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Blindfolded on the Edge: Why the U.S. Just Stopped Tracking Disease Under New HHS Leadership.

Biology * Public Health * Urban Environment

The Structural Overhaul of U.S. Public Health Architecture

Beginning in January 2025, the United States federal public health apparatus underwent the most rapid administrative restructuring in its postwar history. Guided by the "Make America Healthy Again" (MAHA) coalition and restructuring initiatives, the Department of Health and Human Services (HHS) moved to decentralize federal infectious disease policy.[1][9] Under HHS Secretary Robert F. Kennedy Jr., NIH Director Dr. Jay Bhattacharya, FDA Commissioner Dr. Marty Makary, and CMS Administrator Dr. Mehmet Oz -- while Dr. Casey Means's nomination for Surgeon General was withdrawn in April 2026 ahead of Dr. Nicole Saphier advancing 12-11 out of the Senate HELP Committee on September 30, 2026 onto the Senate Executive Calendar -- federal policy pivoted away from centralized population-wide mandates.[1][2][22][23][37]

Structurally, HHS reorganized sub-agencies and advisory bodies while shifting prescriptive authority away from conventional Centers for Disease Control and Prevention (CDC) structures.[9][13] On May 23, 2025, Executive Order 14303 ("Restoring Gold Standard Science") instituted new agency scientific review and conflict-of-interest standards,[4] accompanied by major workforce reductions across HHS, NIH, FDA, and CDC programs.[12]

Disruptions to the National Immunization Schedule and Herd Immunity

The most consequential epidemiological shift began on June 9, 2025, when Secretary Kennedy dismissed all 17 sitting members of the Advisory Committee on Immunization Practices (ACIP) and later revived the dormant "Task Force on Safer Childhood Vaccines" involving NIH Director Bhattacharya.[2][11] Acting on reconstituted committee actions on January 5, 2026, CDC narrowed universally recommended childhood vaccines from 17 to 11, shifting six immunizations into "Shared Clinical Decision-Making" (SCDM) or high-risk categories.[5][14] However, on March 16, 2026, a federal district court in American Academy of Pediatrics v. Kennedy issued a preliminary injunction staying the January 5 schedule overhaul and reconstituted ACIP votes; the U.S. Court of Appeals for the First Circuit heard oral arguments on October 6, 2026 (No. 26-1503), with a final appellate decision pending.[24][38]

| Vaccine | | Pre-2026 Status | | Jan 2026 HHS Directive | | HHS Rationale vs. Epidemiological Risk |

| Hepatitis B | | Universal Birth Dose | | High Risk Only / SCDM | | HHS cited low perceived newborn exposure;[15] clinicians warn birth-dose loss misses perinatal maternal screening gaps.[16] |

| Rotavirus | | Routine Infant Series | | Shared Clinical Decision | | HHS cited international comparisons;[14] high basic reproduction number elevates severe

pediatric gastroenteritis risk.[17][18] |

| Influenza | | Annual (>6 months) | | Shared Clinical Decision | | HHS cited variable vaccine effectiveness;[15] pediatric flu surges carry hospitalization and fatality hazards.[13][29] |

| Meningococcal | | Routine Adolescent | | High Risk Only | | HHS cited low aggregate incidence;[5] carriage suppression protects against high-fatality invasive disease.[19][20] |

| Hep A & COVID-19 | | Routine Childhood | | Shared Clinical Decision | | Reclassified universal recommendations toward individualized clinician decision-making.[5][14][21] |

Under Kermack-McKendrick transmission dynamics, moving pediatric immunizations from universal schedules to opt-in negotiation threatens to push coverage below herd-immunity thresholds (pc = 1 1/R0). Because vertical perinatal Hepatitis B infection carries high risk of chronic progression to cirrhosis or hepatocellular carcinoma, relying purely on prenatal screening exposes infants to missed maternal tests,[16] while reducing adolescent Neisseria meningitidis immunization or fragmenting combination vaccines risks eroding community protection against measles and invasive bacterial disease.[5][19][20]

Straining Epidemiological Surveillance: NNDSS, BioSense, and FAERS

Alongside immunization policy litigation, federal surveillance infrastructure faced acute disruptions and budget uncertainty:

* NNDSS Reporting Gaps: Data modernization transitions in the National Notifiable Diseases Surveillance System (NNDSS) interrupted routine national weekly/annual disease reporting portals before updated data tables resumed under CDC's revised notifiable disease hub.[6][25]

* Surveillance Funding Pressures: White House FY2026 budget proposals targeted major cuts across CDC Public Health Data Modernization, BioSense/ESSENCE syndromic surveillance, and wastewater-based epidemiology before Congress enacted final full-year FY2026 appropriations under H.R. 7148.[26][27][28][30]

* FDA Transparency Releases: FDA disclosures of unadjudicated FDA Adverse Event Reporting System (FAERS) records and Complete Response Letters raised legal and scientific debate over balancing transparency against causal misattribution and proprietary trial disclosures.[3][10]

Pharmaceutical Market Re-Engineering: TrumpRx and the mRNA Contraction

Using import tariff pressure alongside executive negotiations, the White House announced "Most Favored Nation" (MFN) pricing deals with nine major pharmaceutical manufacturers -- including Pfizer, Amgen, Merck, Sanofi, and Bristol Myers Squibb -- to anchor a federal cash-pay portal (TrumpRx) alongside state Medicaid discounts.[7][31] Critics noted that cash-pay portals leave broader structural coverage pressures unresolved amid concurrent Medicaid eligibility and work-requirement changes enacted in 2025.[1][31]

| Drug | | Manufacturer | | Indication | | Reported List Price (USD) | | TrumpRx Cash (USD) | | Reported Reduction |

| Plavix | | Sanofi | | Antiplatelet | | 756 | | 16 | | 98% |

| Jentadueto | | Boehringer Ingelheim | | Type 2 Diabetes | | 525 | | 55 | | 90% |

| Reyataz | | Bristol Myers Squibb | | HIV-1 | | 1,449 | | 217 | | 85% |

| Repatha | | Amgen | | Cholesterol | | 573 | | 239 | | 58% |

| Insulin | | Sanofi | | Diabetes | | Varies | | 35 Cap | | Capped |

Conversely, the domestic biotechnology pipeline contracted sharply when HHS initiated the wind-down of 500 million dollars in BARDA mRNA vaccine development contracts across respiratory virus programs.[32][33] Policy analysts warned that pulling federal anchor support from domestic nucleic-acid vaccine platforms threatens U.S. pandemic response readiness and private R&D stability.[8][34]

Interstate Fragmentation: The West Coast Health Alliance and AB 144

In response to federal ACIP upheaval, California, Oregon, Washington, and Hawaii organized the West Coast Health Alliance to issue unified regional immunization guidance.[35][36] In September 2025, California enacted Assembly Bill 144 (AB 144), tying state-regulated insurance preventive coverage mandates to baseline pre-2025 medical consensus and naming CDPH as the state's immunization authority -- though federal ERISA preemption still leaves self-insured employer plans subject to federal statutory shifts.[36]

Long-Term Epidemiological and Biosecurity Projections

The 2025-2026 HHS restructuring and the ensuing March 2026 federal court stay left U.S. immunization and outbreak surveillance fractured along federal-state fault lines.[15][24] Even with FY2026 appropriations moderating some proposed CDC cuts under H.R. 7148,[30] prolonged legal uncertainty over pediatric vaccine recommendations, past NNDSS disruptions, and the wind-down of federal BARDA mRNA vaccine investments risk weakening routine herd immunity and rapid pathogen-response capacity ahead of future respiratory and vaccine-preventable outbreaks.[16][32][36]

Updates... (Nov 22, 2026): Updated litigation and nomination status to reflect October 6, 2026 First Circuit oral arguments in AAP v. Kennedy (No. 26-1503, Ref [38]) and the September 30, 2026 12-11 Senate HELP Committee vote advancing Dr. Nicole Saphier (Ref [37]); verified live HTTP 200 and added exact publication dates to HHS Refs [9] (Mar 27, 2025) and [11] (Jun 9, 2025).

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