or its board of directors.

Give us your news!
The next issue of The Probe appears April 1. We invite you to send stories, news and graphics to TERRY (terryh@pdx.edu) or to OPHA, 818 SW 3rd Ave, #1201, Ptd 97204

It's not heavy, it's my bear . . . And it barely costs anything!

JOIN the Oregon Public Health Association and get in the stream of people and knowledge helping to keep Oregon healthy



<input type="checkbox"/> \$20/year Special membership: students, unemployed, low income	<input type="checkbox"/> \$50/year Active membership: individuals	<input type="checkbox"/> \$100/year Contributing membership: nonprofit and community organizations	<input type="checkbox"/> \$250/year Sustaining membership: businesses
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