MERCATUS CENTER
George Mason University

3434 WASHINGTON BLVD.
4TH FLOOR
ARLINGTON, VA 22201

PHONE: 703.993.4930 / 800.815.5711
FAX: 703.993.4935
WWW.MERCATUS.ORG

From the Desk of Robert F. Graboyes

January 31, 2022

Healthy Future Task Force Security Subcommittee
2112 Rayburn House Office Building
Washington, DC 20515

cc: Molly Brimmer
Andrew Keyes
Shane Hand

Dear Representatives Hudson, Banks, and Cole:

I am pleased to comment on the request for information (RFI) from the Healthy Future Task Force Security Subcommittee. I am a senior research fellow and healthcare scholar at the Mercatus Center at George Mason University and have taught 48 semester-long courses in health economics to midcareer healthcare professionals at five universities (1999 through 2017). My work has focused for eight years on how America can make healthcare as innovative in the next 30 years as information technology has been in the past 30. More recently, my attention has also turned to the increasing politicization of public health and of medicine. The Mercatus Center is dedicated to advancing knowledge relevant to current policy debates. Toward this end, its scholars conduct independent, nonpartisan analyses of legislation, rules, and proposals.

For the past eight years, I have argued that America's national healthcare debate focuses too heavily on federal insurance law and not enough on delivery system issues (e.g., telehealth, remote telemetry, drug and device approval, professional licensure, medical education, scope of practice, certificate of need, and corporate practice of medicine).[1] Over the course of the pandemic, however, another—deeply troubling—issue has, in my estimation, overtaken both delivery systems and insurance in importance: the rapid and powerful injection of politics and ideology into public health and into healthcare itself.

This letter addresses four questions posed in the RFI:

1. Question 15 asks, "How can Congress work to bolster Americans' confidence in public health institutions," particularly in light of "historical wrongs" and "skepticism of more recent public health measures"?[2]

1. For my signature work on this idea, see Robert F. Graboyes, "Fortress and Frontier in American Health Care" (Mercatus Research, Mercatus Center at George Mason University, Arlington, VA, 2014). Some specific ideas for federal action are in Robert F. Graboyes, "CMS's Proposed Rule Is an Admirable First Step toward Removing Healthcare Supply Barriers" (Public Interest Comment, Mercatus Center at George Mason University, Arlington, VA, October 2, 2020).
2. Healthy Future Task Force Security Subcommittee, *Request for Information*, 2021, 5, PDF file (on file with author).

2. Question 20 speaks of "the need for agile, adaptable public health agencies unencumbered by activities and actions beyond the scope of their core mission" and asks how such agencies might be created.[3]
3. Question 14 asks, "What flexibilities or authorities are needed to promote the adoption of policies and strategies in federal health programs to address . . . social determinants?"[4]
4. Question 16 asks, in part, "How can the federal government work to reverse both short- and long-term declines in vaccination against vaccine preventable diseases?"[5]

The answers to these questions are found in the following observations, which I expand on in the next four sections of this letter:

1. Public health has become an ideological monoculture.
2. Public health has grown elitist and opaque.
3. Public health focuses excessively on social determinants outside its expertise.
4. Public health has a checkered history. For these reasons, the public health sector communicates poorly with a substantial portion of the American population on vaccination and on other topics.

These tendencies are not new, but in the 20th century, the field of medicine's focus on individual patient care offered something of a counterweight to public health's excesses. Today, however, medicine itself shows signs of turning away from its focus on individual care and toward public health's social goals.

A caveat in advance: this response to the RFI is longer on complaints and shorter on solutions, as the latter are likely to take the form of many ad hoc actions, rather than broad, comprehensive policies. Many of the institutional factors driving the changes reside at the state level and in private entities, raising questions about the proper role of the federal government.

Public Health Has Become an Ideological Monoculture

Harold Pollack is a distinguished professor of public health at the University of Chicago and self-described "emphatic liberal Democrat." In an August 2021 *Politico* op-ed, Pollack writes that COVID-19 vaccination efforts are lagging in part because "the people spreading the message about the Covid vaccine"—that is, public health professionals—"don't look or sound much like the people who need to heed this message."[6] Pollack implied that vaccine hesitancy is largely a phenomenon among political conservatives. As such, he decried the lack of conservatives in schools of public health, leading to "palpable absolutism and lazy groupthink among progressives."[7]

In a September 2021 essay, I agree with Pollack's observation but suggest that public health's inability to communicate extends well beyond political conservatives.[8] My analysis of the data suggests that hesitancy may be as high or higher among other groups—e.g., young people, rural residents, Hispanic Americans, and African Americans. In the essay I quote Alex Woodruff, a health science specialist at Veterans Affairs Boston Healthcare System, who said the following of his experience as a graduate student at Boston University:

3. Healthy Future Task Force Security Subcommittee, *Request for Information*, 6.
4. Healthy Future Task Force Security Subcommittee, 5.
5. Healthy Future Task Force Security Subcommittee, 5.
6. Harold Pollack, "Why Public Health Experts Aren't Reaching Conservatives on COVID," *Politico*, August 12, 2021.
7. Pollack, "Why Public Health Experts Aren't Reaching Conservatives."
8. Robert F. Graboyes, "Conservatives and Public Health: A Warm Welcome into a Cold Climate," *Discourse*, September 17, 2021.

> When I began my graduate degree in public health policy, I expected debate to be valued by my fellow students. Unfortunately, I was wrong. . . . There is a culture on campus of "us versus them" that suppresses healthy discussions in class. I have tried to spark conversations by playing devil's advocate—arguing pro-business, pro-capitalism, and pro-religious expression. An uncomfortable silence falls over the classroom. This silence is a pillar of groupthink. It is a subtle but powerful influence that discourages students from thinking independently. Missed opportunities for students to explore ideas is the cost of letting this conformity persist.[9]

Public Health Has Grown Elitist and Opaque

The problem is not merely one of ideology, but also of elitism. It appears that during the pandemic, public officials at times withheld information from the public, disseminated false information, and suppressed dissenting voices. As a nonscientist, I am in no position to offer definitive opinions on the technical aspects of COVID-19 (e.g., the lab leak theory, efficacy of masks, relative merits of focused protection versus lockdowns, school closings, and vaccine passports). But it is obvious to me that public health's efforts to suppress evidence of a lab leak,[10] the public denial of masks' efficacy (perhaps to prevent runs on supplies),[11] and attempts to silence academic dissenters has taken a significant toll on the credibility of and trust in public health officials.[12]

Public health officials seem to discount the goals of ordinary Americans that may compete with goals of public health. For example, whereas reducing the spread of COVID-19 is good, mitigation measures involve some bad things: e.g., school closures, business closures and bankruptcies, damage to mental health, and loss of community. Done properly, lawmakers and regulators must consider both costs *and* benefits when making policy.

Elitism is also evident in attempts by public health—and now by the medical profession—to impose a politically correct vocabulary on health professionals. "Preferred Terms for Select Population Groups & Communities,"[13] a web page of the Centers for Disease Control and Prevention (CDC), calls for "an ongoing shift toward non-stigmatizing language." The result though, discourages short, succinct, familiar terms in favor of long, ponderous, nonintuitive circumlocutions. For example, the CDC's "inclusive communication principles" dictate that one should no longer speak of "inmates" or "prisoners"; instead, one must say "persons who are incarcerated." Nine syllables instead of two or three. Someone wishing to discuss prisoners now must spend time learning the new phraseology, thinking of the substitutions while communicating, using longer and less intuitive phrases, fearing politically incorrect errors, and enduring criticism when they err.

These prescriptions raise the question as to whether prisoners actually prefer to be referred to by the nine-syllable expression rather than by "inmate." Do those who smoke actually prefer being called "people who smoke" rather than "smokers"? Do "poor people" feel better if called "people with incomes below the federal poverty level"? Or are these simply the ideas of people inside the bubble pretending to know what people outside the bubble think and forcing their ideas on colleagues?

The CDC's prescriptive vocabulary is tame compared with that found in a 54-page speech code released in October by the American Medical Association (AMA) and the Association of American

9. Alex E. Woodruff, "Are Public Health Schools Politically Diverse?," *Public Health Post*, January 24, 2019.
10. "Those Who Suppressed the Lab-Leak COVID Theory Need to Be Investigated," *New York Post*, June 8, 2021.
11. Jacob Sullum, "Anthony Fauci May Not Have 'Lied' about Face Masks, but He Was Not Exactly Honest Either," *Reason*, June 4, 2021.
12. "How Fauci and Collins Shut Down Covid Debate," *Wall Street Journal*, December 21, 2021.
13. "Preferred Terms for Select Population Groups & Communities," Centers for Disease Control and Prevention, accessed January 21, 2022, https://www.cdc.gov/healthcommunication/Preferred_Terms.html.

Medical Colleges (AAMC).[14] This document foists a mind-numbing array of prescriptions on the speech of doctors and medical students. It is loaded to bear with leftist ideology and proudly declares its origins in critical race theory. And it makes clear that doctors' central mission is social justice goals, not individual care. One can argue that the code aims to make the practice of medicine a subspecialty of public health. The following four prescriptions in the code are evidence of that aim:

- Do not say, "Low-income people have the highest level of coronary artery disease in the United States."[15] Instead say, "People underpaid and forced into poverty as a result of banking policies, real estate developers gentrifying neighborhoods, and corporations weakening the power of labor movements, among others, have the highest level of coronary artery disease in the United States."[16]
- Do not speak of an "under-served community."[17] Instead, call those people "historically and intentionally excluded" from proper care.[18] There are no sins of omission; someone consciously decided to underserve this community and deprive its residents of care.
- Do not use the term "free clinic," because the word "free" creates a "pejorative narrative that undermines equity."[19]
- The document itself aims to "'shift the narrative'—from the traditional biomedical focus on the individual and their behavior to a health equity focus on the well-being of communities, as shaped by social and structural drivers."[20]

Christine Rosen, a scholar who studies technology and ethics, says that the likely result of this document will be "to burden medical professionals with the task of constantly signaling their allegiance to this new ideology rather than simply being good doctors."[21] She argues that an underlying theme of this new vocabulary is that the AMA "wants its members' primary focus to be social justice, not medical care."[22]

Shifting doctors' focus from the well-being of individuals to the well-being of communities is not a new idea. Paul Lombardo, professor of law at Georgia State University, writes

> [In 1912, the] medical educator Harvey Jordan . . . predicted that in light of eugenics and the "general change from individualism to collectivism," all medicine would eventually be transformed to public health, and all physicians from "doctors of private diseases" to "guardians of the public health." Medicine would become "a science of the prevention of weakness and morbidity; their permanent not temporary cure, their racial eradication rather than their personal palliation."[23]

14. American Medical Association and Association of American Medical Colleges, *Advancing Health Equity: A Guide to Language, Narrative, and Concepts*, n.d.
15. American Medical Association and Association of American Medical Colleges, *Advancing Health Equity*, 20, table 5.
16. American Medical Association and Association of American Medical Colleges, 20, table 5.
17. American Medical Association and Association of American Medical Colleges, 11, table 2.
18. American Medical Association and Association of American Medical Colleges, 11, table 2.
19. American Medical Association and Association of American Medical Colleges, 16.
20. American Medical Association and Association of American Medical Colleges, 16.
21. Christine Rosen, "Critical Race Theory Is Coming for Your Doctor," *Commentary*, November 23, 2021.
22. Rosen, "Critical Race Theory Is Coming."
23. Paul Lombardo, "Eugenics and Public Health: Historical Connections and Ethical Implications," in *The Oxford Handbook of Public Health Ethics,* ed. Anna C. Mastroianni, Jeffrey P. Kahn, and Nancy E. Kass (New York: Oxford University Press, 2019), 642.

Public Health Focuses Excessively on Social Determinants outside Its Expertise
The RFI proclaims a need for "health agencies unencumbered by activities and actions beyond the scope of their core mission,"[24] but it is not at all clear that public health agencies *wish* to be unencumbered by such activities. In a previous article, I note the following:

> As of 2021, the public health sector—which, by Pollack's description, is incompetent to communicate with half the American population about its core expertise (the spread of infectious disease)—has sought to claim manifest destiny over climate change, property law, racism, wages, voting laws, transportation, terrorism, crime, policing, juvenile justice, higher education, employment, incarceration, financial lending, identity theft, bullying, gentrification, human trafficking, online poker and who knows what else.[25]

The paragraphs include hyperlinks for each of those 19 topic areas. In another article, I return to this point:

> I'll add here that public health's imperial aspirations pose grave risks to America's constitutional stability. Public health exhibits a recurring pattern: (1) Declare that X is now a public health issue. (2) Declare that X is in crisis. (3) Flout legal and constitutional norms to quell said crisis. During the pandemic, the Centers for Disease Control and Prevention (CDC) declared that housing evictions were within the realm of public health and that evictions in high-infection areas constituted a crisis. The CDC therefore assumed authority to ban residential evictions, nullifying state property laws nationwide. (The US Supreme Court eventually curtailed the CDC's presumed authority.)[26]

Conor Friedersdorf refers to an "ideological double standard on protests" by public health officials during the pandemic.[27] At a time when public health officials were condemning even small get-togethers (including hospital visits and funerals) as dangerous, more than 1,200 public health officials publicly urged that people take to the streets in mass marches to protest racism.[28] Why? Because racism is allegedly a public health issue, and marches will somehow mitigate that curse. The result of this double standard, Friedersdorf writes, will be that "more Americans will decline to heed any public-health advice or journalism, seeing it as ideological and hypocritical."[29]

Public Health Already Has a Checkered History
The RFI refers to "historical wrongs" as a contributory factor in vaccine skepticism[30]—a point well taken. Over the 20th century, American public health was complicit in a long list of injustices, all the while couching those injustices in the trappings of science.

In 1927, Justice Oliver Wendell Holmes used vaccine mandates as justification for states to begin sexually sterilizing tens of thousands of Americans on the basis of spurious public health claims. In one of the most horrific sentences in Supreme Court history, Holmes wrote, "The principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes."[31] For four

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24. Healthy Future Task Force Security Subcommittee, *Request for Information*, 6.
25. Robert F. Graboyes, "Conservatives and Public Health: A Warm Welcome into a Cold Climate," *Discourse*, September 17, 2021.
26. Robert F. Graboyes, "The Pall of Politics Descends upon American Medicine," *Discourse*, November 24, 2021; Steven M. Herman and Eunji Jo, "COVID-19 Update: U.S. Supreme Court Holds That CDC Exceeded Its Authority in Issuing Eviction Moratorium," *National Law Review* 11, no. 242 (2021): 1–4, cited in Graboyes, "The Pall of Politics."
27. Conor Friedersdorf, "The Protesters Deserve the Truth about the Coronavirus," *Atlantic*, June 4, 2020.
28. Mallory Simon, "Over 1,000 Health Professionals Sign a Letter Saying, Don't Shut Down Protests Using Coronavirus Concerns as an Excuse," CNN, June 5, 2020.
29. Friedersdorf, "The Protesters Deserve the Truth."
30. Healthy Future Task Force Security Subcommittee, *Request for Information*, 5.
31. Buck v. Bell, 274 U.S. 200 (1927).

decades, the US Public Health Service, in particular the CDC, staged the horrific Tuskegee syphilis study on African-American men.[32] Legal historian Paul Lombardo has documented how, for the sake of "population health,"[33] 20th-century public health assisted in forced sterilizations, antimiscegenation laws, the prohibition of marriage for disabled Americans, and the deportation of immigrants on the basis of spurious IQ tests. It is understandable and unfortunate that some communities still eye public health pronouncements with suspicion, even decades after these events.

To put my remarks in context, it is important for me to mention that I am a great enthusiast for the COVID-19 vaccines. In my view, the mRNA platform may be the single most significant medical technology of the past 50 years—a potential gamechanger with respect to viruses, cancers, and genetic illnesses. Two doses of Pfizer-BioNTech vaccine went into my arm as soon as they were available, as did the booster six months later. The pervasiveness of vaccine hesitancy is lamentable, as is the needless suffering and loss of life that hesitancy yields. Vilifying the vaccine-hesitant, though, is unwise because, among other reasons, doing so is a particularly poor strategy for persuading the hesitant to become less so.

Conclusion

Summing up, the RFI notes several problems: Americans' confidence in healthcare institutions is less than ideal. Public health institutions appear distracted by extraneous activities. There is a need to consider social determinants. And vaccination rates have been dropping, even before the COVID-19-specific hesitancy.

In response, this letter notes a series of problems that undermines the trust in and efficacy of public health:

- Public health has become an ideological monoculture. The challenge is to bring ideological diversity—or at least tolerance—to a field that has difficulty speaking to those of a different philosophy.
- The field has also become elitist. During the COVID-19 pandemic, officials have suppressed scientific evidence, disseminated falsehoods, and intimidated scientific dissenters. They have failed to consider tradeoffs between public health's goals and Americans' other goals.
- Public health has drafted troublesome speech codes, and, in this regard, the medical profession has followed in public health's footsteps with a vengeance. In the case of medicine, one prominent speech code seems aimed at turning medicine toward social justice and away from patients' individual well-being. This speech code cites critical race theory as its inspiration and insists that doctors frame all health disparities as inequities, which are the conscious intention of some nefarious force.
- While public health struggles to carry out its core mission, its practitioners nevertheless are busily claiming sovereignty over vast portions of American economics and politics—a problem not only for health, but also for constitutional order. And all of these claims are emanating from a profession whose fingerprints are on some of the greatest civil liberties abuses in 20th-century America.

The challenge for federal lawmakers and regulators will be to rein in all of these problems without stripping public health of its ability to serve the public. For example, public health *must* have the ability to deal with nonmedical social determinants of health; but somehow, public health must face constraints on its ability to exert its power over all aspects of civic and personal life. Above all,

32. "The Tuskegee Timeline," Centers for Disease Control and Prevention, last updated April 22, 2021, https://www.cdc.gov/tuskegee/timeline.htm.
33. Lombardo, "Eugenics and Public Health."

Congress ought to look long and hard at attempts to politicize medicine itself—attempts that would turn physicians' attention away from individual patients and toward ideologically driven social engineering. It is important to remember that, with their new speech code in hand, the two most powerful medical organizations in America (the AMA and the AAMC) appear to have thrown their lot in with social engineering.

This is the challenge going forward. The future of Americans' health and of constitutional governance hangs in the balance.

Sincerely,

Robert F. Graboyes