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Research Article

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Medical Populism and COVID-19 Testing

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Abstract: This paper uses the lens of medical populism to analyze the impact of biocommunicability on COVID-19 testing through a case study approach. The political efficacy of testing is traced through two mini-case studies: the Philippines and the United States. The case studies follow the approach of populism scholars in drawing from various sources that ‘render the populist style visible’ from the tweets and press releases of government officials to media reportage. Using the framework of medical populism, the case studies pay attention to the ways in which coronavirus testing figured in (1) simplification of the pandemic; (2) spectacularization of the crisis; (3) forging of divisions; and (4) invocation of knowledge claims. Identifying and critically analyzing how knowledge is generated is an essential step to recognizing the impact that political styles have on the COVID pandemic. The political actors in each case study have shaped knowledge of the epidemic, in the way they construct the idea of ‘testing’, and in how they mobilize testing as an ‘evidence-making practice’. Their actions shaped how the pandemic—as well as their responses—is measured. This framework contributes to public policy debates by providing evidence of the impact of medical populism on pandemic response efforts.

Keywords: COVID-19, pandemics, viral testing, medical populism, biocommunicability

1 Introduction

As the COVID-19 pandemic has spread across the world, we have seen drastic differences in responses to this unprecedented health crisis along political lines. Political influence—including individual political actors—has affected not just how the virus is transmitted, but how knowledge is produced, and how technology is mobilized—especially in the context of the first pandemic to emerge while citizens have instant access to information at their fingertips. Given the central role of information in the pandemic, this paper uses the lens of medical populism to analyze the impact of biocommunicability—that is, the production, circulation, contestation, and materialization of medical knowledge—on COVID-19 testing through a case study approach. We argue that through discursive practices and policy responses, coronavirus testing became a populist trope that simplifies and spectacularizes the COVID-19 crisis. Testing has drawn its valence from its ability to quantify the pandemic and render the coronavirus visible—as well as from the ways it has been performed and mediatized.

We trace the political efficacy of coronavirus testing through two mini-case studies: the Philippines and the United States. Amid a worsening pandemic, coronavirus testing in the Philippines emerged as a contested field that allowed political actors to either cast themselves as heroes (e.g. through the spectacularization of testing programs—including substandard rapid antibody tests)—or cast the government’s response as a failure (e.g. through demands for ‘mass testing’). Meanwhile, in the United States, the simplification of the crisis through a denialism of its severity slowed the government’s ability to ramp up testing, likewise raising critiques of a failed response—and demands for scaled up testing as key to controlling to the pandemic. Both case studies show that the efficacy of coronavirus testing lies

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beyond its ability to define, however imperfectly, the positive or negative infection status of individuals or populations, but also the fortunes of individual political actors and their decision-making, which can spell the difference between life and death for their publics. That health crises are increasingly vulnerable to politicization has been evidenced in recent years, and SARS-CoV-2 is showing how this divisiveness puts the whole world at risk. Analyzing the public policy-making process using the medical populism biocommunicability concepts, this paper illustrates the impacts of individual political actors on effective response efforts during a pandemic.

2 Background

The field of anthropology has a long history of engaging with epidemics. Relative to the AIDS epidemic anthropologists have contributed a diverse array of work, including calls for culturally appropriate approaches to AIDS prevention (Bolton & Singer, 1992) and local understanding of stigma and social construction of HIV/AIDS (Castro & Farmer, 2005; Moyer et al., 2013). Within outbreaks of influenza anthropologists highlighted a need to focus on diverse issues from politics of knowledge and blame (Leach & Tadros, 2014) to biopolitics (Briggs & Nichter, 2009). During the 2013-2016 Ebola epidemic of West Africa anthropologists highlighted the importance of community-centered responses to epidemic control (Abramowitz et al., 2015) and the positive impact of involving local knowledge and expertise in the response effort (Richards, 2016). Recently epidemic responses have been impacted by the rise of global populist movements.

Hewing closely with the strands of populism scholarship that emphasized the stylistic and rhetorical elements of political performances (Moffitt & Tormey, 2014; Brubaker, 2017), Lasco & Curato (2019) introduced the concept of ‘medical populism’ to describe “a political style that constructs antagonistic relations between ‘the people’ whose lives have been put at risk by ‘the establishment’ in the context of health crises” (p. 1). While any contemporary issue can be used as a populist trope, they argued that health emergencies are particularly vulnerable to politicization given their demands for urgent action and their life-and-death consequences. Following Moffitt (2016), medical populism was defined as a style that thrives by simplifying and spectacularizing complex public health issues, alongside the classic populist element of forging divisions. When faced with fear of a novel virus, there can be a tendency to divide society into ‘us’ and ‘others’, which leads people to distance themselves from the perceived threat (Ennis-McMillan & Hedges, 2020). We have seen this divisiveness play out in other health emergencies such as the initial ‘moral panic’ around HIV/AIDS (Farmer, 1990), as well as recent infectious disease outbreaks like H1N1 (Schoch-Spana, 2008), and Ebola (Gomez-Temesio, 2018).

Building on the above literature, Lasco (2020a) identified four elements of medical populism in the COVID-19 pandemic, namely, (1) simplifying and downplaying the pandemic and denial to the promise of treatments; (2) dramatization of the crisis and government’s responses to it; (3) forging of divisions between the public, elites, and ‘dangerous others’; and (4) invocation of knowledge claims to support the above. Such a style, *The Lancet* averred, has contributed to countries’ failure to address the pandemic (Sacks et al., 2020). While warning that populist leaders have heterogeneous responses and that the lens of populism has explanatory limits, populism scholars have nonetheless acknowledged that this kind of analysis has significance that ‘goes beyond the hype of merely putting the words ‘pandemic,’ ‘crisis’ and ‘populism’ in the same sentence’ (Katsambekis & Stavrakakis, 2020, p. 4; see also Brubaker, 2020; Speed & Mannion, 2020).

To further understand how this political discourse has played out in the public sphere, an investigation of ‘biocommunicability’ (Briggs & Nichter, 2009; Briggs & Hallin, 2010) is useful. The notion of biocommunicability calls attention to the practices that structure the circulation of medical knowledge, the performativity of this knowledge in constructing subjects of biomedicine, and the links between people’s responses to information and uptake or resistance to the messaging. In the context of emerging and ever-expanding global connectivity, knowledge circulation happens at rapid speed and from multiple directions simultaneously. Within this complex web of knowledge production and circulation is a lively dynamic of validity and ‘fake news’. COVID-19 pandemic has coincided with a parallel ‘infodemic’ (Starbird et al., 2020; WHO, 2020), described by the World Health Organization (WHO) as widespread sharing of false and misleading information. In crises people strive to gain knowledge and understanding of what is happening, resulting in searching, disseminating, and synthesizing content (Starbird et al., 2020). This process is called ‘collective

sensemaking' and is a critical step in being able to respond to crisis situations (Comfort et al., 2004; Shklovski et al., 2008). Campaigns of misinformation can influence collective sensemaking and range from spreading organically through friends and relatives on social media to government officials working to consolidate political power.

Living through a pandemic, what is at stake in these contestations of medical knowledge is not just the political fortunes of public officials but also their decision-making, which affects the lives and livelihoods of their constituents—particularly in moments of crisis when exceptional measures are justified. As Briggs and Nichter write: “Any account of infectious disease reifies certain players, circuits, practices, forms of authority and imbues them with different moral and affective characters to produce and hold knowledge” (2009, p. 193). In other words, biocommunicability becomes a matter of biopolitics. The specific focus of this article is the public sphere model for biocommunicability, in which “information is assumed to be useful because it helps citizens and policy-makers to make collective decisions about the public interest” (Briggs & Hallin, 2010, p. 152). Using this model, we focus on how information on COVID-19 responses has been communicated by politicians to the public across media platforms as a form of knowledge generation.

There are many aspects of the pandemic that have emerged as populist tropes and fault lines for biocommunicability—from its very nature (e.g. “It came from a laboratory in Wuhan”), the infectiousness of the pandemic, to the possibility of cures and vaccines (e.g. hydrochloroquine or bleach) (Lasco, 2020). The linchpin to communicating about the pandemic, from transmission rates to response efforts, is testing. Anthropologists have contributed substantially to the literature on testing during epidemic outbreaks, including exploring how testing can take on dimensions of morality (Hardon et al., 2011; Moyer et al., 2013) and equity (Castro & Farmer, 2005). Stigma and discrimination have emerged as prominent themes in these debates. As Schoch-Spana declared in reference to the influenza pandemic, using a ‘fortress mentality’ of imposing quarantines does not always translate into effective disease control because it creates a “geography of blame” (2006, p. 36). Lowe (2010) demonstrated with the Southeast Asia H5N1 avian influenza that responses focused on stopping the disease ‘there’ before it came ‘here’ created boundaries between ‘risk’ and ‘blame’. In addition, Briggs (2004) cautioned against the “politics of exclusion” during cholera epidemics in Venezuela. This article contributes to the literature on viral testing by analyzing the political dimensions of testing, mindful of its ‘symbolic power’ by making the invisible real (Hedges, 2020)—and its prominent role in framing COVID-19’s ‘outbreak narrative’ (Leach & Tadros, 2014).

There is also a rapidly growing body of literature analyzing policy and political responses to the pandemic. Serikbayeva et al. (2020) analyzed state capacity in responding to COVID-19 and found government effectiveness as a key association for lower death rates. Capano (2020) traced the COVID outbreak in Italy and demonstrated that a robust response effort was only possibly through ‘careful preparedness and experience policy-makers (p. 341). Klingler-Vidra et al. (2020) analyzed Vietnam’s state effectiveness and capacity for COVID-19 testing services. Vietnam’s successful development and deliveries of rapid tests were due, in part, to the widespread mobilization of different sectors to respond to the crisis. Their findings support that a key to successfully controlling the pandemic is the ability to mobilize and coordinate international, governmental, and non-governmental responses.

Less explored, however, have been the impacts of populism on health policies, and to return to our earlier concern on biocommunicability, how populism mediates publics’ understandings of infectious disease outbreaks. Notable exceptions include Speed and Mannion’s (2020, p. 1977) work on right-wing populism which found that ‘populist policies tend to create specific barriers and challenges for people accessing services’. Pavolini et al. (2018) also identify which healthcare systems which were more resistant to populist discourse: those that are well resourced, guided by network-based governance, and have medical professionals involved in the policy process (p. 1147). Our contribution to this debate is to analyze how a particular technology—i.e. COVID testing—has been used as a populist trope in various ways, and in the process, illustrate the impacts of medical populism on governance during times of health crisis.

3 Case Studies

Two mini-case studies are presented in this paper, looking at how coronavirus testing emerged as populist tropes in two countries: the Philippines and the United States. These two countries—one representing the Global North, another the Global South—underscore the geographic and cultural range of its instantiations, particularly in light of the two countries’ distinct political contexts: a polarized, two-party system in the US (Lee, 2020), and a more personality-based

political regime in the Philippines (Teehankee & Kasuya, 2020). Noteworthy, too, are the authoritarian tendencies of two countries' leaders—albeit with varying degrees of actualization: while President Rodrigo Duterte has been implicated in extrajudicial killings and acts of violence, Donald Trump's attempts to go beyond his Constitutional powers have been '[clumsy] and to little effect' (Lowndes, 2020, p. 54). Additionally, the authors are citizens and medical anthropologists living in each of these chosen countries, and, as participant-observers, their lived experiences and *emic* perspectives of the pandemic likewise inform this paper.

Each case study was written independently by each author and follow the approach of populism scholars in drawing from various sources that 'render the populist style visible' (Lasco & Curato, 2019), from the tweets and press releases of government officials to media reportage (Moffitt, 2016; Mudde & Rovira Kaltwasser, 2018; Lasco, 2020a). Following a brief overview of the pandemic in the country, each case study is organized thematically, highlighting instances in which coronavirus testing materialized in the actions and rhetoric of political actors—and how the public responded to such performances. Using the framework of medical populism, the case studies pay particular attention to the ways in which coronavirus testing figured in (1) the simplification of the pandemic; (2) spectacularization of the crisis; (3) forging of divisions; and (4) invocation of knowledge claims.

3.1 Testing in the Philippines

Elected in 2016, Rodrigo Duterte's administration has been dominated by populist policies, including a deadly and spectacular 'drug war' that has claimed the lives of tens of thousands of people (Lasco, 2020a). He himself largely stayed away from a dengue vaccine scandal that implicated his predecessor. His allies have nonetheless engaged in medical populism, (Lasco & Larson, 2019), which would also characterize his response to the COVID-19 pandemic. He shifted from downplaying its significance to dramatizing his responses through displays of force, punitive lockdowns, and promises of a forthcoming vaccine. His critics have sharply criticized Duterte's approach, claiming that he has used the pandemic to stifle dissent, perpetuate human rights abuses, and facilitate a public health crisis through his inaction, incompetence, and misplaced priorities.

From the time the first COVID-19 cases were reported in late January, coronavirus testing has served a domain in which such political contestations have been instantiated, taking on heightened significance as the measure and substance of the nation's overall health and as a signifier of the government's overall pandemic response. Which kinds of tests (e.g. PCR vs. rapid tests), who gets tested (e.g. VIP testing vs #MassTestingPH), and what the tests reveal (e.g. positive vs. negative; "flattening the curve" vs. a worsening outbreak), all became points of tension and debate, pitting the national government against local politicians, critics, and health advocates.

3.1.1 Testing as Spectacle

In the early stages of the outbreak, one of the major issues was the capability of the government to perform testing. Initially, the country's Department of Health (DOH) had been sending samples to an Australian laboratory, and news coverage featured the agency's steps towards acquiring capacity and reassuring the public that there were enough primers, test kits, and other supplies. On January 29, 2020, the DOH announced that the country could do local tests, and in mid-February announced the activation of "five subnational laboratories" in different major islands in the archipelagic country. "In line with its strategy to #BeatCovid19, DOH is accelerating its COVID-19 testing capacity," the agency said in a press release (DOH, 2020).

As the number of cases increased, however, public dissatisfaction mounted, calling into question the adequacy of the government testing response and the long delays in test results. Political actors, including Vice President Leni Robredo, donated testing kits in an implicit rebuke of the government's limited capabilities (Cepeda, 2020a). Others advocated for the use of rapid antibody or antigen tests, even as the DOH and other health experts insisted on using the RT-PCR test. "Our testing method, the real-time PCR, remains to be the gold standard because what we measure here is the virus, unlike in the other testing method in which it is the antibodies that are measured," Secretary of Health Francisco Duque said on March 29 (Yasmuan et al., 2020).

While the national government insisted on using PCR as its testing method, local governments used different testing capacities to highlight—and distinguish—their own pandemic responses. Governors and mayors scrambled to acquire testing kits and establish their own laboratories, at times embracing the rapid tests against the advice of DOH and many health experts. At the height of the ‘lockdown’, at least one provincial government conducted rapid testing to all incoming road travelers at a border checkpoint, projecting a safe, COVID-free zone to its citizenry.

In one dramatic example, Marikina Mayor Marcy Teodoro took the initiative of installing a testing facility without DOH blessing. “Frustrated with red tape, Teodoro gave his ultimatum in the morning of April 14: accredit the lab or Marikina runs the facility without the DOH,” as one news article (Cepeda, 2020b) reported. Another high-profile mayor, Manila Mayor Isko Moreno, would initiate “drive thru testing”, claiming that “we have confirmed that people would want to have themselves tested but they do not have access to such” (Lalu, 2020), in another implicit rebuke of the national government’s response. While the testing Moreno was offering utilized rapid antibody tests, this crucial distinction was lost in the ensuing, and largely-positive, media—and social media—coverage that the mayor gained. “This is what the [national] government should be doing! Thank you Mayor,” a news report quoted an online commenter as saying (Yap, 2020).

3.1.2 Testing and Division

Another politically-fraught point of contention in the country was who would be able to access testing. In late February, the DOH categorized people as “Persons Under Investigation” (PUI) or those with symptoms and a history of travel to areas with COVID-19 and “Persons under Monitoring” (PUM) or those who came into contact with PUIs—with only the former eligible for testing (DOH, 2020a). Even as health advocates pointed to the examples of other countries that embraced widespread testing, the DOH and other health experts justified these narrow criteria given the government’s limited testing infrastructure.

This already-restrictive criteria, however, was undermined by news of prominent politicians and their families accessing testing in violation of the policy. What quickly came to be called “VIP testing” elicited outrage, especially amid news reports that some health professionals had died without finding out their status. “What hurts me the most is that here we are, risking our lives, getting exposed to COVID-19, and we can’t even get ourselves and our patients tested,” one frontline medical worker told the author. The outrage over “VIP testing” was accompanied by public demand for scaled-up testing, which were instantiated via social media hashtags such as #MassTestingNow and #MassTestingPH. Through these social media campaigns people demanded that the government test more people, a position informed by a comparative paradigm that evaluated the Philippine government’s response to that of other countries as well as the WHO’s own call for scaled-up testing.

Despite the DOH’s reticence to pursue “mass testing”, it seemed to have been countermanded by the president’s “Inter-Agency Task Force” (IATF), which was in charge of the overall pandemic response. “We are determined to fast track the accreditation of subnational laboratories so we can start the massive testing of persons under investigation (PUIs) and persons under monitoring (PUMs),” Carlito Galvez, the head of the IATF, declared on April 1. “We expect that by April 14 we should be able to start massive testing” (Ornedo, 2020).

However, as the government failed to reach its stated targets for testing, it later claimed ‘mass testing’ is neither feasible nor practicable. “We test those who need to be tested,” presidential spokesperson Harry Roque declared in May 20, “not just because they want to be tested” (Nonato, 2020). He maintained that the plan was to continue “expanded target testing” covering (1) those showing symptoms of COVID-19, those who arrived in the country from abroad (such as overseas Filipino workers, or OFWs coming home), and those who were in close contact with confirmed COVID-19 cases.

Although the national government exhibited ambivalence towards the idea of ‘mass testing’, local politicians embraced it. In Iloilo, a city known for its independence and opposition to President Duterte as well as for a low number of COVID-19 cases until the time of writing, the mayor explained: “We pushed for mass testing because this was the only way that we would be able to find out if a person was infected and infectious” (Espina & Talabong, 2020). Various cities in Metro Manila—the national capital region—also used the language of ‘mass testing’ or ‘mass screening’, likewise communicating the adequacy of their response and the benefits of it to their own citizens, regardless of the quality and actual availability of those tests (e.g. Gotinga, 2020).

Opposition figures and health advocates, for their part, took to filing a petition before the Supreme Court to unsuccessfully compel the government to conduct “free mass testing”, reflecting its polarizing nature (see Vallejo & Ong, 2020). “Without mass testing, the public faces a never-ending quarantine. Without mass testing, the government allows the virus to claim precious Filipino lives, either by sickness or hunger,” the petitioners declared, adding: “The government’s failure to conduct mass testing as advised by experts and as effectively implemented by other countries and even some local government units is dangerous and deadly as it could mean that the coronavirus will not be detected in thousands, if not hundreds of thousands, of Filipinos afflicted with the virus” (Navallo & Merez, 2020).

It is worth adding that although the government had been ambivalent towards mass testing, it has used increased testing as an explanation for rising number of cases. “There’s an increase or trend per week. This is because of our increased testing capacity because we’re also testing now asymptomatic individuals,” one health official reported in late July (Montemayor, 2020). Testing capacity was also invoked by the DOH as a sign of progress, hailing it as the highest in the Southeast Asia even as the Philippines emerged as the country with the highest number of cases in the region (Hallare, 2020). Such statements, and subsequent debates about the reporting of cases, reflect the continuous contestations not just about what kind of tests were used but what the test results signify in relation to the Philippines’ progress in controlling the outbreak.

3.1.3 Simplification and Invocation of Knowledge Claims

The two, interrelated, issues of testing capacity and ‘mass testing’ reveals the emergence of COVID-19 testing as a political trope in the country, with the national government reassuring the public that its testing capacity was adequate, and that they were testing those who actually needed it. In contrast, other political actors, particularly those in local government, distinguished themselves from the national government by offering their own testing centers and methods (e.g. rapid antibody tests) as well as conducting testing beyond the parameters or criteria set by the government. In doing so, they sought to dramatize their response to the health crisis and forge a division between their response and those of the national government. Such dramatizations and divisions relied on knowledge claims (e.g. “Rapid tests are useless”), with ‘science’ at times being invoked and misused by various political actors.

Meanwhile, the idea of testing also resonated with the public because testing quantified the pandemic, allowing it to be monitored and its results ritualized, while ‘mass testing’ took on a life of its own as the key to ending the pandemic. This heightened significance of testing led to debates that were more about semantics than the tests themselves. As a pro-administration blogger put it in late March, while the first demands of mass testing mounted (ThinkingPinoy, 2020):

So some camps are FINALLY adding some nuance to their Mass Testing advocacy, i.e. that mass testing covers only medical frontliners, PUIs, and PUMs. But isn’t that PRECISELY what the government has been trying to do for the past several weeks? Why advocate for something that the government is already desperately trying to do?...Oh please. So you’re now reducing the debate to semantic nitpicking, when the fact of the matter is you’ve been hollering “MASS TESTING!” without any fine print for the past several weeks?

Such discourses of testing—most of which were carried out in social media—simplified the pandemic, and help explain its political and popular significance, regardless of its efficacies as an epidemiological tool.

3.2 Testing in the United States

President Trump was elected in 2016 on a populist agenda and was known for his dramatizing performances around crises, as demonstrated through examples “from building walls, deporting migrants and rounding up criminals” (Brubaker, 2017, p. 366). The Trump administration’s reaction to the COVID-19 crisis is a prime example of the repercussion of medical populism in response to a pandemic. From the first detected COVID positive case in the United States on January 20, 2020 (Harcourt et al., 2020), the national response was fraught with complications. President Trump’s denialist stance was epitomized by his calling the epidemic a ‘democratic hoax’ and something that would just ‘disappear’ can still be felt among citizens today. In July 2020, while death rates were rising, Trump stated that “Many of those people are young people that would heal in a day. They have the sniffles” (Montanaro, 2020).

The politicizing of these perspectives created deep divisions within the country. The political trope of ‘hoax’ was predominately been taken up by citizens aligning with the Republican party. The messaging divided the country between his ‘base’ against the ‘liberals’ in response to a health risk. Trump’s denialism demonstrated a political style of medical populism which can be visually traced in the public through community members’ behavior, such as adhering to or rejecting mask wearing, a willingness or refusal to maintain social distance, and socializing in public or in pictures on social media. Testing for the virus was met with multiple roadblocks, including access to tests, supplies shortfalls, delays in receiving results, and discrepancies on where test results should be reported.

3.2.1 Simplification of Pandemic

The Trump administration attempted to simplify the response to the COVID-19 pandemic by focusing on testing capacity as the single indicator of success. However, even when measured by this indicator the US response failed. Though the WHO warned of the potential global pandemic on January 30th and the US Centers for Disease Control and Prevention (CDC) stated that ‘It’s not so much a question of if this will happen anymore but rather more a question of exactly when this will happen’ (CDC, 2020), the country was still underprepared for testing. The early months were faced with systematic failures. Initially, the Food and Drug Administration rules prevented state and commercial labs from developing their own coronavirus diagnostic tests, which hampered testing capacity (Patel, 2020). Additionally, the first coronavirus test kits sent out were found to have faulty negative controls caused by contaminated reagents (Cohen, 2020). Instead of focusing on fixing these crucial problems with early testing, Trump continued to simplify and downplay the pandemic with tropes such as ‘very well under control’, ‘we shut it down’, and ‘the risk to American people remains low’.

3.2.2 Spectacularization of Crisis

By mid-March 2020 health emergencies were declared in multiple states and Trump shifted political style. On March 13th he announced extensive plans for widespread testing by using the private sector throughout the US. “We’ve been in discussions with pharmacies and retailers to make drive-through tests available in the critical locations identified by public health professionals,” said President Trump. While Trump spectacularized the widespread plans for a testing program, he overlooked the supply chain needs for implementing an efficient national testing strategy. The promises of March were clearly falling short by April.

We need to significantly ramp up not only the number of tests, but the capacity to perform them, so that you don’t have a situation where you have a test but it can’t be done because there isn’t a swab, or because there isn’t extraction media, or not the right vial,” Dr. Anthony Fauci, director of the National Institute of Allergy and Infectious Diseases, told Time magazine in late April 2020. “I am not overly confident right now at all that we have what it takes to do that. We are doing better, and I think we are going to get there, but we are not there yet (Park, 2020).

Trump resisted numerous calls to invoke the ‘Defense Production Act,’ which would secure industrial production of needed medical supplies (i.e. testing materials, ventilators, PPE) (Kavi, 2020), claiming that it was the responsibility of the individual governors to obtain medical equipment, not the federal government (Rogers et al., 2020). By June, NPR reported that only 4% of the private sector stores in Trump’s testing strategy were hosting drive-through testing (Pfeiffer & Mak, 2020). Without a comprehensive national testing strategy, responsibility was pushed to state and local initiatives, resulting in disjointed efforts throughout the country.

An additional challenge in delivering an impactful testing program was who qualified for a test. Early CDC guidelines were focused only on those with a history of travel to a COVID-19 infected area. These guidelines stayed in place even after evidence began emerge that community spread was happening. History of travel was finally dropped as a criterion, but the updated criteria still focused on prioritizing those with active symptoms, even as evidence mounted of a large percentage of asymptomatic carriers. The CDC new guidelines were expanded to include “testing is recommended for all close contacts of persons with SARS-CoV-2 infection” (CDC 2020a). Still, across the country, healthcare professionals who cared for confirmed positive patients were not given a test unless they developed symptoms. In contradistinction,

the US president was tested on a regular basis. According to him, “Because I am the president, everyone gets tested before they see me” (Fox News, 2020).

3.2.3 Invocation of Knowledge Claims

While Trump relied on testing as an accurate safety clearance check for himself, he continued to argue against widespread testing for the US population. A recurring political trope that Trump used was to blame testing for why the US epidemic was uncontrolled. When asked about the rising number of cases, his response was simply “because we test more people.” He went on to claim that the “US has the best testing in the world.”

Don't forget, we have more cases than anybody in the world. But why? Because we do more testing,” Trump said. “When you test, you have a case. When you test, you find something is wrong with people. If we didn't do any testing, we would have very few cases. They [the media] don't want to write that (Lee, 2020).

When challenged to explain positivity rates or hospitalization rates, he repeated the same narrative of ‘when you test more, you have more cases.’ At his own Trump political rally in Tulsa, Oklahoma in June he stated we needed to “slow down testing” (Solender, 2020). In an interview with FOX News he stated “testing creates cases” (Begley, 2020).

On August 3rd Trump tweeted: “Cases up because of BIG Testing! Much of our Country is doing very well. Open the Schools!” (Trump, 2020).

In a more alarming response of controlling the testing number that “makes the US look bad,” the Trump administration diverted test results from being reported to the CDC and instead sent to a private organization that reported directly to the White House (Huang, 2020). This development challenged the notion of ‘misinformation’ relative to the Trump administration’s understanding of statistics and suggests instead a realm of ‘disinformation’, or the intent to spread false information. In late August 2020, it seemed that Trump’s calls to ‘slow down’ testing were being implemented as the CDC updated their testing protocols to state that even those who have been in close contact with a COVID-19 infection but have not symptoms “do not necessarily need a test unless you are a vulnerable individual or your health care provider or state or local public health officials recommend you take one” (CDCb). This significant change appeared as an update to the CDC website without a public announcement. This shift drew stark criticism from public health experts and scientist since testing and identifying asymptomatic people with the virus are crucial to slowing the spread of the virus (Sullivan, 2020).

In early October 2020, President Trump tested positive for SARS-CoV-2 (Conley, 2020). He was monitored and treated by his own team of doctors at the White House and at Walter Reed National Military Medical Center. After downplaying the severity of the virus and contradicting medical professionals on the importance of wearing masks, many hoped that his own infection might change his political stance. Throughout his illness he was treated with dexamethasone, remdesivir, and regeneron (Gallagher, 2020). These medications were not available to the average US citizen and have only been used in severe cases. However, the president released a video statement on Twitter from Walter Reed Medical Center invoking knowledge claims: “I’ve learned a lot about COVID. I learned it by really going to school. This is the real school” (Trump, 2020a). However, after being released Trump continued to downplay the severity of the virus by using his own recovery as example and encouraging the country to ‘not be afraid’.

I will be leaving the great Walter Reed Medical Center today at 6:30 P.M. Feeling really good! Don't be afraid of Covid. Don't let it dominate your life. We have developed, under the Trump Administration, some really great drugs & knowledge. I feel better than I did 20 years ago! (Trump, 2020b)

3.2.4 Forging Divisions

One of the components of medical populism that has played out through the COVID-19 pandemic is the state versus federal response. The Trump administration has blamed the failing response and discrepancies across the country on state leadership while taking credit for any successes. Early on Trump made it clear that for states to get any assistance from the federal government they would have ‘show appreciation’ (Kelly et al., 2020). These sentiments and actions played

out across political lines, with Republican governors offered more assistance than Democratic ones. In one example, a shipment of FEMA supplies was rerouted mid-delivery to a Republican governor (Kanno-Youngs & Nicas, 2020).

Further dividing the nation has been attempts to discredit Dr. Anthony Fauci (Lederman & O’Donnell, 2020), with testing again emerging as a point of contention. Throughout March and April, Dr. Fauci—a member of the country’s Coronavirus Task Force—regularly appeared in the president’s daily press briefings, becoming a household name and reference. As the US saw surges in multiple states after reopening, a schism over testing developed between task force members. Dr. Fauci testified before Congress and spoke publicly with the media, stating that the administration’s testing strategy was inadequate in identifying asymptomatic individuals and young people, therefore the country would struggle to isolate and contain the virus. After these public statements, there was a clear distancing between the administration and Fauci marked by ‘dramatically decreased’ meetings (Budryk, 2020). The evident distancing morphed into a ‘smear’ campaign as the White House compiled a list of public comments and advice by Fauci, ostensibly to serve as evidence of his flawed perspective (Lederman & O’Donnell, 2020). This populist critique of biomedical authority led many Trump supporters to oppose the medical establishment by spreading distrust of medical advice.

4 Discussion

“The idea that medicine lies outside the boundaries of the political is rooted in a set of assumptions about the nature of medical knowledge and how it is—and should be—produced and circulated,” Briggs & Hallin (2010, p. 149) note. While health communication used to be the province of health professionals, it is now recognized that the expansion of social media has brought medical knowledge into the realm of public communication. When politicized, coronavirus testing emerges as an “evidence-making practice” in which political actors participate in different forms of “evidence performance” (Rhodes et al., 2019). What is at stake, then, in the politics of coronavirus testing is not just the invocation and circulation of medical knowledge claims, but the impact of such ‘evidence’ on public policy.

In this article, we have focused on the public sphere model of biocommunicability in which information is assumed useful for policy-makers collective decisions over public interest (Briggs & Hallin, 2010, p. 152). Within this model we have examined how politicians, using familiar political styles within the rubrics of medical populism, have asserted their own agenda into public health communication across social media platforms, thereby impacting their country’s pandemic responses. Taken together, our case studies weave biocommunicability with medical populism in an era of infodemics (see Table 1).

Table 1: Elements of Medical Populism and COVID testing.

Element of medical populism	The Philippines	United States
Simplification of the pandemic	Demands for “mass testing”, use of rapid antibody tests as an easy solution	Demands for massive testing
Spectacularization of crisis	Setting up of testing centers Installation of testing centers by mayors; performance of tests in checkpoints	Federally tested facilities launched, ‘US has best testing in the world’, and later defunding testing
Forging of divisions	Healthcare establishment vs. maverick mayors; national vs. local government	President Trump vs. state governors; federal vs. state responses; Republicans vs. Democrats
Knowledge claims	Efficacy of rapid antibody tests; High number of cases is a result of more tests	“Testing making us ‘look bad’”

In these examples we focus on the representation of political action that was communicated to the public. In both case studies the politicians used claims of the power of biomedicine and utilizing ‘advanced technology’ as evidence of successfully addressing the outbreak. In the first place, the political and popular demands for testing—encouraged by

political actors—oversimplify the entailments of pandemic response with the proposition that ‘mass’ or ‘massive testing’ can address the pandemic itself as a singular or at least primary solution. In both case studies testing was discussed as the simple one-step action needed to mitigate the virus. Missing from this simplified approach is a discussion and mobilization of the resources and capacity needs of multiple mitigation steps that make testing effective (i.e. testing, contact tracing, isolation). On the other hand, those who oppose testing likewise simplify the pandemic by claiming it will go away soon (e.g. Donald Trump), that the testing itself ‘makes up’ the pandemic (e.g. Rodrigo Duterte), and thus, either way, testing is ‘overrated’.

This oversimplification of statistics can be classified as misinformation that can have powerful effects during a crisis (Starbird et al., 2020), given its ability to reduce feelings of uncertainty or provide a (false) sense of safety and control (Crabtree & Masuda, 2019). While many citizens may perceive that testing does not actually cause the cases, accepting this misinformation can help soothe the fears and anxieties created by increasing cases and expanding outbreaks. In this way the political trope shapes people’s perception of COVID risk and influences their behaviors to mitigate or ignore that perceived risk.

Alongside oversimplification we have also seen examples of spectacularization of testing. This has been enacted by politicians who ‘perform’ testing through highly-visible acts of setting up testing centers, distributing testing vouchers for their constituents, and, in both case studies, through speeches and public statements. While demanding credit for a large number of tests as a sign of successfully addressing the pandemic, Trump also used this same indicator to oversimplify the outbreak, blaming the number of tests for the US ‘looking bad’. This argument has also been raised by Philippine government officials amid unfavorable comparisons with other Asian countries. These narratives were reproduced throughout public conversations and used as a justification for ignoring public health advice (i.e. mask wearing in U.S.).

As for the forging of divisions, testing is divisive at different levels, with attitudes toward testing organizing people along political fault lines (e.g. Republicans vs. Democrats; Duterte supporters vs. critics). Testing also divides people into ‘negative’ or ‘positive’ cases, which also has political consequences. Testing capacity and efficiency have been politicized, with such questions raised in both the Philippines and the United States to either criticize or praise the administration’s efforts. In the case of Donald Trump, testing failure were also blamed on other entities like China and the WHO. Trump has also forged divisions between the federal government and state government. After failing to organize a national testing strategy, Trump claimed that this was the responsibility of each U.S. state. In like manner, Rodrigo Duterte and his allies accused critics and health experts who object to his testing policy (or lack thereof) as fomenting ‘revolution’, pitting ‘the economy’ against ‘public health’ in a language that would not be out of place in the Trump administration.

Finally, testing rests on knowledge claims about the test’s efficacy and what the tests ‘do’, both of which render the tests ‘controversial’. This has implications for public health, given that, as Rhodes et al. note: “Evidence-based controversies in public health intervention highlight that knowledge negotiations involve multiple actors of vested interest drawing upon, as well as generating, multiple forms of knowledge concerning how an intervention is constituted and valued” (2019, p. 261). The decision on who to test, when to test, and which test to use, influences the very outcome of testing, and the very evidence it creates, further underscoring the fraught nature of testing and its ‘multiplicity’ (Mol, 2002). While the pandemic continues, these divisions are becoming even more heightened with questions surrounding testing: who gets tested, who will pay for the test, when the results will come out, in what situations are the results required, and ultimately, what the tests signify.

Identifying and critically analyzing how knowledge is generated is an essential step to recognizing the impact that political styles have on the COVID-19 pandemic. Tracing the elements of medical populism within the two cases studies highlights how simplification, spectacularization, forging divisions, and invoking knowledge claims have influenced each country’s response efforts. This political style combines multiple forms of knowledge (i.e. experience, emotions, beliefs) (Myhalovskiy & Weir, 2004) for political gain.

Our analysis of COVID-19 testing contributes to the public policy debate by providing evidence of the impact of medical populism during a pandemic. For countries to successfully respond to a health crisis, there needs to be government preparedness (Capano, 2020), effective ability to increase capacity (Serikbayeva et al., 2020), along with ability to mobilize across diverse sectors (Klingler-Vidra et al., 2020). Populist rhetoric and policies have been shown to increase barriers and challenges to enable these capacities within health care systems (Speed & Mannon, 2020). This paper reinforces and expands our understanding of these barriers by demonstrating how political actors using medical

populist perspectives to generate knowledge of a pandemic for the public and, in doing so, simplify and spectacularize the epidemic while also forging of political divisions.

5 Conclusion

This article, in part, answers the call for a medical anthropology of epidemics to provide insight into the “factors and actors that shape the ongoing production of knowledge about epidemics” (Briggs & Nichter 2009, p. 197). The political actors in each case study have shaped knowledge of the epidemic in their countries, both in the way they construct the idea of ‘testing’ and in how they mobilize testing as an ‘evidence-making practice’ that shapes how the pandemic and their responses to it are measured. Here, we have identified how testing becomes a populist trope and presented a critical analysis of how knowledge is generated by leaders through specific political styles. In doing so, this paper contributes to “[breaking] down undemocratic pragmatic structures and biocommunicable models” (Briggs & Nichter, 2009, p. 198), adding to vocabulary with which to hold leaders to account and to interrogate the political construction of biomedical technologies. Such a framework is urgently needed in addressing the impact of policies on people living through a pandemic. Indeed, our paper makes clear that oversimplification, spectacularization, and division will likely continue to accompany the use of testing, but what is yet to be determined is the final impact these actions will have on the full story of the COVID pandemic.

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