Public Health Strategy and the Police Powers of the State

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The preparedness of the U.S. public health system to respond to acts of terrorism has received a great deal of attention since September 11, 2001, and especially subsequent to the anthrax attacks later that year. The use of biologic agents as a weapon has served as a catalyst to better aligning public safety and health strategies through public health law reforms. Associated with this work is the renewal of the debate over the most appropriate means to both protect the public and asssure the rights of individuals when implementing readiness strategies. A key element of the debate focuses on what is a reasonable application of state-based police powers to ensure community public health standards.

The doctrine of state "police power" was adopted in early colonial America from firmly established English common law principles mandating the limitation of private rights when needed for the preservation of the common good. It was one of the powers reserved by the states with the adoption of the federal Constitution and was limited only by the Constitution's Supremacy Clause—which mandates preeminence of federal law in matters delegated to the federal government—and the individual rights protected in the subsequent Amendments.[1,2] The application of police power has traditionally implied a capacity to (*1*) promote the public health, morals, or safety, and the general well-being of the community; (*2*) enact and enforce laws for the promotion of the general welfare; (*3*) regulate private rights in the public interest; and (*4*) extend measures to all great public needs.[3]

The application of "police powers" is not synonymous with criminal enforcement procedures; rather, this authority establishes the means by which communities may enforce civil self-protection rules. More specifically, public health police power allows the states to pass and enforce isolation and quarantine, health, and inspection laws to interrupt or prevent the spread of disease. Historically, the exercise of public health police power was enforced with strong support of the courts and restraint of police power occurred only when there was open disregard for individual rights.

The abilities of states to exercise their police powers has been constrained since the 1960s by the legal and social reexamination of the balance of power between the individual, the states, and the federal government, which affects contemporary efforts to reform public health law in the face of terrorism.

Given the development of the criminally based threats to health marked by bioterrorism, the relatively recent emphasis on the personal rights side of the equation should be reassessed.[4] A reexamination of the legal, ideological, and social limits of police power is appropriate since increased state capacity can be crucial for first responses to terrorist threats or actions. Effective first responses may be hampered in the

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absence of pragmatically designed realignments of the state-individual relationship and the redesign of state public health infrastructures.[5]

This article begins with an historical overview of the doctrine of state police power, addresses recent limitations imposed on the implementation of public health police powers, then uses the example of the imposition of quarantine orders to illustrate the state's capability to impose such orders in exercise of its police power. Finally, it suggests changes in state public health agency governance, focus, and regulation to rebalance public and private interests.

HISTORICAL BACKGROUND

Police powers of the states are an expression of civil authority**,** i.e., the state's ability to control, regulate, or prohibit non-criminal behavior.[6] Health officials may use these powers to compel treatment, prohibit or direct a particular conduct, or detain and isolate in a quasi-criminal nature.[7] The courts have consequently held that states must demonstrate that public health actions are intended to further public health objectives in order to avoid criminal law constitutional limitations.[8]

State police power was validated for the first time a few years after the end of the Revolutionary War, when Philadelphia was isolated to control the threat of yellow fever.[9] By the time the federal Constitution was drafted, quarantine was already a well established form of public health regulation, and was considered proper exercise of the police power of the states; the Supreme Court, in its affirmation of this power, noted that the state had the power to quarantine "to provide for the health of the citizens."[10,11] The uncontrollable nature of epidemic diseases moved the Supreme Court to uphold such extreme measures on the basis of the defense of the common good.[8] The communitarian philosophy underlying this approach was carried into later judicial holdings, further consolidating states' exercise of public health police power.

Subsequent doctrinal elaborations during the 19th and early 20th centuries consistently sustained the states' powers to respond to public health threats. Remedies included regulation of private property and behavior and the power to detain and hold individuals without pre-intervention review.[12,13] The enforcement of state powers—including police power—was proper unless an express constitutional right was prejudiced in violation of republican principles of government.[14] Generally, the courts reviewed police power measures only when the degree of restriction of personal liberty was found to be unconscionable.

The legal principles employed to sustain state public health police power were *sic utere tuo ut alterum non laedas* (use that which is yours so as not to injure others) and *salus publica suprema lex est* (public well-being is the supreme law).[12] The principle of *sic utere* describes the power of the state to prevent or prohibit "the use of private property or the commission of private acts in a manner harmful to others."[15] The principle of *salus publica*, on the other hand, recognizes police power as a means to "prevent or avoid public harm even if the action has not harmed others."[15] While the *salus publica* doctrine implied a more extensive exercise of police powers, state actions allowable under its aegis were, generally speaking, under the discretion of the state legislature,[16] and limited only by infractions to an express constitutional right or by actions opposite to the principles of representative government.[15]

The principles of *sic utere* and *salus publica* remained virtually unchanged by subsequent legal developments. This includes the pro-business interpretations of the Fourteenth Amendment that rapidly evolved into a barrier against regulation of private concerns.[17] The courts and legislatures continued to uphold public health activities necessary for the defense of the common good despite their disinclination to regulate private businesses and property.[18]

The treatment of quarantine reflects the latter. Courts and academics rarely expressed doubt about the validity of quarantine regulations, since the courts presumed that actions taken under the police power were constitutional.[10,11] Challenges to the Fourteenth Amendment, usually successful when governmental intervention interfered with individual liberties, were not well received by the courts when communicable disease regulations, including quarantine, were involved.[19] This viewpoint was validated in the seminal case of *Jacobson v. Massachusetts,*[20] wherein the Supreme Court upheld the validity of quarantine through a deferential standard of review that confirmed the universally held presumption of quarantine statutes' constitutionality.[10,11]

Historically, the communitarian bases of the American legal system supported the subordination of individual rights when necessary for the preservation of common good. Quarantine measures were subjected to a deferential review supporting the states' right to substantially limit individual rights for the community's benefit. Viewed through this lens, vigorous judicial support for certain public health activities may generally be considered an essential element of effective public health practice.

Limits to police power

The doctrines regarding police power enforcement were firmly established at the beginning of the 20th century with near unanimity regarding its reach when rapid actions were necessary to preserve health, even if those actions infringed on individual freedoms. The latter part of the 20th century, however, brought legal, social, and ideological transformations that substantially limited such powers. The main forces that restricted public health police powers were: (*1*) the advent of civil rights jurisprudence; (*2*) the rise of patient autonomy and the rapid expansion of state personal health services expenditures; and (*3*) federal encroachment on state authority.

However, the reemergence of infectious diseases as well as the use of biologic agents for terrorist purposes challenges these more recent developments. The traditional posture of the courts was significantly altered by pro-individualistic jurisprudence and legislation with the consequence that adverse effects on responses to bioterrorism or emerging diseases could be contemplated. Understanding the new dynamics in public health caused by terrorism is essential because of the potential negative impacts on the states' capacity to respond effectively to public health threats.

Civil rights jurisprudence

The Supreme Court changed markedly during the two decades beginning in the late 1950s. This was a time when the ideology of individual rights and freedom became salient. In response to the social pressures brought about by the Vietnam War, the fight for African-American rights, and the rise of feminism, the Warren Court (1953–1969) revitalized and strengthened its position on issues of equality and civil liberties.[21, 22] Warren Court emphasis on individual rights remade the basic tenets of police power.[23,24] The Warren Court substituted the traditional deferential treatment of public health activities with a heightened standard of review, which demands that the least restrictive limitation to constitutional rights be used to further compelling state interests**,** and closely scrutinized the exercise of police power for constitutional infractions.[25] The declaration of new constitutional rights unmentioned in the text of the Constitution also affected the exercise of police power.[26] The Court curtailed police power by establishing that: (*1*) the exercise of police power could be limited by express or implied rights; (*2*) the rule of reason supporting public health actions would be replaced by strict analysis; and (*3*) the states should show a compelling interest to allow exercise of police power limiting an individual right.[26]

Approaches to orders of quarantine are emblematic of the changes ushered in by the Warren Court. The treatment of quarantine moved from a presumption of constitutional validity to strict scrutiny for constitutionality. Under traditional police power doctrine, the remedy against quarantine was limited to a subsequent petition for habeas corpus that did not allow the detained individual to break quarantine until the petition was decided.[27] Quarantine is now reviewed under heightened procedural protections under the Fifth and Fourteenth amendments.[10,11] Warren Court focus on civil rights moved attention from the community interest in the exercise of police power to the deprivation of individual liberties; this, in turn, led to the extension of the rights to pre-hearing notice, to legal counsel, to confront and cross-examine witnesses, to be committed only by clear and convincing evidence, and to preserve a record on appeal, to any citizen subject to an order of quarantine.[19]

The Warren Court decisions also affected public health activities such as testing, contact testing, and closing places identified as foci of contagion.[26] Public authorities moved to limit the collection of data to test, trace, and detain the spread of infectious diseases in response to the Court's newly declared privacy right.[28]

The response to the AIDS epidemic illustrates the Warren Court's civil rights tilt in the areas of surveillance and tracing. Data gathering and the reporting of information on HIV-infected individuals has been affected by legal restrictions imposed through state legislation. The questions that emerged on informed consent for HIV testing, named HIV reporting, confidentiality vs. the duty to warn, and effective surveillance have generally been decided by courts and legislatures through the creation of burdensome mechanisms elevating HIV/AIDS to an "exceptional" status, which has made effective control of the disease increasingly complicated.[29] This tendency toward the limitation of surveillance has affected other areas of public health activity; the National Vaccine Advisory Committee recommendation for a national vaccination surveillance registry allows parents to opt out, thus weakening the usefulness of the registry as a tracking and detection tool.[30]

The Warren Court has also imposed pre-intervention review of administrative acts in non-criminal cases, that is, the ability to question an administrative order before it is executed**,** thus equating certain public health measures with criminal law enforcement from a due process perspective.[31] This is a departure from the traditionally limited intervention in non-criminal cases under police power, which allowed only for post-intervention review while detention was maintained in order to preserve the effectiveness of the intervention.[27]

The Warren Court decisions have continued to affect the exercise of police power despite the apparent reassertion of such power at the state level.[32–34] The dynamic imbalance between individual and public rights continues to impact state health department management, as demonstrated by restrictive legislation inspired by the Court's judicial holdings that impede effective surveillance and tracking, and by restrictive court decisions inhibiting effective preventive detention and quarantine.[35] The proposed remaking of police power in the post-9/11 world should facilitate states' capability to act in the public interest. This requires a difficult rebalancing of public and private rights based on the historical boundaries of police power.

CURRENT FOCI OF ATTENTION

Profound changes in societal perceptions of the relative weight of individual rights vis-à-vis state powers, as well as shifts in the economics of personal health care services, have combined to further limit the traditional scope of police powers. A renewed ability to exercise police power will heavily depend on a recasting of these factors.

Patient rights

The historic public health response to epidemics was compulsory population-based measures. Mandatory inoculation, quarantine, and other restrictions were broadly ordered and enforced since prevention and containment were the most employed means of disease control. Obligatory inoculation against smallpox during the 18th century and forced isolation of tubercular patients during the 19th century are examples of this approach. These measures did not consider individual responses and were imposed on entire communities.

The general acquiescence to compulsory public health measures started to decline, in large measure, as a consequence of the improvements in health care outcomes. The advent of effective curative medicine gradually promoted an individualized perspective of health care wherein patients exercised a growing authority in deciding whether treatments were necessary or desirable. This culminated in the concept of patient autonomy, i.e., the individual's ability to make key decisions regarding their health care after careful education and guidance from health care providers.[36] Under this new view, public health has no special status; autonomy is given a special force, which could be seen as the

outgrowth of judicial and social perceptions that medical issues were more personal than public.[37]

The 1960s witnessed the ascendancy of personal rights in society, which in turn changed the perception of health and access to health services, including new principles of patient autonomy. Reinforcing this shift was a coinciding growth in personal health care services funding, marked most dramatically by the establishment of Medicaid and Medicare.

However, the primacy of patient autonomy raises concerns for public health. A clash between public and private interests becomes increasingly unavoidable when the ethos of patient autonomy is transferred wholesale to the sphere of public health. The process that permits individual health care decision-making cannot be replicated when dealing with community concerns. To be effective, public health activities might in some instances have to be implemented without regard for individual preferences. The increasing opposition to infant inoculation provides a good example of the effects of imposing patient autonomy rights on the public health sphere. Some parents oppose mandatory inoculation based upon their consumer right not to choose preventive treatment for their children.[38] Other parents have refused to inoculate children based on the unsubstantiated fear of adverse effects.[39] The resurgence of controllable childhood diseases may be a consequence of refusals to vaccinate, but these decisions are allowed to stand despite legal precedents validating compulsory vaccination.[20,40–42] Individual objections are routinely upheld, and even enshrined in state legislation, completely ignoring the serious effects of non-inoculation on the objector group and cross-infection of the inoculated population.[43]

The transfer of the patient autonomy ethos into public health activities creates a situation for explosive threats to community health. Courts and legislatures routinely support the priority of personal preferences over public health needs based on the principle of patient autonomy in court decisions and public health legislation. Such results are less justifiable in the face of intentional health threats or the emergence of new infectious diseases. The recent experience with SARS shows that even a small break in the chain of control may signify the difference between a contained outbreak and a deadly epidemic.[44] Established epidemiological facts argue in favor of the primacy of public health measures over individual preferences when such major threats loom.

State-funded personal health services

The direct provision of personal health care services by the states has also affected the public health mission. This is in part a result of the different and sometimes incompatible goals of public health and personal health care. The personal health care paradigm demands the dedication of resources to meet each individual's health requirements. The prioritization of this goal can detract from the broader vision and focus of public health.[45]

The transformation of many public health departments into personal health care agencies was propelled by the enactment of Medicaid in 1965. Pressures for increased funding of personal health care sometimes displaced some population-based programs of public health departments with larger and better-funded programs; demands for personal health care expansion affected states' abilities to develop innovative public health programs since resources were channeled into those services at an increasing rate.[46] The increase in the cost of personal health care and demographic changes in the age and infirmity of Medicaid beneficiaries have further impacted public health initiatives. Tensions between public health and personal health care services have been characterized as a key factor underlying the shortcomings of the American public health system.[27]

State governments are often reluctant to favor public health measures that detract from expansions of personal health services programs because of political repercussions.[27] This may short-change population-based measures. The recent anthrax scares show that state governments are not well prepared to confront large-scale biological attacks.[47] Adequate preparations for such contingencies demand resources that may have to be diverted from state-funded personal health care to programs designed to prevent or contain public health threats. It is also clear that additional federal funds will have to be appropriated to correct these imbalances.

Transfer of federal funds under the Public Health Security and Bioterrorism Preparedness and Response Act of 2002,[48] as well as the ongoing CDC cooperative agreements, is underway. Such funds are intended for additional staff, as well as training and other resources. Federal transfers alone, however, cannot remedy the problem. State budgetary constraints have led to cuts in public health programs with the expectation that federal bioterrorism prevention funds will supplant state funds. Federal funding may, paradoxically, weaken some of the states' public health infrastructures while preparedness is left unimproved.[49] The effort toward preparedness requires a back-to-basics stepping away from an unduly restrictive personal health care focus in state health departments. It necessitates refocusing and re-empowering these departments to execute well designed, efficient, and effective public health response systems in the public interest.

Federal implications

The Constitution ostensibly limits the powers of the federal government to the enumerated powers.[50] One of these powers, the Commerce Clause, allows federal regulation over interstate and international commerce. However, distinct constitutional constructions of the Commerce Clause have resulted in expanded federal powers to regulate public health matters. The expansion of federal power over those matters began with a novel doctrine under the New Deal Supreme Court (1933–1945), which held that Congress had the authority to regulate any economic activity, including intrastate economic activity.[51–53] This interpretation of the Commerce Clause allowed Congress to regulate labor, agriculture, and manufacturing.[52] Direct federal regulation of other spheres, including education, health care, and police and security, soon followed.

Federal activity in public health grew rapidly during the 20th century. The 1960s and 1970s saw a dramatic expansion of the federal role in public health as Medicare and Medicaid were enacted along with the National Environmental Policy Act and the Occupational Health and Safety Act, water and air quality standards, food and drug safety statutes, and tobacco advertising regulation.[54–57] The federal

government now possessed the authority to directly engage in public health matters formerly reserved to the states. Activities of state and local public health authorities were increasingly influenced or overtaken by federal programs, grants, initiatives, or laws, with a notable shift in the balance from local to national public health priorities under a new "national police power."[58]

The federal government's capability to directly regulate public health is great. The federal government surveys the population's health status and health needs, sets policies and standards, passes laws and regulations, supports biomedical and health services research, helps finance and delivers personal health care services, provides technical assistance and resources to state and local health systems, and supports international initiatives aimed at improving global health. Clearly, the greater resources and enforcement capability of the federal government have, in large measure, preempted the states' ability to regulate internal police power matters. State public health activities must count on the federal government's expanded operational and financial support to be effective. This expansion, however, has shifted the balance of public health measures in favor of national constituencies not necessarily representative of, or responsive to, state or local needs. The direction of federal financial assistance in response to such constituencies could further impede the local approach of state agencies and may skew programmatic focus in reaction to federal pressures.

Quarantine is uniquely impacted by the imperfect federal-state balance of power over public health. Suspected cases of communicable diseases arriving from outside the United States and the spread of communicable diseases between states are controlled by federal legislation.[59] Interjurisdictional clashes, conflicting legal standards, and clashing control over quarantine orders may result. The consequences of such situations may be prevented through legal reform devolving immediate control of first response to the states while implementing augmented coordination between federal and state authorities.

THE REDESIGN OF POLICE POWER

First response to a public health emergency will invariably be local.[60] The erosion of state authority has diluted the states' capacity to create and implement innovative local solutions. The federal government will be unable to handle a massive public health emergency on its own.[61] Coordination of an adequate response from centralized federal agencies is problematic and limited. Reconstruction of the public health infrastructure should be undertaken with a critical review of the primary public health role of the states. Yet the redesign of the states' public health capabilities is largely unlikely without a redefinition of the legal, social, and ideological limitations existing on public health police power. Likewise, a greater understanding and acceptance by the general public of the communitarian goals of public health is needed; without this, the individualist ethos now prevalent may negate any effective response.

The proposed redesign of public health police powers should impact three key areas to achieve the goal of strong and effective public health activities: (*1*) the primary role of state public health activities; (*2*) the proper balance of public and private rights and; (*3*) the separation of civil authority from law enforcement.

Re-establish the primary role of the state in public health activities

States must be clearly viewed as the leadership venue for public health responses. Recapturing and restoring abilities to provide for prompt local solutions while coordinating with the federal government is the key to adequate public health responses to terrorism or new pathogens. This may be accomplished by the devolution of financial, legal, and operational control of first response to the states.[62] Appropriate state legal ability to act will also be crucial to achieve these goals.[63]

Funding for states' public health initiatives should increase substantially to remedy the chronic financial shortcomings of population-based programs. Recruitment, training, and retention of capable state public health technicians and experts need proper financial and technical support from the federal government. Efforts should be shifted away from the disproportionate attention to personal health care services. The final result should be increased capability to prevent and respond through improved human resources, equipment, communications, and data-basing. Securing the funds necessary to guarantee these measures is essential.[64]

Rebalance public vs. private rights

Population-based measures in response to increased public health threats assume diverse forms. These are essentially clustered in two distinct groups: prevention (detection, data-basing, and tracking), and remediation (containment of actual damage).

Preventive measures entail mechanisms to control and track the movement of persons and things. This type of activity may involve the enactment and enforcement of unsympathetic laws and regulations affecting real or perceived spheres of rights. Effective enforcement will depend on the public health authorities' ability to safely overcome resistance to these measures. The control of the flow of information may also result in restrictions to the access and publication of public health information.

Remediation demands even greater degrees of control over persons and property. Remediation measures could include: (*1*) quarantine and involuntary holds when and where necessary for an indefinite period limited only by the cessation of the state of emergency; (*2*) suspension of habeas corpus in case of quarantine with very limited post-detention remedies for the individuals affected; and (*3*) property rights (establishment of "public interest easements" on private property in anticipation of an emergency and deputization/commandeering private-sector resources for public use during an emergency). Remediation measures must be rapidly implemented in the event of biological attack or new infectious disease.[65]

Significant normative measures in this respect have been proposed at both the federal and state levels.[66] The Model State Emergency Health Powers Act (MSEHPA) illustrates this effort. The MSEHPA contains projected measures based on potential terrorist threats and proposed preventive and

remedial measures as well as a detailed description of the protection of individual and business rights during an emergency.[67] The State Emergency Powers Act's purpose is to create a unified response system whereby the states put into effect standardized measures.[68] The driving principle behind this uniform legislation is twofold: on the one hand, standardization and modernization of obsolete or inapplicable state laws regulating public health responses, and on the other, creation of balance between states' ability to control individual activity and constitutional rights.[4] The goals of the MSEHPA are, inarguably, meritorious.[69] Nevertheless, there are valid concerns regarding the effects of the attempted balance of public and private interests on the states' ability to carry out an effective public health response.

There is foundation for these concerns. The MSEHPA's balancing act may sidestep the needed mechanics of infectious disease control by unduly incorporating post-Warren Court legal restraints—pre-intervention notices, hearings, heightened burden of proof, and access to witnesses—into the law.[70] The MSEHPA fails to restore the historic deference to public health activities or enhance the crucial scientific and administrative underpinnings of public health enforcement actions.

Stringent preventive and remedial public health measures are necessary to face contagion. The recent experience with quarantine measures as the principal method used against SARS validates this conclusion.[44] Taiwan successfully implemented a broad quarantine program: 131,132 persons were placed under strict quarantine orders that required them to stay where they were quarantined, submit to periodic temperature checks, and sharply restrict transportation or visits to public places. These measures were needed because of the unknown transmissibility of SARS; they are associated with the rapid control of the epidemic in that country.[71] Although the Canadian government attempted to use voluntary isolation, ultimately orders were issued for mandatory quarantine when the use of voluntary isolation became difficult.[72] The Canadian government's response was later characterized as deficient, while the limited spread of SARS in Canada has been attributed to chance.[73]

It is hard to envision the application of the MSEHPA in a manner congruent with stringent quarantine measures. The procedural guarantees in the MSEHPA may well be impossible to implement due to the risk of exposing judges, witnesses, and the public to possible contagion. In addition, the judiciary and public authorities are not prepared to implement quarantine orders due to lack of familiarity with public health doctrines or logistical shortcomings.[74,75] The effects of one successful injunction resulting from these shortcomings—very likely under the MSEHPA—allowing, for example, a single SARS super-spreader to avoid quarantine, could be devastating.[76]

A perfect balance between private and public rights in the face of a highly infectious disease may not be attainable, or even desirable. Emergency activities will be effective if the states' exercise of public health police power is strengthened by good scientific practices and rigorous application of justified means of control. Expiration of any extraordinary powers once the emergency is controlled remains an obligatory feature unless there is reauthorization on the basis of solid scientific evidence.

The ultimate goal of public health law should be the reinforcement of public health on the basis of historic principles of police power allowing broad but temporary administrative activities that are needed to face an impending emergency when the situation warrants.[77] This necessitates a return to the traditional historic bases of public health police power. Recommended steps in this direction should include: *(1)* reinforcing the administrative capability for the issuance of robustly evidence-based public health orders properly issued under authority of law; *(2)* removing all judicial pre-intervention review measures of such orders while limiting review of public health orders to the post-execution phase; *(3)* subjecting all public health orders to automatic expiration terms and making renewal of the orders contingent on the same robust degree of evidence allowing the original order.

Clarify the distinction between civil authority and law enforcement in matters of public health

Public health police powers are an expression of the civil, not criminal, authority of the state. Separation between these two spheres is essential. Public health activities could be severely curtailed if existing public health law is conflated with law enforcement activities. Public health authorities collaborate in the search and detection of potential criminals in enforcement activities.[78] This type of collaboration will presumably increase in the future. Public health authorities, however, cannot become an arm of law enforcement. If that were to occur, the legal protections applicable to criminal enforcement would transfer to public health measures, hampering the ability of public health authorities to take appropriate actions.[79]

Public health law must retain this distinction. Quarantine should not be used to detain a suspect in anticipation of criminal trial or to punish in lieu of criminal conviction. Information obtained in the context of public health activities should generally not be used as evidence against a suspect. Any participation of public health authorities in the search for criminal evidence must be effected within the purview of the constitutional guarantees against unreasonable searches, presumption of innocence, and probable cause.

Maintaining the strictly civil nature of public health activities will be crucial in maintaining the viability of response to bioterrorism.

CONCLUSION

A renewed sense of communal purpose can serve as the underpinnings of a reassertion of state police powers. American legal tradition is grounded on such a foundation. Members of the community are called to temporarily sacrifice certain personal liberties to ensure the continued maintenance and existence of society. The limitations that currently affect the police powers of the state are legal, ideological, and social. Reviewing the communitarian foundations of American law and society is indispensable in order to palliate some of the consequences of individualism and centralization. This is especially urgent since such attitudes could result in injury or incapacity of citizens otherwise entitled to effective public protection.

Strong leadership should guide the American public in understanding the implications of public health activities as well as the potential need for some control of private rights and property. Properly justified public health measures will be accepted by the citizenry if the bases of public health measures are explained.[80] The strengthened legal foundations of state public health agencies could result in a more effective and measurable state public health infrastructure. As Haas indicates: "As long as the natural rights of citizens are not violated, priority should be given to the common good so that the well-being of the largest number of citizens can be advanced as far as possible. In such circumstances, sentimentality cannot direct public or institutional policy; instead, those policies should be guided by reasonable judgments about the benefits than can be derived for the common good from the decisions of those in authority."[81]

President George Washington said, "When any great object is in view, the popular mind is roused into expectation, and prepared to make sacrifices of both ease and property." Redefining the role of public health activities by rearticulating the social pact that gives the state the power to protect the community is essential. We face a dangerous world. Regaining our commitment to a comprehensive and effective public health umbrella is a matter of survival.

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