Public Health Policy Consolidation After the Pandemic

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Robert F. Kennedy Jr. has not had a quiet tenure as Secretary of Health and Human Services. Since taking office, he has restricted COVID-19 vaccine recommendations for healthy individuals, narrowed the FDA's authorization scope, restructured the Advisory Committee on Immunization Practices (ACIP) with members his critics describe as unqualified, and removed the FDA's top vaccine official. In March 2026, a federal court temporarily blocked several of these changes, finding they likely violated federal law.

Kennedy's critics treat this as a story about one man's views. It isn't. His allies did not invent the authority Kennedy exercises. It was built by the very program he has most strenuously criticized: Operation Warp Speed (OWS). The emergency powers consolidated under HHS during the COVID-19 pandemic did not disappear when the pandemic did. They remained, waiting for whoever came next to use them to their advantage.

The Ratchet Mechanics of OWS

OWS succeeded at its stated mission. Two COVID-19 vaccines received emergency use authorization within six months of the program's launch in May 2020. But the partnership's most consequential effects may not be the vaccines themselves.

Using Robert Higgs's (1987) ratchet effect framework, the pattern is familiar: a crisis justifies a rapid expansion of governmental power and scope. An often fearful and dismayed public readily trades in their economic and personal liberties in hopes a more pervasive government will cut short the crisis. But when the crisis ends, governments seldom return to their pre-crisis involvement in personal and economic affairs (Goodman, Coyne, and Devereaux 2021).

Crisis conditions in early 2020 were severe. By May 30, national confirmed COVID-19 infections approached 1.7 million, with roughly 104,000 deaths. Unemployment reached

14.8% in April. Pew Research Center found that 88% of respondents considered the pandemic a major threat to the U.S. economy. These conditions produced exactly the public receptiveness to government intervention that Higgs's framework identifies as the precondition for lasting expansion.

OWS pledged approximately $10 billion in federal funds—dwarfing the NIH's annual vaccine development budget of roughly $900 million across all projects from 2000 to 2019 (Kiszewski et al. 2021). The partnership granted HHS sole authority to determine vaccine standards for authorization and distribution. As HHS explicitly stated, "the protocols for the trials will be overseen and set by the federal government, as opposed to traditional public-private partnerships" (HHS 2020b, 3).

A critical component of this consolidation came in September 2020, when then-HHS Secretary Alex Azar issued an order rescinding "any prior delegation of rulemaking authority" to HHS sub-agencies, including the FDA. The practical effect was a dramatic concentration of regulatory power in HHS leadership. Former FDA Commissioner Scott Gottlieb called it "exactly the wrong message at a time that we want to reaffirm the independence of these agencies" (Quinn and Tillett 2020). As applied to the FDA, the order was partially reversed: Secretary Xavier Becerra issued a Federal Register delegation notice in September 2021 restoring the FDA's rulemaking authority (86 Fed. Reg. 49337). For the remainder of HHS—including the CDC, ACIP, and CMS—no comparable restoration was issued, and the centralization of Secretarial authority remained intact.

This distinction matters for evaluating Kennedy's subsequent actions: his authority over ACIP restructuring and vaccine recommendation policy flows through non-FDA channels where the Azar-era consolidation persisted, while FDA-specific actions such as removing the agency's top vaccine official likely rest on ordinary Secretarial appointment and removal authority rather than on OWS-era rulemaking consolidation.

Evidence of the Ratchet

Federal funding for COVID-19 vaccines continued long after OWS ended. By March 2023, the federal government had spent more than $30 billion on COVID-19 vaccines (Kates, Cox, and Michaud 2023)—despite only 15.7% of adults being current on boosters as of November 2023. Vaccines subsidized and used at this time were also only approximately 54% effective against new variants (Link-Gelles et al. 2024). COVID-19 vaccines were commercialized in fall 2023, coinciding with FDA authorization of updated XBB.1.5

monovalent vaccines and the wind-down of federal procurement and distribution programs. The CDC Bridge Access Program, launched in September 2023 to provide temporary free coverage to uninsured adults, was itself ended in August 2024. What persists is not non-commercialization but residual federal involvement: vaccines remain covered under Medicare Part B, Medicaid, and CHIP through ordinary public insurance channels. That coverage represents a more limited form of federal entanglement than the original OWS procurement architecture—but it is not a full retreat to market allocation, and the conditions under which these access programs should be wound down remain unresolved.

The monkeypox outbreak of 2022 provides a more telling example. The Biden administration's response borrowed directly from OWS's institutional design—CDC-administered distribution, DOD involvement in logistics, and the Strategic National Stockpile as the primary vaccine source—applied to a considerably less severe threat. These were all utilized despite widespread knowledge that monkeypox mortality was "not a concern" when the emergency was declared (Ren, Li, and Gao 2022). Rather than state-led public health responses ending after the pandemic, the government found new occasions to exercise the authorities it recently acquired.

HHS Consolidation and the RFK Jr. Problem

Under the Biden administration, HHS expanded further along three distinct pathways—each with different legal origins, though all benefiting from the centralizing norms OWS had established. These three pathways are: (1) drug price negotiation, (2) drug shortage authority, and (3) HHS reorganization. The Medicare drug-price negotiation program arrived via the Inflation Reduction Act (IRA) of 2022, a long-standing Democratic legislative priority that gave HHS new authority to negotiate prices for a limited set of high-spending Part D drugs—authority that had never existed at CMS before. Drug shortage authority is the pathway most directly enabled by OWS. The statutory foundation—manufacturer notification requirements under FDASIA (2012) and device-shortage authority added by the CARES Act (2020)—predates OWS, but OWS gave HHS a template for directing cross-agency supply-chain responses that it subsequently extended to non-COVID drug shortages well beyond what those statutes alone required.

Under Biden, that OWS-modeled coordination was formalized for drug shortages more broadly: a 2024 ASPE supply-chain report and a 2025 GAO recommendation called on HHS to institutionalize cross-agency coordination mechanisms, extending the pandemic-

era template to routine supply disruptions. Most directly traceable to OWS-style institutional logic is the March 2025 HHS reorganization under Kennedy himself: 28 divisions consolidated into 15, regional offices halved, and roughly 20,000 personnel separated—all justified as eliminating duplicative sub-agency functions. Though federal courts enjoined portions of the reorganization, the structural consolidation is largely intact as of mid-2026. This is where the ratchet argument is strongest: Secretarial centralization, normalized during the pandemic emergency, continued through successive administrations as an organizing principle rather than a temporary accommodation (March 2025a).

This is the irony that defines current vaccine policy. Kennedy entered an office strengthened by both Republican and Democratic administrations. His capacity to restrict vaccine recommendations, reshape ACIP, and remove the FDA's top vaccine official all flow from HHS authority that OWS helped consolidate. Former FDA Commissioner Gottlieb's warning about a "power grab" turned out to be underspecified: the grab outlasted its architects and became available to whoever inherited the office.

Kennedy's emphasis on transparency is not without merit as a general principle. The rent-seeking dynamics embedded in OWS—including OWS scientific director Moncef Slaoui holding approximately $12 million in Moderna stock while in his government role, and pharmaceutical industry lobbying averaging $233 million annually even before the pandemic—are precisely the kind of problems that warrant scrutiny (Arnsdorf 2020; Wouters 2020). But dismantling FDA independence is not the same as improving it. The greatest threat to vaccine policy is not any particular HHS Secretary's views. It is the concentration of regulatory authority that makes those views dispositive.

Policy Recommendations

The ratchet effect is not inevitable, but reversing it requires deliberate institutional change.

- **First, Congress should restore the FDA's statutory independence over vaccine authorization.** The Azar order's rescission of delegated rulemaking authority was administratively issued; it should be legislatively foreclosed.

- **Second, Congress should establish clear criteria governing residual federal vaccine access programs.** Though COVID-19 vaccines were commercialized in fall 2023, public insurance coverage and access programs remain in place without explicit sunset

conditions. With utilization rates below 16% and vaccine prices having more than tripled since 2020, continued open-ended federal access programming lacks demonstrated justification. Congress should define the conditions under which such programs terminate and require affirmative reauthorization to continue.

- **Third, future public health emergency responses should explicitly include mandatory sunset provisions for any expanded authorities granted to HHS or its sub-agencies.** These provisions should be designed to lapse automatically absent affirmative congressional reauthorization—not merely expire subject to renewal, as the history of legislation like the PATRIOT Act demonstrates that sunset clauses without automatic lapse are routinely extended without meaningful review. Narrow triggering conditions, supermajority thresholds for renewal, and explicit scope limitations should accompany any such grants. Crisis-era authorities should not persist by institutional inertia.

The question is not whether OWS succeeded in its immediate mission. The question is what persists after the mission ends. Right now, what persists is a concentration of authority at HHS that no administration designed for any single purpose and that no administration has meaningfully reduced. Restoring trust in public health agencies requires more than removing people. It requires removing power.

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