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Vaccine hesitancy and regulations in the United States: A Foucauldian Perspective

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ABSTRACT

Vaccine hesitancy represents a critical barrier to equitable herd immunity, disproportionately affecting racial and socioeconomic minorities. This piece argues that state-imposed vaccine mandates reflect a paternalistic model of health governance that may inadvertently deepen public resistance. Drawing on Foucauldian biopower theory and empirical trust research, I argue that since citizens consistently distrust national health authorities over personal physicians, top-down mandates risk being perceived as instruments of state control rather than public care. I propose decentralizing health messaging toward independent professional bodies and trusted clinicians, adopting opt-out vaccine frameworks, and directing future research toward community-based delivery models that prioritize autonomy alongside uptake.

1. Introduction

Vaccine hesitancy poses a significant threat to public health, particularly for already-marginalized communities. Research demonstrates that hesitancy functions as a structural barrier to achieving equitable herd immunity among racial minorities, deepening existing health disparities [1]. Yet the dominant policy response of state imposed mandates may itself be part of the problem. In the United States, all 50 states condition school enrollment on proof of immunization against a core set of diseases. Required vaccines universally include MMR (measles, mumps, and rubella), varicella, DTaP, and polio; some states additionally mandate hepatitis B, meningococcal, and HPV vaccines [2]. While the federal government does not impose a national vaccine mandate on the general public, these state-level school entry requirements function as de facto mandates for ordinary families because compliance is a precondition for accessing public education. This piece argues that vaccine mandates reflect a paternalistic, state-centered model of health authority that may inadvertently fuel the very resistance it aims to overcome.

2. Limitations of Current Conventions

Hesitancy is not simply ignorance. It is, at its core, a crisis of trust in health authority. Evidence consistently shows that individuals place far greater confidence in their personal physicians than in national public health institutions. Silver et al. [3] found that only 2.3% of participants identified their own doctor as their least-trusted health information source, compared to 9.3% who attributed that distinction to national-level experts such as those at the NIH or CDC. This gap illuminates a fundamental mismatch: public health campaigns are frequently delivered through the very channels that citizens distrust most as health messengers.

This distrust is not irrational; it is, in many cases, ideologically grounded. Foucault's concept of biopower offers a useful theoretical frame: the clinic and allied state institutions produce scientific "truth" that serves to regulate populations, not merely to heal individuals [4]. When vaccination campaigns are administered through state apparatuses, citizens who perceive these interventions as exercises of "power over life", treating them as biological problems to be managed rather than autonomous agents, are likely to reject them outright. Resistance becomes a form of reclaiming bodily sovereignty and autonomy.

The consequences of this dynamic are visible internationally. In Zimbabwe's COVID-19 response, state biopower initially aimed at optimizing life gradually assumed the coercive character of sovereign and disciplinary authority as vaccines became more available [5]. This trajectory from healthcare to control mirrors the fears held by hesitant populations in Western democracies as well, and underscores why mandates, even when well-intentioned, risk entrenching rather than resolving resistance.

3. Potential Solutions

The school-entry MMR and varicella mandates described above are the primary context for this analysis. These requirements are unambiguously

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state-imposed: families who decline vaccination for their children on non-medical grounds are denied access to public education in 35 states, which do not permit personal belief exemptions [6]. The coercive dimension is therefore not hypothetical.

Addressing hesitancy in this framework requires decentralizing health authority away from federal agencies and toward trusted, nonpartisan professional bodies (i.e American Academy of Pediatrics when it comes to childhood vaccination) that carry scientific credibility without the political baggage of government affiliation. Guidance should flow clearly to physicians, who remain the most trusted messengers, rather than being broadcast primarily through state channels. Empowering clinicians to lead conversations about vaccine uptake reframes the interaction as personal healthcare rather than state compliance.

Where school requirements for vaccines such as MMR and varicella remain appropriate, incorporating personal belief-based opt-out provisions (rather than hard enrollment denials) may better balance coverage goals with individual autonomy. Evidence from behavioral health settings supports this approach: opt-out program designs achieve higher overall participation while preserving individual autonomy, as demonstrated by Richter et al. [7] in the context of tobacco treatment. Applied to vaccination, such a framework would maintain high coverage rates without the adversarial dynamic that coercive mandates create.

4. Future Directions

Future research must move beyond measuring hesitancy as a static attitudinal variable and instead focus on identifying trusted non-medical messengers within specific communities (i.e faith leaders, educators, and local advocates) who can deliver credible, culturally resonant health information. Equally pressing is the need to evaluate community-based vaccine delivery programs at scale, generating evidence on which models most effectively convert trust into uptake without reliance on state coercion.

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