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Populism and health policy: three international case studies of right-wing populist policy frames

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Abstract Over the past decade, some of the world's most stable parliamentary democracies have witnessed a revival in right-wing populist political parties, movements and leaders. Although there is a growing body of theoretical and empirical literature documenting the rise of populism, there has been very little exploration of the implications for health policy of this important political development. In this article, we draw from three illustrative international cases, originating from the USA, the UK and Italy, to explore the ways in which right-wing populism influences health policy: the election of President Trump in the United States (and subsequent healthcare reforms), the United Kingdom's vote to withdraw from the European Union (Brexit), and how this has played out in the context of the UK National Health Service, and the rise of a politically aligned anti-vaccination movement in Italy. Drawing on the work of the influential socio-political theorist Ernesto Laclau, we interpret populism as a performative political act, predicated on drawing logics of equivalence (and difference) between different actors. We use this theoretical framing to explore the ways in which the recent upsurge in right-wing populism creates a specific set of barriers and challenges for access to healthcare and the health of populations.

Keywords: populism, health policy, comparative politics, anti-vaccination, Affordable Care Act, Laclau

Introduction: an upsurge in populism

Over the past decade, many established liberal democracies have witnessed a new wave of 'right-wing populist' political movements, parties and leaders. The 2016 election of President Trump in the United States and, in the same year, the United Kingdom's vote to withdraw from the European Union (Brexit) as well as the election of the coalition government in Italy in 2018 have all been held to exemplify a populist backlash against the traditional institutions of liberal democracy. While these right-wing populist parties may have failed to win overall electoral victories, they have nevertheless succeeded, in many cases, in entering into coalition government, and have helped to shift mainstream political debate in the direction of agendas favoured by right-wing populists (Bernhard and Kriesi, 2019).

In this article, we consider the ways in which the upsurge in right-wing populism creates a set of specific barriers and challenges for access to healthcare and the health of populations. Our analysis is presented over four sections. To provide context to our argument, we first review

recent academic literature in the areas of populism and public health and health policy to help flesh out the contours of right-wing populist health policy making. We then situate this literature in relation to Laclau's work on the theory of populism. Following his logics of equivalence and difference, we elaborate a conceptual framework which surfaces processes underpinning populist policy making. We then survey a range of different policy regimes to identify three illustrative empirical case studies which demonstrate the key features of these policy processes. In essence, we are seeking to undertake sensemaking of populist politics with regards to health policy using different and appropriate country contexts. Our examples originate from the USA, the UK and Italy. All three empirical cases provide examples of the complex interactions between right-wing populist politics and the making of health policy, identifying points of complementarity and contradictions between particularistic populist policies which valorise specific groups contrasted with more universalistic health systems, predicated on a principle of a democracy of access. In presenting this analysis, we do not suggest that these health systems are comparable, rather that they are specific examples of the application of a performative politics of healthcare populism, such as the role of expertise and experts (see the Italian example), the role of government in relation to the provision of healthcare (the USA example), and issues of immigration and universality of access to healthcare (the UK example). We are interested in identifying the logics of equivalence and difference (Glynos and Howarth, 2007) which appear across each case and used to mobilise populist healthcare policies (despite differences in the ways that these healthcare systems are organised and managed). By identifying the influence of common populist practices across three very differing national contexts, we seek to surface the myriad ways in which right-wing populist politics serves to prioritise (or marginalise) particular approaches to health policy. We conclude by outlining the implications of our analysis for access to health care and the health of populations. For the sake of clarity, we note that populism is not necessarily associated with right-wing politics, and that it may also be linked to left-wing and centrist politics. Nevertheless, the examples we use in this paper are all examples which focus on the impact of right-wing populism on health policy, (from here, just populism).

Populism, policy and healthcare

Political ideology is central to how politicians and policy makers frame and devise solutions to healthcare issues (Herwartz and Theilen, 2014). In addressing these political processes, Lasco and Curato (2019) develop the concept of medical populism, which they define as 'a political style that constructs antagonistic relations between 'the people' whose lives have been put at risk by "the establishment" (p. 1)'. It is, they argue, characterised by three components, first, appeals to 'the people', which emphasise threats to public's health and safety. We see this mobilised in all three cases, but most notably around Brexit in the UK. Second, there is an emphasis on how healthcare issues might be performed as a crisis, usually through the creation of 'folk devils' and moral panics, where apparent threats to collective values and interests are amplified through inflammatory rhetoric and emotional appeals (Mannion and Small, 2019). Again, this is present through all three cases, but is most foregrounded in the Italian Anti-Vaccination case. Finally, the public outrage and anxiety engendered by such moral panics are addressed through 'common sense' solutions with political bargaining and compromise viewed as unnecessary and weak. This is most evident in our analysis of the reform of the Affordable Care Act (ACA) in the United States but again, it also features in the other two cases. Implicit in all three cases is a distrust of evidence-based policy interventions and the denigration of professional-technocratic expertise, often promoted via social media (Friedman 2019, Lasco and Larson, 2020, Mavragani and Ochoa, 2018). Similarly, Greer *et al.* (2017)

link populism with nativism, authoritarianism and a preference for ‘the common sense of the people’ over elite or expert and professional knowledge (see also Mudde 2010). Stoker (2019) sets out similar arguments in relation to the people’, that is, ‘as a group with shared ambitions and interests’ (p. 9) who are contrasted against a corrupt elite or establishment groups who are represented as failing the people. This is often promoted in populist rhetoric through notions of regret, nostalgia and the loss of past cultural identities with the aim of attenuating the potential for expressions of ‘mutuality and solidarity’. In all of these definitions there is an emphasis on the need to distinguish between the people and the elite, and furthermore to demarcate precisely which social groups comprise the people and which social groups are viewed as outsiders or the ‘other’. The populist logic is that it is the job of government to serve only the people and to ensure that those who are not deemed to comprise the people have more restricted access to services and public resources. These features are consistent across our three cases. In our analysis, we utilise the different cases to foreground specific elements of right-wing populist policy making.

Whilst well established in social and political science, the implications for populism for public health (Lindström 2020) and health policy are less elaborated. Taking an international perspective on the rise of populism, Pavolini *et al.* (2018) identified three key components that they contend are critical to an understanding of the complex relationship between healthcare governance, professions and populism: economics, governance and trust. Healthcare systems which are more resistant to populism tend to be those healthcare systems which are well-resourced, with a well-developed network-based model of governance and with professions who are seen to be involved in the policy process. Conversely, health systems that are more amenable to populism tend to be poorly resourced, with high levels of command and control New Public Management-type (NPM) governance arrangements, together with low levels of trust in healthcare providers. These findings echo Agartan and Kuhlmann’s (2019) findings on the impact of populism in the Turkish context. In the context of the three cases developed in this paper, the NHS systems of the UK and Italy might best be described as examples of Pavolini *et al.* (2018) second type, i.e. poorly resourced, with high levels of command and control NPM governance arrangements, and low levels of trust in healthcare providers. Certainly in the UK in 2016 the Royal College of Physicians (RCP) published a report claiming the NHS was underfunded, under-doctored and overstretched (Royal College of Physicians, 2016). Similarly, issues of affordability and access might be read as contributing to a lack of trust in US healthcare from the perspective of ‘the people’.

However, as De Cleen *et al.* (2018) argue, characterisation’s like this can give populism an apparent solidity and concreteness that bears very little resemblance to how it is actually enacted in real world policy contexts. Here, populism is better viewed as a set of rules (or grammars) which play out across all forms of politics, (regardless of whether they are expressly identified as populist or not), rather than being unique or distinct forms of a contemporary (predominantly) right-wing political zeitgeist. In taking this approach, it becomes necessary to direct an analytical focus onto the performative components of populist politics (that is to say, what it accomplishes, and how). In this framing, populism represents a set of rules or logics which can be used to accomplish particular types of political practice, including the reform of healthcare without (necessarily) provoking a crisis of political legitimacy.

Conceptualising populism

Laclau (2005a, 2005b) posits that a performative politics of populism is structured around logics of equivalence and logics of difference.

A logic of equivalence, as De Cleen, *et al.* (2018) outline, is not necessarily that particular groups are seen to (positively) have the same interests in common (i.e. have equivalence), but rather, more negatively, in that ‘they are all frustrated and endangered by “the elite”’ (p. 652). This is the point where they are equivalent and unites them against a common enemy. Populist appeals, couched in a context of finite and limited economic resources available to fund statutory healthcare (performed as a fiscal crisis), are intended to create equivalences between a range of actors (or ‘the people’), whose access to healthcare appears to be under threat from ‘unentitled free-loaders’ who have not made sufficient contributions (Murphy, *et al.* 2018). Similar arguments underpinned much of the health-related discussions of Brexit in the UK. In turn, these equivalences bleed into issues of welfare chauvinism, immigration control, racism, mistrust in politicians and expert professions and so forth. Particular groups are ‘othered’ through these processes to create an elite who are ‘depicted as depriving (or attempting to deprive) the sovereign people of their rights, values, prosperity, identity, and voice’ (Albertazzi and McDonnell 2008, p. 3).

Alternatively, a logic of difference is concerned with practices which seek to maintain existing structures, (Glynos and Howarth, 2007) by actively breaking down those self-same equivalences outlined above, such that people are not united in opposition to a self-serving elite. In this context, social demands and identities are managed in ‘ways that do not disturb or modify a dominant practice or regime in a fundamental way’ (Howarth 2010 p. 321). Furthermore, an emphasis is placed on policies developed with the intention of undermining any ‘challenges to the status quo . . .’ and this tends to be accomplished ‘by addressing some (or all) of the concerns expressed by various groups or subjects, thereby preventing the linking together of demands’ (*ibid* p. 321). That is to say, preventing the development of a logic of equivalence by effectively operating on a principle of ‘divide and conquer’ whereby the dominant regime seeks to separate the population into particular communities or groups. The subsequent operation of these different groups then prevents the articulation of demands and identities into a generalised challenge to the dominant regime (Glynos and Howarth, 2008). So, healthcare reform in the USA, for example, may be motivated by a desire to prevent the rise of social medicine challenging the established medical insurance vested interests in American political fields.

Logics of equivalence and difference enable the enactment of particular social rationalities and perform very specific functions for those deploying them. Laclau (2005a), argues that ‘populism’s relative ideological simplicity and emptiness should be approached in terms of what those processes of simplification and emptying attempt to perform, that is to say, the social rationality they express’ (p. 14). By focusing on what populism does, on which lines of equivalence and difference it draws in specific circumstances or cases, it becomes possible to conceive of populism not as a type of political movement, but rather as a form of political logic (i.e. similar to a set of rules for grammatical syntax), which allows a specific type or types of politics to be realised.

In seeking to surface how these populist performances are enacted within different healthcare contexts we now present three illustrative cases.

Case 1: The USA

Our first example considers attempts by president Donald Trump to repeal the Affordable Care Act (ACA) in the USA, and the mobilisation of a populist policy agenda in relation to reproductive healthcare. In terms of the ACA, the aim of the original legislation, enacted in 2010, was to make all Americans insurable, by requiring insurers to accept all applicants at rates based on population averages regardless of health status. According to Hall and Lord (2014), the ACA legislation resulted in 9 million previously uninsured people receiving healthcare

insurance. An election promise espoused repeatedly by Trump in the 2016 campaign was that he would repeal the ACA. In January 2017 Trump issued an executive order that

... directed federal agencies in his new administration to take immediate action to slow, impede, or halt the implementation of any provision of the Affordable Care Act that imposed a “burden” on individuals, healthcare providers, insurers, and states. (McCarthy 2017, p. 1)

In this extract, we see the mobilisation of a crisis around an issue of presumed financial unsustainability of the ACA. In March 2017, new proposed legislation intended to replace the ACA, (the American Health Care Act, the so-called Trump Care Act) was considered by the Congressional Budget Office. It stated that the proposed Trump Care Act would save \$337 billion, but that it would result in an increase in numbers of people without health insurance in the USA to 24 million. Much of Trump’s rationale on the need for the reforms focused on identifying a corrupt elite, and emphasised the purported economic burden and spiralling costs of the ACA, allied to claims of government over-reach, even that the government was slipping into socialism (Quadagno 2014). Appeals to these negative consequences were intended to legitimise these reforms, such that the fear of socialism would outdo the fear of a lack of insurance. These characterisations of the ACA, (in line with Lasco and Curato’s (2019) criteria of crises met with common-sense solutions), are gross over-simplifications of very complex legislation. Indeed, the ACA cannot be conceived of as a single piece of legislation, rather it is multifaceted with several distinct components (see Kamerow 2017, Sommers and Epstein, 2017). These include ‘subsidized health insurance exchanges, individual and employer mandates, regulations of the individual insurance market including a defined package of essential benefits, and Medicaid expansion’ (Sommers and Epstein p. 1). Any concrete analysis of burden and cost in relation to the ACA is difficult to argue with any certainty, and at best, the available evidence can only offer economic analysis operating at an individual rather than a population level. Claims to the contrary, are at best spurious, and could be said to evidence a performance of populist rhetoric intended to legitimise a specific social rationality, predicated upon a set of reforms, which on one level, could be argued to operate against the collective interest of the majority of the population. The Trump Care Act failed to pass through the legislature as senior Republicans voted in July 2017 against the proposed repeal. It is this failure that raises a number of issues with regard to a populist framing. Trump stood on a manifesto promise to repeal the ACA. In the context of performative populism, it could be argued that his electoral success meant that the electorate had voted for a real-terms reduction in access to affordable healthcare. However, populism did not work in this way in this particular context, and while Trump was elected, he was unable to reform the ACA. This suggests that there might be limits to how far it is possible to push a populist agenda. In this instance, it was not possible to blame the people for not being populist enough in their political support. Rather, the populist logic determined that blame for populist policy failures had to be attributed to political opponents and could not be apportioned to ‘the people’. This is because the logic or grammar determines that a populist politician cannot be seen or perceived to go against ‘the people’. Consider how ACA reform was framed as a campaign issue, based on nativist appeals to the unaffordability and unsustainability of a programme. This framing attempted to create a crisis or moral panic in the context of a policy which had extended healthcare to an additional 24 million people. In addressing this apparent contradiction, Ennsner-Jedenastik (2018) has argued that there is a very specific US context to these debates. The way in which the ACA was implemented as an equality-based system contradicted a dominant US cultural view of welfare nativism (whereby the principle of equality is negatively perceived as precluding the

possibility of nativism). Consequently, ‘universal healthcare and means-tested social assistance programmes are more prone to draw nativist appeals’ (p. 1). In this context, by focussing on principles of equality, it became possible for Republican politicians to raise the spectre of ‘socialized medicine’—and thereby to depict the ACA as un-American (Tuohy 2018 p. 445). This is clearly a form of nativism, but by opposing the ACA, it is simultaneously and somewhat contradictorily operating against the best (healthcare) interests of (all of) the people. A key component to covering over this contradiction appeared to involve performing the ACA crisis across fears about the triumph of socialism over American nativism, thereby ensuring that the groups being interpellated into the populist performance feel that the populist politicians are speaking to the general will of the people. As long as American nativism, with the distaste for big government and socialised medicine, can out flank questions of equality and social justice, then the contradiction can hold. As it actually played out, the failure of Trump’s alternative legislation, (the American Health Care Act, notice the imbricated nativism in the title of the legislation) suggests that this contradiction did not hold. There was clearly a degree of performative political work going on which enabled these contradictory positions. However, moves to repeal the ACA by the federal government continued after this initial failure. In December 2018, a federal judge in Texas ruled that the ACA was unconstitutional on a technicality around fiscal policy (Hoffman *et al.*, 2018).

In a performative sense, the failure might be seen to have occurred because the invocation of ‘the people’ was too weak to avert the restrictions on healthcare access that the American Health Care Act entailed. The articulation of ‘common sense’ socio-political demands failed to reach the level in which their aggregation could be said to express the general will of the people. However, the ways in which well-rehearsed populist appeals were mobilised against an imagined enemy, (represented as un-American and elitist) demonstrated the key populist grammars of (i) the sovereign people, (ii) the corrupt elite and (iii) asserting the general will of the people. All three were clearly mobilised in a logic of equivalence against the implied threat of purportedly socialist modes of government.

Reproductive rights represent another related area of health policy that have been affected by the proposed repeal of the ACA. Early in his term, Trump issued an executive order limiting access to abortion services (Starrs 2017). This order extended the global so-called ‘gag ruling’ on the use of family planning funds to pay for abortion services, (under the US Foreign Assistance Act). This worked in terms of preventing family-planning funds from being divested to foreign Non-Governmental Organisations that ‘provide abortion services, counselling, or referrals, or advocate for liberalisation of their country’s abortion laws—even if they use non-US government funds for these activities’ (Starrs 2017, p. 485). The 2017 executive order extended this principle, such that all global health assistance (i.e. not just family planning funding) was covered by this caveat. While having direct implications for abortion services, this would also adversely affect funding for healthcare programmes across low- and middle-income countries with regard to HIV/AIDS, the Zika virus, malaria, tuberculosis, nutrition and maternal and child health services, where those funded organisations may have links to abortion services (Starrs, 2017). Furthermore, there is a clear disconnect between research evidence and the formulation of policy. For example, Starrs highlights the lack of robust evidence to suggest that the global gag rule resulted in reduced rates of abortion. The harmful impact; however, was potentially far greater with the net result that millions of women ‘living in low resource settings’ may now be unable to obtain the care they need, when they need it (p. 486).

The performance of populist politics in relation to reproductive rights correspond with post-election claims made by Trump about women needing to be ‘punished’ for abortion, as well as claims that he would only appoint judges with an anti-abortion stance to the supreme court

(somewhat contradictorily, these comments deviated from public pronouncements made prior to his presidential campaign, see Girard 2017). In this context, ‘the people’ are the pro-life Christian right. This policy frame privileges a social rationality predicated upon an explicit Christian moralism, juxtaposed against empirical public health and population health data. As such, whilst the policy itself might not be characterised as populist, it is constructed and communicated in a populist grammar or framework, where logics of difference are clearly articulated through the stated policies. From this initial executive order, abortion rights have become a significant policy issue in the USA. As of June 2019, up to 12 states had implemented over 20 abortion bans, in what Nash, (2019) describes as conservative state legislator attempts to give the US supreme court ‘the opportunity to overturn or at least drastically undermine abortion rights’ (p. 2).

The fact that legislative measures targeting issues around reproductive health would appear to have had more political success where the less directly divisive ACA reforms have failed suggests two things. First, that attempts to invoke a logic of equivalence around socialist medicine in the reform the ACA largely failed, but, secondly, that attempts to invoke a logic of difference, around reproductive health, largely succeeded. This logic of difference was intended to bolster a heteronormative, Christian conception of family structure, and was accomplished through the use of populist tropes which would increase levels of inequality in relation to reproductive health.

Case 2: The UK

Our second case considers the 2016 referendum for the UK to leave the European Union (Brexit) and how the NHS was portrayed in political debate. The most immediate example when considering the role of healthcare in the Brexit debate was the oft repeated claim by *Vote Leave* during the campaign that EU membership cost UK taxpayers £350 million a week. This figure was displayed on side of the ‘Vote Leave’ campaign bus with a claim that following Brexit, this money would be spent on the NHS. However, rather than focus on the performance of this fiscal crisis, here our attention is on issues related to Brexit which possibly represent a more pernicious set of practices. We identify issues relating to equity of access, in terms the status of EU immigrants and their rights to seek or retain employment in the UK NHS, as well as entitlements around access to healthcare (either as EU nationals in the UK, or as post-Brexit UK nationals in the EU).

The UK NHS relies on the principle of freedom of movement within the EU to gain access to a skilled healthcare workforce. Populism, on the other hand, plays out against a background of national protectionism, and ways of limiting international cooperation and movement. In the wake of the UK vote to leave the EU, the principle of freedom of movement of EU citizens in the UK will be revoked. At the point of the referendum in 2016, this amounted to 55,000 people in the NHS’s 1.3 million work force, (McKenna, 2016). This raises fundamental questions with regard to how sustainable the provision of a national health service might be in post-Brexit UK? Here, we aim to demonstrate the performative nature of populism, by considering how it accomplishes certain effects at specific structural moments. Certainly, there appears to be a logic of equivalence which seeks to align against, and ‘other’, all that is ‘European’. Several commentators have argued that proving the (un)sustainability of the NHS is a long-time target of the political right in the UK (Davis *et al.*, 2015, Speed and Mannion, 2018). As such, performative appeals which created a healthcare crisis were coupled to a vocalised need to control and restrict immigrants’ access to the domestic labour market. In turn, this contradicted the fact that maintaining staffing levels in the NHS is impossible without the contribution of a trained and mobile immigrant labour force. If the popular mood within the country is anti-immigration, and if NHS levels of performance worsen because of the lack of migrant labour, the simple solution (i.e.

employ more migrants) becomes harder to implement—that is to say, it is a social rationality that is obviated or denied. The official government narrative may then become that the failure of the NHS can only be arrested by fundamental reform, for example, expansion of private provision, co-payments for non-essential services, payments for access to GPs and so forth. Indeed, many of these issues feature in ongoing policy debates about the sustainability of current funding models for the NHS (Jones and Loader, 2016). In this context, the decline of the NHS, at least in part, turns into an issue of immigration, played out amidst a contemporary populist rhetoric which maintains this as a price worth paying to ‘take back control’ of UK borders. By this elision, (a lack of) wider political commitment to the NHS is backgrounded by concerns around immigration and the need to expand co-payments and the like.

A similar logic of equivalence plays out in relation to inward health tourism which has been invoked as a major draw on scarce NHS resources. Rather than highlighting chronic underfunding, (see Royal College of Physicians, 2016), a populist explanation for an over-stretched NHS is to lay the blame firmly at the door of so-called health tourists. Hanefeld, *et al.* (2017) argue that this is nothing unique to the UK NHS. Concerns about patients who are resident in one country using a healthcare system in another country (without making a financial contribution), are frequently invoked alongside concerns about the sustainability of national health services and an inability for countries to control their national borders. In the UK, the government announced that from April 2017, hospitals in England would have a legal duty to charge patients who are not UK residents before any non-urgent planned treatment, in order to meet a targeted level of £500m in savings (McCartney 2017).

Even assuming that this might be possible, there is no way of assessing how much it would cost the NHS to recoup these savings. Hanefeld *et al.* (2017) note that of the total possible number for visitors from the European Economic Area (EEA), only 16 per cent were charged previously, compared with 65 per cent for patients from other countries—so the focus on EU nationals appears misplaced at best and pernicious at worst. In this regard, Lunt *et al.* (2015) highlight how many NHS trusts were actively targeting international patients as they were regarded ‘as a possible route to ameliorating pressure on stretched NHS resources’ (p. 338). Furthermore, there is a dearth of reliable evidence in this area. The International Passenger Survey (Hanefeld *et al.* 2017) identifies 52,000 foreign patients coming to the UK for treatment annually, but this figure includes all those people visiting with the intention to pay for their treatment, that is, there is no distinction between payers and non-payers. Contra to the 52,000 figure, the data further suggest that 63,000 UK patients, eligible for NHS care, go overseas for treatment, thus in effect providing a net saving to the NHS of over 11,000 patients, (but this could be more when private patients are considered). Relatedly, reciprocal EU rules mean that approximately 1 million UK citizens living outside the UK in the EU are entitled to the same healthcare as local residents (Simpkin and Mossialos, 2017). This means that EU nationals have the same rights to access healthcare in the UK. Comparatively, the number of UK pensioners in Europe stands at 145,000 compared to 4000 EU pensioners registered to use the NHS (Simpkin and Mossialos, 2017)—a difference (in favour of the UK) of over 140,000 patients. But the logic of equivalence works in the context of the individual patient, or the individual older grandparent, who cannot access a service. The foreign ‘other’ is then mobilised and blamed. Populist claims about negative effects of health tourism serve to direct attention away from an underfunded, understaffed and overstretched NHS. With an emphasis on radical change, populist tropes in the context of the NHS tend to be mobilised around logics of equivalence rather than logics of difference. These populist logics of equivalence therefore serve to express a particular social rationality predicated upon an EU other, who threatens the long-term sustainability of the NHS. Invoking this as a threat, right-wing politicians are able to argue that the best way to protect the NHS is to leave the EU. An alternative argument

might be that the supposedly negative economic consequences of Brexit may result in increased levels of health inequality due to insufficient fiscal reserves being available to fund a population-level health service. This alternative argument is backgrounded against a range of right-wing populist appeals to these wider processes.

Case 3: Italy

The development of vaccination is one of the most successful public health interventions in history, bringing with it the drastic reduction in the morbidity and mortality of a wide range of infectious diseases, including measles. Italy is a country with a long-standing tradition of high coverage of vaccinations, (Day 2019) but over the past five years a populist fuelled Anti-Vaccine movement has emerged which has questioned the safety of mandatory vaccination policies. There has been a reported drop in levels of MMR vaccination in Italy from 90 per cent in 2013 to 85 per cent in 2016 (Kennedy 2019), and the Anti-Vaccine movement has been influential in promoting the idea, particularly on social media platforms, that vaccinations are linked to autism (Lasco and Larson, 2020). This has resulted in a national ‘moral panic’ whereby parents were scared to vaccinate their children leading to a measles epidemic in which reported cases of measles in Italy rose from 840 in 2016 to more than 5000 in 2017 (Kennedy 2019). In a specific study of the Italian context, Giambi *et al.* (2018) reported that 15 per cent of Italian parents were vaccine hesitant, and that the primary reported reasons for this hesitancy were safety concerns. In response to the dramatic falloff in vaccination rates the Italian coalition government, led by the centre-left Democratic Party, introduced a law in July 2017 which made 10 childhood vaccinations (including measles, mumps and rubella) mandatory for all preschool and school-age children (*ibid*). This vaccination issue was then played out across a range of political contexts. In the lead up to the Italian national election in March 2018, two populist parties, the right-wing, anti-immigrant Lega Party, and the anti-establishment Movimento Cinque Stelle (5-Star Movement) both campaigned with Anti-Vaccine groups, promising to repeal the law that made vaccines mandatory for children. Both of these parties subsequently helped form a coalition government. During the campaign, Beppe Grillo, the founder of the 5-Star movement, linked mandatory vaccination policies with causing ‘leukaemia, poisoning, inflammation, immunodepression, inheritable genetic mutations, cancer, autism and allergies’ (Dyer, 2018). Other members of the movement backed the idea of promoting hazardous ‘measles parties’ where children gather to infect each other and build up immunity. Once in power, the new coalition government attempted to lift the mandatory requirement for vaccination. According to Day (2019), the government made plans ‘to reverse, then not reverse, then partly reverse’ this law. It proposed a new policy in July 2018 of ‘self-certification’ whereby parents would no longer be required to produce documentation of vaccination before their children would be allowed to enrol in school. Due to these ongoing problems in implementing this legislation, the Italian government, in December 2018, dismissed the entire panel of expert health policy advisers (30 in total). This resonates with populist appeals against professional expertise. For example, Day (2019) quotes Riccardi (then president of the Italian National Institute for Health) who stated in his resignation statement that it’s ‘clear that when the deputy prime minister says that for him, as a father, there are too many vaccines, and that they are useless and dangerous, this is not just an unscientific approach; it’s antiscientific’ (Day p. 1).

In one sense, there is nothing new in terms of these issues of vaccine hesitancy, the novelty lies in the Italian case of the alignment between vaccine hesitancy, Anti-Vaccine movements and populism. In terms of vaccine hesitancy, Dubé *et al.* (2013) detail how much of this behaviour is underpinned by doubts about the safety and usefulness of vaccines, typically organised around tropes of ‘risk perception and trust in health professionals’ (p. 1769).

This context presents a very salient case for thinking through the interplay and performative overlap between processes of populism and health policy. Larson *et al.* (2014) identify an additional contextual factor contributing to levels of vaccine hesitancy around the prevailing social norms of vaccination, that is, whether immunization is regarded as a social norm or whether it is seen as unnecessary or even a social harm. It would seem to be that it is in this space, around the perceived or assumed benefits (or lack thereof) of vaccination that performances of populism emerge, that is, that the doubts and concerns of vaccine hesitant citizens are mobilised and acted upon. For example, in an analysis of populist politics and vaccine hesitancy in Europe, Kennedy (2019) demonstrates a highly significant positive association 'between the percentage of people in a country who voted for populist parties and who believe that vaccines are not important' (p. 1). Kennedy (2019) argues that 'vaccine hesitancy in Western Europe ... seems to be driven by similar dynamics to those of political populists—that is, a profound distrust in elites and experts among disenfranchised and marginalised people' (p. 4). Here we see the mobilisation of familiar logics of equivalence, this time railing against a scientific elite. However, just as with the ACA where the policy outcome will be reduced access to healthcare, or with Brexit where population healthcare may prove more difficult to provide, it is hard to see what the political or populist 'gain' might be in promoting behaviour that could lead to epidemics, that could be seen to harm the health of 'the people'. This becomes even more problematic when we consider the fact that people, especially children, are vulnerable to these processes, and may die as a result of these populist logics of equivalence. This raises a question of how it is possible to maintain a populist position in the face of a moral question of increased childhood mortality from preventable diseases? In addressing this apparent contradiction, we see the utility of the populist Anti-Vaccination position, as it functions, directly and emotively, to undermine and discredit a system of scientific-technical knowledge. In this context, the populist Anti-Vaccination movement is perhaps better regarded as a political recruitment tool rather than a legitimate claim for counter-expertise. Therefore, Anti-Vaccination serves as a clarion call for the populist cause. Mavragani and Ochoa (2018) in a study of the relation between the Anti-Vaccine movement and the internet, demonstrate a strong negative correlation between online interest (i.e. internet searches) for the term 'Anti Vaccine' and the fluctuating worldwide immunization levels from 2004 to 2018. They suggest this link may 'be supportive of previous work suggesting that conspiracist ideation is related to the rejection of scientific propositions' (p. 1) and that the internet (and by extension social media) has been pivotal in the reproduction of bogus arguments around anti-vaccination.

Certainly, the populist alignment with the Anti-Vaccination movement in Italy is an example of a populist performance involving the 'post-truth' dissemination of 'fake news' (Speed and Mannion 2017), via social media platforms, to create and sustain a moral panic which plays on deep seated atavistic fears around vaccination and public safety. Here, logics of equivalence are drawn around purportedly brutal acts of state oppression and immunisation in emotionally charged tweets which compare vaccination to a 'death sentence'. In this performance, a 'vertical division' is made between 'the people' who are portrayed as victims and the political and medical establishment who are depicted as being in the pocket of big pharma to promote a profit driven health policy that causes autism in children. The performance of these practices serves to align 'the people' with, in the Italian case, Lega and the 5 Star Movement.

Discussion

Across these three cases we have sought to highlight how conceiving of populism as a form of political logic allows an analysis of the ways in which right-wing populist politics mobilises

differential social rationalities, in pursuit of political ends. We have demonstrated how populist policies tend to create specific barriers and challenges for people accessing services, and for the types of services that are available. We elaborate on these points in Table 1.

Table 1 summarises how logics of equivalence and difference have been mobilised in our three cases. Across the cases we contend that it is possible to identify five common characteristics structured around the following questions: (i) who are mobilised as ‘the people’?, (ii) who are mobilised as enemies of the people?, (iii) how the people and their enemies are associated and articulated in terms of a crisis?, (iv) what the claimed cause of the crisis is?, and (v) what the proposed solution to the crisis is? These characteristics combine insights from our own analysis presented here and support ideas developed in previous research (see Lasco and Curato, 2019, Stoker 2019). They demonstrate the ways in which complex health issues come to be interpellated into wider social rationalities which problematise opposing political views (e.g. socialism, pan European government or population level public health) and create policies which seek to block or challenge those views. The performance of populism through health policy becomes a vehicle for wider political critique by populist actors.

In the context of the ACA, the fiscal unsustainability of the programme of provision was evoked as a primary need for reform. In the context of Brexit, distant (indeed foreign) patients and bureaucrats were mobilised as a threat to people’s ability to access free universal healthcare. As with the ACA example, the UK example was also predicated upon concerns around fiscal sustainability, but these were more explicitly aligned to nativism and welfare chauvinism. In Italy, questions of expertise were called into question, and mobilised around a threat to levels of child morbidity and even mortality.

While Table 1 highlights how Laclau’s logics of equivalence and difference can be used as lenses to explore how populist performances are enacted as crises or moral panics, it does not illustrate the consequences of these solutions (e.g. how these logics of equivalence will result in 24 million Americans no longer having health insurance cover, or in Italy, an increased likelihood of a measles epidemic, with attendant fatalities). This is because these consequences do not feature in the performance in terms of the logic of equivalence. This is in large part because (implicit) in all three components is a distrust of technocratic expertise. Certainly, the moves contained within these policies would correspond with a model of healthcare governance more predisposed to populist characteristics (Pavolini *et al.* 2018).

Concluding remarks

In this article, we have interpreted populism as a set of performative practices which serve to mobilise public opinion towards particular populist political projects in the context of healthcare policy. Our intention has been to focus on, and critique, what populism does, rather than point to what it is. As such we argue that we need to be able to consider the ways in which populist politics are enacted in and around particular sets of healthcare policies (as sites of political demands or practices, i.e. specific social rationalities), which may be organised to bolster (or resist) alternative political positions. This is accomplished through the imposition of the specific types of challenges and barriers we address in this paper, in terms of welfare chauvinism, nativism and the like.

In a health policy context, by focussing on what populism does, we attempt to shed light on the direct consequences of these tactics. The political value of populist strategies is largely self-evident in terms of the purchase it gives politicians in reforming healthcare systems (the perversity of populist practices effectively limiting public access to healthcare is not lost on

Table 1 *Logics of equivalence and difference*

	<i>The people</i>	<i>The enemies</i>	<i>The crises</i>	<i>The causes</i>	<i>The solutions</i>
USA	American citizens/ pro-life campaigners UK tax payers/ Leave voters/pro Brexit politicians	Opposition politicians (i.e. democrats)/socialists/ pro-choice campaigners Supra-national government (i.e. the EU)/ remain voters/anti-Brexit politicians	Unsustainable healthcare provision Unsustainable healthcare provision	Big government & socialism Ineffective immigration controls Un-entitled foreign patients draining NHS resources	Repeal the legislation End freedom of movement Take back control by replacing EU legislation with UK laws Promote and implement individual choice and anti-vaccination policies
Italy	Italian Parents	Health professionals/state healthcare/big pharma	Dangerous vaccinations	Self-serving medical elites and scientific experts/population level public health	

us). However, it is insufficient to simply highlight problems with the veracity of populist rhetoric. The examples we have selected illustrate a tendency to perform populism around logics of equivalence, which function to demarcate in-groups from out-groups and mobilise public and political actions in relation to those groups. In this context performative populist practices can be understood as attempts to forge new political alignments through processes of contestation and change. Simultaneously, they can also be mobilised to protect and maintain partisan and vested interests. It is for this reason that it is vital that we work with a conception of populism that allows for the fluidity and dynamism of the populist performativity to be considered. In regard to health policy, populist practices can be seen to be promoting a range of social, political and economic inequalities in population health. It also has a very real effect on determining which inequalities might be targeted for treatment and covered by research funding (and by implication those that are ignored or marginalised). If health policy is to remain a process whereby government provides a level of healthcare to the population, or in the case of reproductive health, where the state takes a role the determining the legality of specific interventions, the role and influence of populism on health policy needs to be better understood in order to safeguard universal access and promote equity of treatment and access for all groups in society. These concerns remain current as it is clear that populist leaders across the world have used public anxiety created by the COVID-19 pandemic to reinforce nativist appeals around the need to defend borders and control immigration. This will become increasingly salient as we exit the pandemic with rising economic insecurity and the potential for a second wave of infections fuelling xenophobic claims with others/migrants being invoked as limiting the ability of 'native' citizens to access health and welfare services.

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