The Trust Deficit:

HOW AMERICA'S HEALTH INSTITUTIONS LOST THE PUBLIC — AND WHAT IT'S COSTING US

HEALTH EQUITY COLLABORATIVE

White Paper

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The Health Equity Collaborative

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About the Author

The Health Equity Collaborative (HEC) is a diverse community comprised of dozens of national, public health, patient advocacy, and multicultural organizations that are committed to supporting equity and combating disparities experienced by underserved populations. HEC is officially a project of MANA Action, a 501c4 not-for-profit organization.

Executive Summary

Public trust is a cornerstone of an effective healthcare system. When patients believe medical institutions operate on evidence and in the public interest, they are more likely to seek care, follow treatment guidance, and participate in preventive health programs. But when that trust erodes, healthcare behavior changes and health outcomes are consequently less favorable. For this reason, health researchers increasingly recognize trust itself as a social determinant of health.

Before the COVID-19 pandemic, scientific institutions enjoyed historically high levels of confidence in the U.S. However, surveys repeatedly found that trust in scientists and public health agencies fell significantly between 2020 and 2024. Over a similar timeframe, childhood vaccination rates declined while vaccine-preventable diseases began to reappear.

Recent federal policy actions have deepened rather than reversed this erosion of trust. There have been leadership replacements at key health agencies, with new leadership questioning the medical consensus and bypassing long-standing scientific advisory processes. These actions drew strong criticism from the medical and scientific communities.

Public health experts have expressed alarm over the politicization of vaccine advisory structures and the abandonment of institutional evidence-based review procedures. Thus far these criticisms have been to little avail.

Communities already facing structural barriers to healthcare — particularly women of color — are disproportionately affected by declining institutional trust. Research consistently demonstrates that trust level is strongly predictive of healthcare utilization, which in turn is predictive of healthcare outcomes.

Structural pressures on the healthcare system, too, are intensifying. Medicaid coverage losses are affecting millions, while the closure of safety-net providers affects disadvantaged rural and urban areas, alike. Moreover, growing administrative barriers effectively block access to care for many. The loss of institutional trust compounds these pressures, often resulting people with healthcare coverage who nonetheless do not receive care.

Rebuilding trust in healthcare institutions will require stronger safeguards. These include the robust protection of healthcare agency integrity and the restoration of evidence-based decision-making. Misinformation must be prevented from undermining patient confidence. Policymakers must also ensure that medical innovation proven to provide health benefits — from vaccines to emerging treatments — remains accessible.

In short, trust is required for healthcare system to be effective.

Introduction

Trust is an unseen facilitator in modern healthcare systems. Preventive medicine, vaccination programs, clinical treatment, the development of pharmaceuticals and treatment, public health guidance, and even the decision whether to seek care all depend on patients believing that medical institutions operate according to scientific evidence and in the public interest. Healthcare systems are better able to improve health outcomes when trust in healthcare institutions is present. Health researchers are therefore increasingly recognizing institutional trust as a determinant of health outcomes.

The COVID-19 pandemic placed extraordinary pressure on public health institutions, requiring scientific agencies to communicate evolving evidence in real time amid intense political polarization and a rapidly expanding digital misinformation environment. Credibility eroded within a healthcare system already marked by deep disparities in access, coverage, and treatment quality. For this reason, populations with pre-existing barriers to care were the most affected.

This paper examines the erosion of trust in American healthcare institutions in the years following the COVID-19 pandemic and the policy developments that have further strained that trust. It also explores how declining institutional credibility interacts with existing structural inequities. Finally, it outlines actions that would restore confidence in evidence-based medicine and strengthen the institutional foundations of the nation's healthcare system.

SECTION ONE

The Post-Pandemic Collapse of Trust

BY THE NUMBERS

A growing body of survey data and public health indicators reveals a measurable decline in Americans' trust in scientific and medical institutions in the years following the COVID-19 pandemic.

Trust in scientists to act in the public interest fell from 87% in April 2020 to 73% by late 2024, according to Pew Research Center surveys tracking attitudes toward scientific institutions during and after the COVID-19 pandemic.[1]

Republicans' confidence in scientists fell nearly twice as sharply as Democrats' over the same period, contributing to the increasing politicization of trust in scientific institutions.[2]

A national survey conducted by the Annenberg Public Policy Center found that trust in federal public health agencies such as the CDC and FDA declined significantly during the post-pandemic period, with fewer Americans expressing confidence that those agencies act independently of political influence.[3]

Research from the Vaccine Confidence Project documented measurable declines in vaccine confidence in several high-income countries following the COVID-19 pandemic, including the United States.[4]

U.S. kindergarten vaccination coverage for key vaccines, including measles-mumps-rubella (MMR), declined from roughly 95% before the pandemic to levels below the herd-immunity threshold in multiple states by 2024–2025.[5]

The United States recorded growing measles outbreaks in 2025, with public health authorities linking many outbreaks to declining vaccination rates in communities with falling immunization coverage.[6]

Research shows that exposure to vaccine misinformation significantly reduces vaccine confidence and vaccine uptake, particularly when misinformation originates from figures perceived as authoritative or trustworthy.[7]

Studies consistently demonstrate that patients with lower levels of trust in healthcare institutions are significantly less likely to seek preventive care, adhere to treatment recommendations, or accept recommended vaccinations.[8]

Historical experiences of discrimination and exploitation in medical institutions continue to shape levels of trust in healthcare among minority populations today.[9]

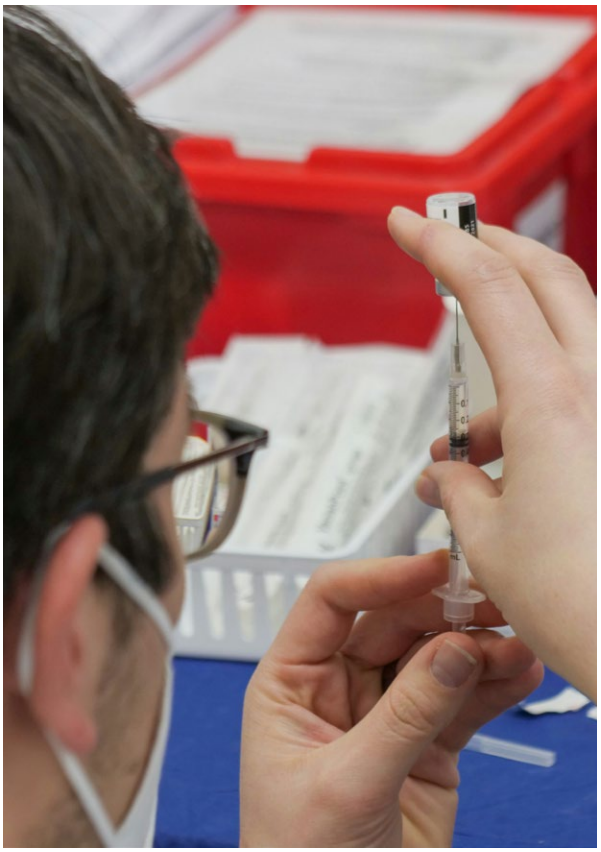
Institutional trust has been identified as one of the strongest predictors of vaccination uptake, even after controlling for demographic, socioeconomic, and educational factors.[10]

COVID-19 AS ACCELERANT

Distrust of the American healthcare institutions did not begin with the COVID-19 pandemic. Surveys conducted before 2020 consistently found that a small but persistent share of the population questioned vaccine safety, pharmaceutical industry influence, or the motivations of government health agencies. However, during the early days through the peak of the crisis, health agencies communicated evolving scientific evidence in real time. Guidance on masking, vaccines, and social restrictions changed as more data emerged. Those shifts were frequently interpreted as evidence of institutional incompetence or deception. This dynamic transformed public health guidance into a central arena of political conflict that amplified skepticism toward scientific institutions.

Public health researchers have long identified institutional trust as a top predictor of vaccine acceptance, noting that individuals who distrust government institutions or medical authorities are significantly less likely to accept recommended immunizations or participate in preventive health programs.[11] Studies of vaccine attitudes in the United States and Europe similarly found that declining confidence in vaccines often reflects broader skepticism toward political and scientific institutions rather than concerns about specific medical products.[12] This preexisting landscape of skepticism meant that when COVID-19 placed unprecedented attention on public health agencies and vaccine development. The resulting debates therefore took place within an environment where trust was already fragile.[13]

During the COVID-19 pandemic, recommendations on masking, vaccine eligibility, school closures, and social distancing shifted over time as researchers learned more about viral transmission, immunity, and population risk. Within the scientific community, such changes reflected the normal process of evidence-based decision-making under conditions of incomplete information. For many members of the public, however, evolving guidance appeared inconsistent or contradictory, particularly when communicated through highly politicized media environments. Research on pandemic communication has shown that rapid shifts in public health recommendations can undermine institutional credibility when audiences interpret scientific revision as evidence of incompetence or political influence rather than the expected progression of scientific understanding.[14] In this environment, debates over pandemic policy



increasingly intersected with political messaging, media amplification, and online misinformation ecosystems, further complicating efforts by public health agencies to maintain credibility and public confidence.[15]

The COVID-19 pandemic also exposed longstanding challenges in communicating with communities that have been historically underserved by the healthcare system. For many in these communities, trust in the healthcare system is inseparable from both this history and ongoing inequities.

Research has shown that disparities in healthcare access, treatment quality, and provider representation can weaken institutional credibility in communities that already face structural barriers to care. For example, CDC survey data found that nearly one in three Black women reported experiencing mistreatment during pregnancy and delivery, including being ignored when requesting help or denied adequate pain management.[16] At the same time, disparities in healthcare access remain widespread: Hispanic Americans are more than twice as likely as white Americans to be uninsured, limiting access to consistent relationships with healthcare providers and institutions.[17]

These inequities shape how medical institutions are perceived long before a public health crisis emerges. When institutional credibility came under strain during the COVID-19 pandemic, communities already navigating structural barriers to care were often among the most affected. This demonstrated how disparities can exacerbate pre-existing distrust.[18]

In all, pre-pandemic mistrust, historical mistreatment, and current healthcare inequities combined with the COVID-19 pandemic to leave U.S. scientific and health institutions vulnerable.

INSTITUTIONAL DESTABILIZATION

In the years following the acute phase of the COVID-19 pandemic, several major federal health agencies experienced disruptions. This instability raised concerns among researchers, clinicians, and public health leaders concerned about the integrity of processes governing the safety and approval of medical advice and treatments.

Food and Drug Administration

The Food and Drug Administration (FDA) plays a central role in regulating medicines, vaccines, and medical devices in the United States. In recent years the agency has experienced a wave of senior leadership departures and organizational disruption that has strained both operational capacity and institutional memory. Oversight bodies have similarly noted that staffing shortages and retention challenges within federal health agencies strain regulatory capacity in institutions depending heavily on specialized scientific expertise and institutional continuity.[19] Sustained turnover among senior leadership can create uncertainty within regulatory agencies whose effectiveness depends heavily on technical expertise and institutional continuity.[20] This instability has further complicated efforts to maintain or restore institutional trust.

Centers for Disease Control and Prevention

The Centers for Disease Control and Prevention (CDC) has likewise faced a period of institutional disruption during the post-pandemic era. Changes affecting the CDC's advisory and scientific review processes have drawn concern from researchers and public health organizations about maintaining the independence and continuity of evidence-based decision making.[21] Advisory committees such as the Advisory Committee on Immunization Practices (ACIP), have historically served as a key mechanism for ensuring transparency and scientific review in federal vaccine policy.[22] Public health experts have warned that disruptions to advisory committee processes or scientific review structures within federal health agencies could further complicate efforts to rebuild trust in public health guidance during the post-pandemic period.[23]

National Institutes of Health

The National Institutes of Health (NIH), the nation's largest public funder of biomedical research, has also faced a period of uncertainty affecting the broader scientific community. Changes to research funding priorities and administrative processes

within federal health agencies have prompted concern among academic researchers and research institutions about maintaining the stability and independence of the biomedical research enterprise.[24] Because NIH funding supports a large share of basic and translational research conducted at universities and medical centers across the United States, shifts in grant programs or funding priorities can have ripple effects throughout the national research infrastructure. Researchers and university leaders have warned that sustained uncertainty surrounding federal research funding and governance could complicate long-term scientific planning and weaken confidence in the institutional structures that support evidence-based medicine.[25]

Department of Health and Human Services

Broader changes across the Department of Health and Human Services (HHS) have further increased concerns about institutional stability within the federal health system. Because HHS oversees agencies including the FDA, CDC, and NIH, shifts in departmental leadership, policy direction, and administrative priorities can influence the broader governance structure of U.S. public health and biomedical research. Public health organizations and medical institutions have warned that HHS' actions could disrupt coordination among scientific regulators, researchers, and healthcare providers responsible for implementing national health policy.[26]

As federal health agencies continue to navigate these institutional changes, the broader challenge facing policymakers is not only restoring operational stability, but also rebuilding public confidence in the scientific institutions that guide national health policy.

SECTION TWO

The Rise of MAHA and Its Erosion of Public Health Infrastructure

The “Make America Healthy Again” (MAHA) movement emerged during Robert F. Kennedy Jr.’s 2024 presidential campaign, when it was initially organized as a political action committee aligned with Kennedy’s platform. Following Kennedy’s endorsement of Donald Trump and his subsequent appointment as Secretary of the Department of Health and Human Services, the movement’s agenda began to influence federal health policy directly through the executive branch.[27]

ORIGINS AND IDEOLOGICAL FOUNDATIONS OF THE MAHA MOVEMENT

MAHA's core ideology centers on the belief that the United States faces a widespread chronic illness crisis driven by the pharmaceutical and food industries and enabled by regulatory capture within federal health agencies.[28] The movement has also promoted claims that vaccines cause autism and that longstanding scientific consensus on vaccine safety and other medical issues has been corrupted by industry influence. Public health researchers and medical organizations have rejected these claims, noting that the alleged vaccine–autism link has been extensively studied and repeatedly disproven by large-scale epidemiological research and reviews by scientific bodies including the Institute of Medicine.[29]

Public opinion toward the MAHA movement, and thus toward Kennedy as Secretary of HHS, has remained divided. A national survey conducted in January 2025 found that roughly 30 percent of Americans viewed Kennedy favorably while 42 percent viewed him unfavorably.[30]

Criticism of MAHA's vaccine-related positions has come from across the political spectrum, including policymakers who support certain aspects of the movement's focus on food policy and chronic disease but reject its broader approach to vaccine science. Senator Bernie Sanders, for example, has argued that while some of Kennedy's critiques of the food system are "exactly correct," his broader views on vaccines and public health policy are "extremely dangerous."[31] In addition to concerns about the movement's scientific claims, watchdog groups and journalists have raised questions about potential financial conflicts among individuals associated with MAHA who have promoted products or services aligned with the movement's messaging. These concerns have intensified calls for greater transparency and accountability as MAHA-aligned figures have assumed positions of influence within federal health policy.[32]

INSTITUTIONAL ACTIONS UNDER THE MAHA AGENDA

Following Robert F. Kennedy Jr.'s confirmation as Secretary of Health and Human Services, elements of the MAHA movement's agenda have influenced vaccine governance, federal scientific advisory structures, public health messaging, and biomedical research oversight. These actions have drawn sharp criticism from public health experts, medical associations, and policymakers who argue that the administration has bypassed established scientific review processes and weakened institutional safeguards designed to ensure that federal health policy reflects the best available evidence.

Several of the most consequential policy actions associated with the MAHA agenda, taken together, represent a shift in how federal health policy decisions are made and raise questions about the role of scientific review and institutional safeguards in current public health governance.

ACIP Leadership Purge

In June 2025, Secretary Kennedy dismissed all seventeen members of the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices (ACIP), the independent scientific body responsible for evaluating vaccine evidence and issuing immunization recommendations in the United States.[33] The dismissed panel members were replaced with individuals, several of whom lacked formal expertise in epidemiology, immunology, or vaccine policy and had previously expressed skepticism about established vaccine science.[34]

The decision prompted immediate concern from medical organizations, former federal health officials, and public health scholars who warned that dismantling ACIP's existing structure could undermine one of the central scientific review mechanisms guiding U.S. vaccine policy.[35]

In March 2026, a federal judge in the U.S. District Court for the District of Massachusetts ruled that the reconstituted ACIP could not meet until its legitimacy was assessed, finding that the process used to restructure the committee likely violated the Administrative Procedure Act and describing the circumstances as "a strong indication of something more fundamentally problematic."[36]

Childhood Vaccine Schedule Overhaul

In January 2026, Secretary Kennedy and the acting Director of the CDC announced a unilateral revision to the recommended childhood vaccine schedule. The change reduced the number of diseases covered by routine childhood vaccination from eighteen to eleven, eliminating recommended protection against hepatitis A, hepatitis B, respiratory syncytial virus (RSV), dengue, and two forms of bacterial meningitis.[37] The policy was implemented outside the standard ACIP review process, which historically evaluates vaccine evidence through a multi-stage scientific assessment involving epidemiological data, clinical trial evidence, and cost-effectiveness analysis.[38]

Administration officials defended the change by arguing that the revised schedule would more closely resemble the national vaccination schedule used in Denmark. Medical experts rejected the comparison, noting that Denmark's health system differs substantially from the United States in population size, universal health coverage, and the presence of a national patient registry capable of monitoring vaccine outcomes across the entire population.[39] The controversy intensified after a major Danish study published in July 2025 found no evidence that aluminum exposure from vaccines causes harm. Secretary Kennedy publicly demanded that the journal retract the study; the journal declined to do so.[40]

In March 2026, a federal court blocked implementation of the revised vaccine schedule following a lawsuit filed by the American Academy of Pediatrics, the American College of Physicians, and other medical organizations. Dr. Richard Besser of the Robert Wood Johnson Foundation described the ruling as "a day to celebrate the triumph of science over misinformation."[41]

COVID-19 and Hepatitis B Vaccine Restrictions

Additional changes to federal vaccination guidance affected both COVID-19 and hepatitis B immunization policy. In May 2025, federal health authorities removed COVID-19 vaccines from the recommended schedule for children and pregnant people who were not considered high-risk. The decision diverged from prior CDC recommendations that emphasized the role of vaccination in protecting vulnerable populations and limiting severe disease outcomes.[42]

Later that year, in December 2025, the CDC eliminated its decades-long recommendation that all newborns receive the hepatitis B vaccine within 24 hours of birth. The universal birth-dose policy had been a cornerstone of U.S. hepatitis B prevention strategy and had contributed to a 99 percent reduction in hepatitis B infections among American children.[43]

Public health experts warned that removing the birth-dose recommendation could increase the risk of undetected transmission. Between 12 and 18 percent of pregnant women in the United States are not screened for hepatitis B infection during pregnancy, meaning the newborn vaccine has historically served as an essential safety net for infants whose mothers' infections were not identified before delivery.[44]

General Messaging and Institutional Culture

Public statements by federal health leadership have raised further concerns among medical professionals about the administration's approach to scientific communication and evidence-based policymaking.

Senior officials within HHS have suggested that antidepressant medications may contribute to mass shootings, characterized selective serotonin reuptake inhibitors (SSRIs) as "as addictive as heroin," and questioned the safety of acetaminophen during pregnancy without presenting credible scientific evidence to support these claims.[45] [46] [47]

Criticism intensified after the MAHA Commission's May 2025 report was found to contain multiple citations to sources that did not exist. The White House later described the citation problems as "formatting issues," though researchers and journalists argued that the errors reflected deeper concerns about the rigor of the report's analysis.[48]

Acetaminophen and Autism Claims

In September 2025, President Donald Trump stated that acetaminophen use during pregnancy was "strongly linked" to autism and urged pregnant women to "fight like hell not to take Tylenol."

Large-scale epidemiological evidence does not support this claim. A Swedish cohort study examining approximately 2.5 million children found no association between prenatal acetaminophen exposure and autism, attention deficit hyperactivity disorder, or intellectual disability.[49]

Public health experts warned that such statements could create confusion and fear among pregnant patients. These risks may be particularly acute for patients of color and others who already face barriers to consistent prenatal care and who may rely more heavily on self-managed health decisions due to gaps in access to medical services.

CDC Website Changes on Vaccines and Autism

In November 2025, changes to the CDC website's public information pages suggested a potential connection between vaccines and autism, drawing immediate criticism from physicians, researchers, and medical organizations who argued that the revisions misrepresented the scientific consensus on vaccine safety.[50]

Reporting by KFF Health News and other outlets indicated that the administration also promoted leucovorin as a potential treatment for autism despite limited clinical evidence supporting its safety or effectiveness for that purpose.[51]

Vaccines and Autism: Scientific Consensus

The alleged connection between vaccines and autism remains one of the most extensively studied claims in modern medicine. Large epidemiological studies and systematic reviews have consistently found no evidence supporting a causal relationship between vaccination and autism. Scientific reviews conducted by the Institute of Medicine and subsequent research syntheses confirm that the available evidence favors rejection of a causal link between vaccines and autism. Analyses of autism prevalence trends indicate that rising diagnosis rates are primarily explained by improved screening, expanded diagnostic criteria, and increased awareness rather than environmental exposures from vaccines or medications.[52]

Misattributing the causes of autism to vaccines risks diverting attention from the real needs of autistic individuals and their families, including expanded access to diagnostic services, educational support, and long-term care resources.

Taken together, these MAHA-influenced actions represent a departure from institutional processes that have historically governed federal public health decision-making. Advisory committees, independent scientific review, and transparent evidence evaluation have long served as safeguards designed to insulate health policy from political or ideological pressure. Their weakening or abandonment has concentrated authority within the executive branch and increased doubt in federal health recommendations. Consequently, the credibility of health institutions, themselves, is now in question.

SECTION THREE

The Human Cost of Trust Erosion

The consequences of the breakdown in institutional credibility have not been evenly distributed. For many Americans—particularly in communities already facing provider bias, language barriers, and unstable coverage—declining trust in healthcare institutions increasingly manifests in real world decisions that adversely affect healthcare outcomes. These decisions often involve whether and how often to seek care.

TRUST AS A DETERMINANT OF CARE-SEEKING

A large body of health services research shows that institutional trust strongly predicts healthcare utilization. Individuals who report low trust in healthcare systems are more likely to delay seeking care, avoid preventive screenings, and initiate prenatal care later in pregnancy—even when insurance coverage and geographic access to providers are available.[53] Communities that report the lowest levels of trust in healthcare institutions are often the same communities most dependent on public programs such as Medicaid for access to care.[54] Delayed or foregone care can translate directly into preventable harm. The decline in trust therefore disproportionately impacts disadvantaged communities.

POST-COVID TRUST COLLAPSE AND UTILIZATION DECLINES

The COVID-19 pandemic accelerated institutional distrust through several reinforcing mechanisms, including rapidly evolving public health guidance, highly visible disparities in COVID-19 mortality, and inequities in early vaccine access. For many communities of color, these experiences reinforced a perception that public health institutions respond unevenly across the population.[55]

Evidence suggests that the utilization effects of this distrust have persisted beyond the acute pandemic period. Preventive care—including prenatal visits, cancer screenings, and routine primary care—declined during the pandemic and has recovered more slowly among low-income populations and communities of color. Delayed initiation of prenatal care, one of the strongest predictors of adverse maternal outcomes, remains elevated in populations that report the lowest levels of trust in healthcare institutions.[56] [57] [58]

DISPARATE IMPACTS ACROSS COMMUNITIES

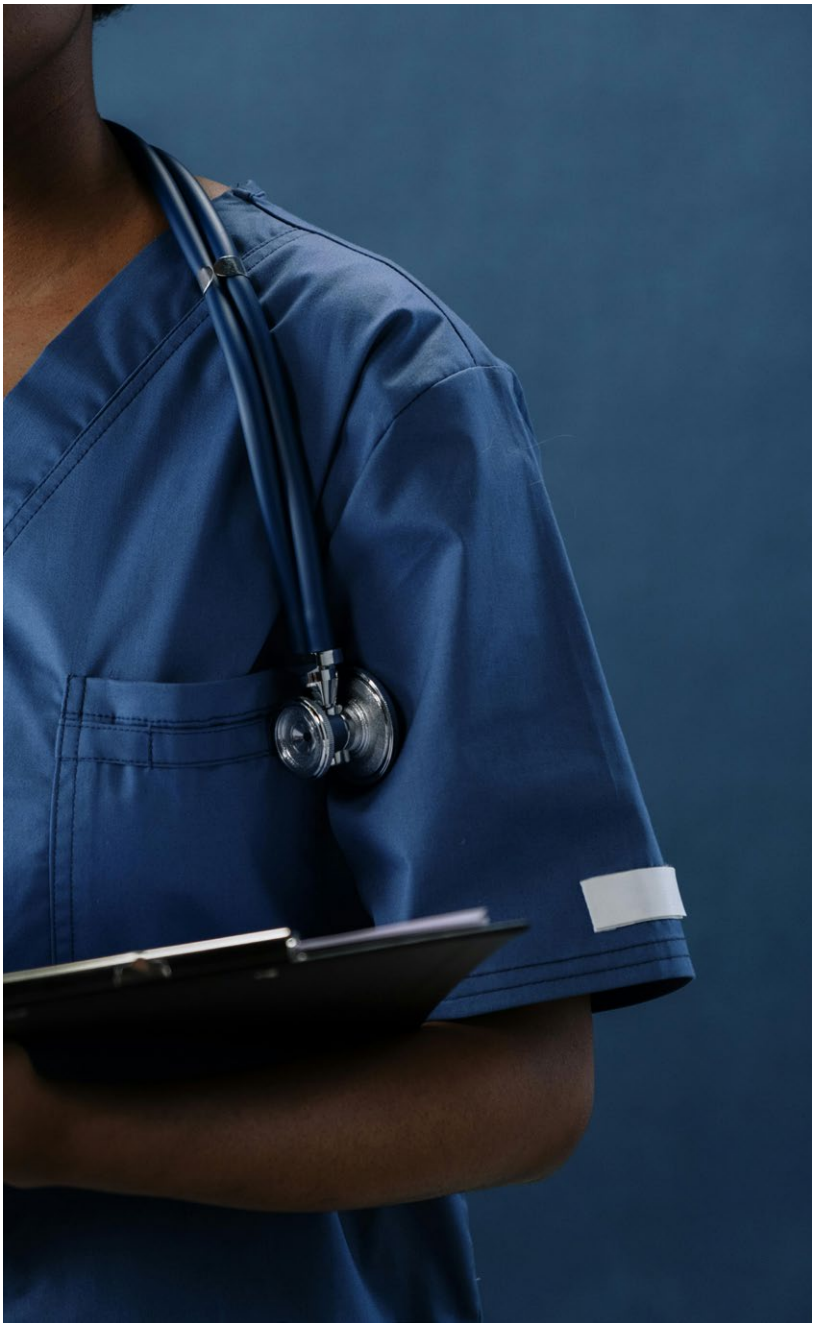
The consequences of trust erosion are particularly severe among populations already facing structural barriers to healthcare. Black women report significantly higher rates of mistreatment during pregnancy and childbirth—including being ignored when requesting help, shouted at by providers, or denied adequate pain management. A national survey conducted by the Centers for Disease Control and Prevention found that nearly one in three Black women reported some form of mistreatment during maternity care. These experiences are associated with lower rates of follow-up care and reduced engagement with prenatal and postpartum services—outcomes that contribute to maternal mortality rates for Black women that remain more than three times higher than those for white women.[59]

Hispanic and immigrant communities face additional barriers related to language access and concerns about immigration enforcement, both of which have been documented as deterrents to healthcare utilization independent of insurance coverage. Linguistic barriers are associated with missed prenatal appointments, delayed diagnoses, and poorer maternal outcomes when language-concordant care is unavailable.[60] [61]

Native American and Alaska Native communities confront a different set of challenges. American Indian and Alaska Native women experience some of the highest pregnancy-related mortality rates in the United States, and Native Hawaiian and Pacific Islander women are also disproportionately affected by pregnancy-related deaths. Tribal health systems already face severe staffing shortages, and many tribal clinics rely heavily on Medicaid reimbursements to sustain operations. Disruptions to these systems can eliminate care access entirely in rural or reservation-based communities.[62] [63]

WHEN COVERAGE EXISTS BUT CARE DOES NOT

The interaction between insurance coverage and institutional trust is central to understanding the health consequences described in this report. Coverage loss clearly reduces access to care. But insurance coverage does not guarantee that individuals will seek care if they distrust healthcare institutions or anticipate negative clinical experiences. Research consistently finds that institutional distrust is associated with delayed care, missed preventive services, and lower adherence to recommended treatment even when insurance coverage is available.[64]



This distinction is particularly important for populations that rely heavily on Medicaid as their primary entry point into the healthcare system. Medicaid functions not only as a coverage mechanism but also as the institutional infrastructure through which millions of low-income Americans interact with the formal health system.

Administrative barriers within Medicaid can themselves reinforce distrust. During the 2023 Medicaid "unwinding," Black and Hispanic adults were significantly more likely than white adults to lose coverage due to procedural issues such as incomplete paperwork or missed notices. These disparities reflect structural challenges in navigating bureaucratic systems that many communities already experience as barriers rather than access points.[65]

Mental health conditions—including suicide and substance use disorders—are now the leading cause of pregnancy-related deaths in the United States, with nearly half of maternal deaths occurring between seven days and one year after childbirth. Nearly every state has extended postpartum Medicaid coverage to twelve months specifically to address this risk.[66] Women with extended postpartum coverage are substantially more likely to access mental health services during the postpartum period.[67]

Coverage alone simply does not guarantee healthcare utilization. For patients who have experienced clinical mistreatment, who face cultural or linguistic barriers within healthcare settings, or who distrust provider assessments of their health concerns, formal coverage may not translate into engagement with available services. In these circumstances, the erosion of institutional trust functions as a filter between coverage and care—one that current health policy frameworks rarely acknowledge or address.

SECTION FOUR

Rebuilding Institutional Trust as a Public Health Priority

The evidence presented in this report demonstrates that declining institutional trust in healthcare is not merely a cultural or political challenge—it is a structural determinant of health outcomes. Disruptions to scientific advisory processes, public health messaging, and evidence-based policy have contributed to measurable declines in care-seeking and widening disparities in health outcomes. Rebuilding trust requires restoring institutional safeguards that ensure public health guidance is evidence-based and that treatments are accessible to populations most in need of them.

The Health Equity Collaborative calls on Congress and state governments to take immediate steps to defend evidence-based public health institutions, support promising medical innovations, and strengthen oversight of federal health communications.

DEFENDING VACCINES AND STRENGTHENING TRUST IN EVIDENCE-BASED MEDICINE

The scientific consensus on vaccine safety is clear. Claims that childhood vaccines cause autism—central to the MAHA movement's critique of modern immunization policy—are not supported by decades of scientific evidence. Large epidemiological studies involving hundreds of thousands of children have repeatedly found no causal relationship between vaccines and autism spectrum disorder.[68] Autism is overwhelmingly associated with genetic and developmental factors, with hundreds of genes linked to autism risk and no single vaccine or medication identified as a cause.[69]

Arguments that children today receive "too many vaccines" also misrepresent the underlying science. Although the number of recommended vaccines has increased since the 1980s, the number of immune-stimulating antigens contained in vaccines has declined dramatically as vaccine technology has advanced. Modern vaccine formulations expose children to far fewer antigens than earlier generations of vaccines.[70]

The public health consequences of declining vaccination rates are well documented. During the 1989–1991 measles resurgence in the United States, more than 55,000 measles cases and over 120 deaths were reported, primarily among children.[71] More recently, measles outbreaks have expanded again as childhood vaccination rates have declined following the COVID-19 pandemic.[72]

These risks fall disproportionately on low-income families. The Vaccines for Children (VFC) program, which provides vaccines at no cost to children without insurance, relies on recommendations issued by ACIP to determine which vaccines are covered.[73] Changes to the vaccine schedule or disruptions to ACIP's scientific review process therefore threaten the primary pathway through which millions of low-income children receive routine immunizations.

Policy Recommendation

Congress and state governments should act to restore and protect the independence of ACIP and reaffirm their commitment to evidence-based immunization policy. This includes reappointing qualified epidemiologists and immunologists to federal advisory panels, maintaining the evidence-based vaccine schedule used by the Vaccines for Children program, and investing in community-based outreach to rebuild vaccine confidence—particularly in communities of color where historical mistreatment and systemic barriers have contributed to long-standing mistrust of medical institutions.

SUPPORTING MEDICAL INNOVATION AND EXPANDING EQUITABLE ACCESS TO EMERGING TREATMENTS

Rebuilding trust in healthcare institutions also requires demonstrating that the health system can deliver meaningful medical innovation, including to populations that are disproportionately affected by chronic disease. One of the most significant recent advances in this area is the development of GLP-1 receptor agonist medications, including semaglutide-based treatments such as Ozempic and Wegovy.

Obesity and related chronic conditions represent one of the largest drivers of poor health outcomes in the United States. Obesity accounts for over $170 billion in annual healthcare expenditures and leads to chronic health problems and shorter life expectancy. Nearly three-quarters of American adults are overweight or obese, increasing the risk of diabetes, cardiovascular disease, and other serious health conditions. Moreover, obesity impacts some people more than others, including Black, Hispanic, and Native American communities, as well as adults with less education.[74]

GLP-1 medications have demonstrated substantial benefits beyond weight loss, including improvements in cardiovascular health and reductions in diabetes and kidney-related complications.[75] Yet access to these medications remains deeply unequal. For example, coverage of these medicines for weight loss are explicitly excluded from coverage in Medicare and optionally covered in Medicaid.

Public policy will play a critical role in determining whether these innovations reduce or exacerbate health disparities. A CMS BALANCE model, announced in December 2025, offered one potential framework for expanding access by enabling coordinated drug pricing negotiations and coverage pathways for Medicare and Medicaid beneficiaries. However, the model has since been put on hold due to low insurer participation.[76]

Policy Recommendation

Congress and federal health agencies should support policies that expand equitable access to promising medical innovations, including GLP-1 medications and other emerging therapies. Medicaid programs should be authorized—and encouraged—to cover FDA-approved GLP-1 medications for obesity treatment where clinically appropriate, as determined by a patient's treating physician. The recent suspension of CMS's BALANCE model highlights the limitations of relying on voluntary plan engagement to expand access to high-cost therapies. While the current bridge approach is expected to maintain transitional access to GLP-1 therapies through 2027, it does not establish a durable framework for affordability or long-term coverage. Policymakers should therefore pursue more sustainable and accountable approaches that improve affordability while ensuring patients can access clinically appropriate, FDA-approved treatments without undue coverage restrictions.

Emerging technologies such as artificial intelligence–assisted diagnostics, telehealth expansion, and remote patient monitoring also hold significant promise for improving access to care in underserved communities. Ensuring that these innovations are deployed responsibly and equitably will be essential to strengthening trust in the healthcare system's ability to deliver meaningful improvements in population health.

CONFRONTING GOVERNMENT-SPONSORED HEALTH MISINFORMATION

Finally, restoring institutional trust will require addressing the growing problem of health misinformation originating from within government institutions themselves. When federal health officials promote claims that contradict established scientific evidence, the credibility of public health agencies—and the guidance they provide to patients and clinicians—is significantly weakened.

Congress should therefore maintain a permanent oversight posture regarding federal health communications. Regular hearings should review the evidentiary basis for major shifts in public health policy, particularly when those shifts diverge from longstanding scientific consensus or established international standards.

Legislative tools may also be necessary to protect scientific integrity within federal health agencies. Congress should consider strengthening statutory safeguards—through appropriations language or scientific integrity legislation—to ensure that advisory committees, research programs, and public health communications remain insulated from political interference.

Federal health reports and commission findings should be held to the same standards of citation transparency and peer review expected across the scientific community. Errors, unsupported claims, or "ghost citations" in official reports must be corrected promptly and publicly in order to maintain institutional credibility.

Finally, state and local public health agencies should be empowered to serve as independent validators of public health information. Community health workers, nonpartisan medical societies, and local public health departments remain among the most trusted sources of health information in many communities. Expanding support for these institutions—particularly in underserved areas—will be essential to rebuilding trust in the healthcare system during a period of heightened institutional skepticism.

Conclusion

The analysis presented in this report shows that the erosion of trust in public health institutions has become a defining challenge for the American healthcare system. During the COVID-19 pandemic, evolving guidance and political polarization strained confidence in medical authorities and public health agencies. More recently, federal policy changes threatened the credibility of institutions responsible for evaluating medical evidence.

These developments have had negative human consequences. Vaccination rates have declined. Care-seeking is often postponed, reduced, or ended. Maternal health outcome disparities have widened. Preventive services have declined. The critical healthcare facilitator, trust, is not functioning as it must.

Rebuilding trust is therefore a health imperative. It will require the re-installation of institutional safeguards that protect evidence-based standards. It will establish decision-making transparency. It will hold decisionmakers accountable. It will restore independence to scientific advisory bodies. It will ensure federal health communications are accurate. These measures, all within reach, will rebuild the bridge between health institutions and the people they are intended to serve.

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