Michelle Falkenbach
Scott L. Greer *Editors*

The Populist Radical Right and Health

National Policies and Global Trends

Foreword by Martin McKee

Springer

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Foreword

If anyone had any doubts about the importance of the political determinants of health, the COVID-19 pandemic should have dispelled them. Published only a few months before the onset of the pandemic, the Global Health Security Index looked in detail at pandemic preparedness in 195 countries. The United States and the United Kingdom ranked first and second, respectively. Yet, a year after the first cases were identified, we can see that these were two of the worst-affected countries. Countries that had ranked much lower in apparent preparedness, such as New Zealand in 35th position, Vietnam in 50th position, or Uruguay in 81st position, fared far better in suppressing infections. So, if it wasn't objective measures of preparedness that differentiated how these countries would perform, what was it? When other countries are included in the analysis, such as Brazil, India, or Russia, the inescapable conclusion is that politics matters. As even the casual observer will note, many of the countries that have done worst during the pandemic have one defining characteristic; they are led by politicians that have powerfully promoted populist policies.

This book examines one of the most important political developments of the twenty-first century, the emergence of the populist radical right. By exploiting popular discontent among those who feel left behind in a rapidly changing world, populist radical right politicians have attained power. Once in power, they have often implemented policies that worsen the conditions for those who supported them yet manage to retain their support by blaming others. Aided by social media, they have promulgated the most bizarre conspiracy theories, creating dangerous fractures in society and undermining long-established institutional safeguards of public health. In this way, they can perpetuate the conditions that enabled their rise to power, but at a terrible human cost.

I am writing this foreword a few days after a violent mob stormed the Capitol in Washington, D.C. Those who participated in this insurrection, like many millions of other Americans, firmly believed that the 2020 US presidential election had been stolen, even though this was clearly false. Many believed that they were acting on the defeated President's instructions, someone whose policies have contributed to more than 400,000 American deaths from COVID-19.

Yet for those of us who study population health, the problems lie not only in those countries that are led by populists such as Donald Trump. They also arise in countries where long-established mainstream parties have been pulled away from the center, perceiving a need to adopt the policies of those on the extremes. In the United Kingdom, the shift from one nation conservatism to a nationalism willing to accept enormous self-harm arising from Brexit in the midst of a pandemic has been remarkable.

Our understanding of the determinants of health has evolved. The biological and environmental determinants have been joined by the social, the commercial, and the political. In the same way that we would be shocked if a public health professional failed to understand the importance of tobacco or alcohol in the health of populations, so should we be concerned if they were unaware of the political factors. Among them, one of the most important is exposure to populist radical right policies. We should be grateful to Michelle Falkenbach and Scott L. Greer for assembling what will, in the future, be seen as a warning to us all.

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Preface

This volume stems from a generous invitation from Janet Kim, senior editor at Springer. Janet approached me at the 2018 European Public Health Conference in Ljubljana, Slovenia, with the idea to create a compact book based on the 2018 published article, "Political parties matter: The impact of the populist radical right on health", by Michelle Falkenbach and Scott L. Greer. She envisioned an elaboration of the piece arguing for its application globally. After consulting with Stefano Guicciardi, a public health, hygiene, and preventive medicine specialist, an initial team was put together.

With the COVID-19 outbreak at the beginning of 2020, the team had to undergo some changes. Dr Guicciardi was needed full-time in his position as hospital unit medical director at the Azienda USL in Bologna, Italy. In March 2020, Scott L. Greer, professor of health management and policy, professor of global public health, and professor of political science at the University of Michigan, joined the team as co-editor. At this point, we decided to expand what was originally meant to be a compact book into a full-length volume.

This book is the result of excellent collaboration among PhD scholars, young assistant professors, established researchers, and senior professors from various countries. Sixteen authors worked together on ten country cases spanning four continents, showcasing that populist radical right politicians, especially when they are in government, do, in fact, impact health policy.

Ithaca, NY, USA — Michelle Falkenbach

Acknowledgements

We are deeply indebted to Marleen Bekker, president of the public health policy and politics section of EUPHA, the European Public Health Association. She included us in her workshop at the 2020 European Public Health Conference in Rome, Italy, and ensured that some of our authors were given access to the conference. Her engagement has resulted in sustained collaboration.

Abbreviations

ACA	Affordable Care Act
AfD	Alternative für Deutschland (Alternative for Germany)
AN	Alleanza Nazionale (National Alliance)
BNP	British National Party
BVA	Insurance Institution for Public-Sector Employees
BVAEB	Insurance Institution for Public-Sector Employees, Railways and Mining
BZÖ	Bündnis Zukunft Österreich (Alliance for the Future of Austria)
CDA	Christian Democratic Appeal
CdL	Casa delle Libertà (House of Freedoms)
CDU	Cristiani Democratici Uniti (United Christian Democrats (Italy))
CDU	Christlich Demokratische Union Deutschlands (Christian Democratic Union of Germany)
CETA	Comprehensive and Economic Trade Agreement
CJEU	Court of Justice of the European Union
CPP	Communist Party of the Philippines
CSU	Christian Social Union in Bavaria
DDS	Davao Death Squads
DPP	Danish People's Party
EEA	European Economic Area
ENDS	Electronic Nicotine Delivery Systems
EU	European Union
FdI	Fratelli d'Italia (Brothers of Italy)
FDP	Freie Demokratische Partei (Free Democratic Party)
FGS	Funding for Growth Scheme
FI	Forza Italia
Fidesz	Hungarian Civic Union
FN	Front National (the French National Front or National Rally (as of 2018))
FPÖ	Freiheitliche Partei Österreichs (Austrian Freedom Party)
FSII	Federation of Social Insurance Institutions

FvD	Forum voor Democratie (Forum for Democracy)
GDP	Gross Domestic Product
GP	General Practitioner
IVF	In Vitro Fertilization
JFvD	Youth Forum for Democracy
Text	Lega Italian League
LGU	Local Government Unit
LN	Lega Nord
M5S	Movimento 5 Stelle (Five Star Movement)
MP	Minister President
MSI	Movimento Sociale Italiano (Italian Social Movement)
MSZP	Magyar Szocialista Párt (Hungarian Socialist Party)
NHS	National Health Service
NPA	National People's Army
NPD	Nationaldemokratische Partei Deutschlands (National Democratic Party of Germany)
OECD	Organisation for Economic Co-operation and Development
OFW	Overseas Filipino Workers
ÖGK	Österreichische Gesundheitskasse (Austrian Health Insurance Fund)
ORF	Österreichischer Rundfunk (Austrian Broadcasting Corporation)
ÖVP	Österreichische Volkspartei (Austrian People's Party)
PD	Partito Democratico (Democratic Party (Italy))
PdL	Il Popolo della Libertà (The People of Freedom)
PiS	Prawo i Sprawiedliwość (Law and Justice Party)
PLN	Polish złoty
PO	Platforma Obywatelska (Civic Platform Party (Poland))
PPE	Personal Protective Equipment
PR	Proportional Representation
PRIKRAF	Private Hospitals Financing Fund
PRR	Populist Radical Right
PSC	Partido Social Cristão (Social Christian Party (Brazil))
PSDB	Partido da Social Democracia Brasileira (Brazilian Social Democratic Party)
PSL	Partido Social Liberal (Social Liberal Party (Brazil))
PT	Partido dos Trabalhadores (Workers' Party (Brazil))
PvdA	Partij van de Arbeid (Labour Party (the Netherlands))
PVV	Partij voor de Vrijheid (Party for Freedom (the Netherlands))
RIVM	National Institute for Public Health and the Environment
SDH	Social Determinants of Health
SHI	Statutory Health Insurance
SLD	Sojusz Lewicy Demokratycznej (Democratic Left Alliance (Poland))
SP	Socialistische Partij (Socialist Party the Netherlands))
SPÖ	Sozialdemokratische Partei Österreichs (Social Democratic Party of Austria)
SVP	Schweizerische Volkspartei (Swiss People's Party)

SVS	Sozialversicherungsanstalt der Selbständigen (Social Insurance Institution for the Self-Employed)
SV-OG	Social Insurance Organisational Act
SZDSZ	Szabad Demokraták Szövetsége (Alliance of Free Democrats (the Netherlands))
UK	United Kingdom
UKIP	United Kingdom Independence Party
US	United States
VAEB	Versicherungsanstalt für Eisenbahnen und Bergbau (Austrian Insurance Institution for the Railways and Mining Industry)
VAT	Value-Added Tax
VdU	Verband der Unabhängigen (Federation of Independents)
VVD	Volkspartij voor Vrijheid en Democratie (People's Party for Freedom and Democracy (the Netherlands))
WHO	World Health Organization

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Editors and Contributors

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Introduction

Michelle Falkenbach and Scott L. Greer

Introduction

The last decade has been a good one for populists, especially those on the right (Caramani and Manucci 2019; Diamond 2020; Eiermann et al. 2017; Inglehart and Norris 2016; Pappas 2019). In the United States, Donald Trump was elected president in November 2016. In the United Kingdom (UK), the 2016 Brexit vote ushered in a competition to claim populist credentials on the left and right, while the country's departure from the European Union under Prime Minister Boris Johnson in 2020 marked a triumph for populism. Retired military officer and marginal political figure Jair Bolsonaro, to much surprise, won the Brazilian presidential election in 2019. The Austrian and French populist right were strong second-place finishers in presidential elections, the Austrian right went on to enter government, the Five Star Movement in Italy became a major threat to established politicians who faced general elections in 2018, and the German AfD (Alternative for Germany) emerged as the strongest political party in the 2019 Saxony and Brandenburg elections. Populism brought along democratic backsliding in many cases. Donald Trump eroded the quality of democracy and the rule of law in the United States. Poland and Hungary backslid on democracy while led by the populist radical right (PRR), to the point that Hungary is clearly not a democracy (Kelemen 2017), and Rodrigo Duterte's Philippines was tainted with violent securitization – though the government was committed to universal health care. The result of these events has

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seen an increase in research and commentary on populism in public health and health policy (Abbasi 2016; Falkenbach and Greer 2018; Greer 2017; McKee 2017; Rinaldi and Bekker 2020).

COVID-19, the greatest public health threat in the modern history of many countries, has been a major test for governments and an opportunity to understand them better. Choices about how (and whether) to confront the coronavirus were telling. Populist radical right governments adopted strategies from authoritarian lockdowns to a gradual restriction of freedoms to complete denial, distraction, and blame-shifting up to Donald Trump's flat statement that he did not take responsibility at all and his focus on relabelling it the "China virus" (Lasco 2020; Lasco and Larson 2020). While social democratic and conservative leaders chose gradual strategies consisting of school and business closures, curfews, and an eventual stay-at-home orders in some shape or form while communicating messages of solidarity and the importance of health above all else, populist politicians chose alternative strategies and messages. Countries such as the United States, the United Kingdom, and Brazil saw their leaders denying the severity of the disease, ignoring and undermining scientific evidence and advice as to how to combat the spread of the virus and ultimately failing to communicate messages that would protect citizens from mass infection and death (Falkenbach and Greer 2020). Hungary rapidly closed its borders, implemented curfews for restaurants and bars, and restricted access to hospitals to make room for corona patients, thereby avoiding a mass outbreak in the first wave. PiS (Law and Justice party) in Poland used the pandemic to secure more power (Klajn 2020). Populist leaders in opposition, especially those of the right, were quick to advocate for border closures in their respective countries and pointed their messaging against migrants whom they thought were responsible for the spread of the disease (Falkenbach and Greer 2020; McKee et al. 2020).

Both the rise of populist politicians worldwide and the COVID-19 pandemic have made the study of this specific group of populist politicians and their decisions with regard to health and health policy more relevant than ever. While there has been an increase in research surrounding the PRR and their reactions (or lack thereof) to the coronavirus (De Cleen and Speed 2020; Falkenbach and Greer 2020; Labonté and Baum 2020; McKee et al. 2020), what we have found to be distinctly missing is a general discussion surrounding the concrete impact of the PRR and their influence on health and health policies across countries.

This substantial gap will be filled through the presentation of ten country cases including the Austrian Freedom Party (Freiheitliche Partei Österreichs, FPÖ), Jair Bolsonaro in Brazil, the Alternative for Germany (Alternative für Deutschland, AfD), President Trump in the United States, the Lega in Italy, Law and Justice (PiS) in Poland, Rodrigo Duterte in the Philippines, Fidesz in Hungary, Boris Johnson and the United Kingdom Independence Party (UKIP), and the Party for Freedom (Partij voor de Vrijheid, PVV) in the Netherlands. These ten case chapters will highlight the impact of PRR politicians on health policies in their respective countries. The goal of these cases is twofold: (1) to determine how PRR politicians

act with regard to health when given a position of power[1] and (2) to establish a system of classification for PRR politicians and their policy impact.

Many of the case countries have seen PRR politicians in governments over a longer period of time (Austria, Italy), giving these chapters the longitudinal advantage of documenting policy changes. In several countries there will be noticeably little to say about health policy impact. If the problem is that the institutional features of the healthcare system, e.g. Bismarckian financing schemes, limit the possible effects of any one party's place in government, then our authors pay more attention to social policies. Not only does this gain analytic leverage on the impact of the PRR. It also matters for health since so many social policies do matter so much for health. All country chapters classify their PRR politicians in terms of the welfare framework laid out later in this chapter.

In this introduction we first review the literature in public health and political science on the topics and suggest the particular areas where one can contribute to the other. The ambition is that as a result, there will be less risk of health researchers reinventing the wheel and more effective cross-fertilization between health and political science research (Greer et al. 2017; Fafard et al. 2021). There is a great deal of data and expertise in health research that have barely fed over into political science, whether it is on the relationship between opioid use and Trump votes or on the impact of exclusionary policies on health outcomes. Likewise, there are many areas where the literature in health circles is relatively thin – such as the strategies of populist right parties – but where we can draw on extensive political science research to increase understanding.

We go on to discuss the overarching concept of populism, identifying common definitions of it as an anti-pluralist and anti-elitist style of politics with little additional content. Given the thinness of populism as a guide to policy-making, it then argues that we should study a particular kind of political family with special urgency, namely, the populist radical right (PRR). PRR politics is composed of the combination of three ideological features: nativism, authoritarianism, and populism. It is practiced by both explicitly PRR political parties such as the Austrian Freedom Party (FPÖ) and the Italian League (Lega) and is also widely adopted by "mainstream" parties and politicians. In fact, the latter adoption of PRR stances and styles by mainstream parties has produced far more effects because mainstream parties such as the United States (US) Republicans, United Kingdom (UK) Conservatives, or those of the Dutch centre right are more likely to actually enter power and make policy. We then argue that looking at the policy impact of PRR politics in government is a key area where we can both gauge more effectively their impact on health, including public health and the health of vulnerable populations, and where a nuanced approach to policy in an area such as health can enrich a literature that shies away from complex policy and prefers to focus on political process and statements.

[1] The exception is the case surrounding the AfD in Germany, which has never been in government. This case will serve as an example as to how opposition parties can also help to shape health policies.

Table 1 Hypotheses

Hypotheses	Categorization
1. Increase welfare generosity and exclusivity	Welfare chauvinism
2. Decrease welfare generosity and increase exclusivity	Liberal chauvinism
3. Decrease welfare generosity	Conservative
4. Increase welfare generosity for the "common man", generally anti-welfare state	Welfare populism
5. Administration of welfare programmes become more clientelist under PRR	Clientelism
6a. PRR are more likely to act on arguments with less scientific validity 6b. PRR are more likely to undermine science by starving education and research	Antiscience

The chapter concludes by presenting six hypotheses (Table 1) as to how the PRR in office go about making health policies, thereby shedding some light on the types of welfare strategies PRR politicians typically choose to pursue. Welfare chauvinism, liberal chauvinism, antiscience, and clientelism will be explored through ten country case studies examining which hypotheses hold up in which countries under which circumstances. The introduction will conclude with a layout of the book.

Populism and Health: Identifying What We Know

We combined two bibliographic strategies. The first was a standard literature review of political science on the area of populism in general, including reading works by and pursuing references from the bibliographies of key authors (including Camus and Lebourg 2017; Kitschelt and McGann 1997; Mudde 2016a, b; Weyland and de la Madrid 2019). This literature review helped us identify the general political science literature and focused our attention on the different kinds of populism and an apparent gap in research on the actual public policy impact of populists.

The second was a systematic review intended to identify literature focused on the activities of the populist radical right in government (health as a specific policy area was too narrow a search to explore what is known about policy effects in this sparse literature). The goal of the search was to find articles discussing PRR parties that have been in government and more importantly the articles needed to include specific policies relating to health that the PRR parties implemented while in government. Electronic bibliographic databases (i.e. Political Science Complete, JSTOR, and Google Scholar) and manual searches (bibliography combing) were used to identify relevant publications. A general search with search terms (populism or populist) policy ("radical right" or "radical right wing") and "in government" resulted in 2.090 hits, and a more specific search containing (populism or populist) "health policy" ("radical right" or "radical right wing") and "in government" resulted in 41 hits in the fall of 2020. In addition, a further search was made to

specifically encompass the Central and Eastern European (EU-10) PRR literature as almost none appeared in the first search. The following combinations of keywords were used in this supplementary search: "populist radical right" and "policy" and <Eastern European country of interest>. Through these search terms, 308 articles and books were identified. In all three searches, titles of articles were first reviewed for relevance, then the abstracts of articles were reviewed for applicability, and finally the article was thoroughly read for content. Published articles in peer-reviewed journals were chosen if the full text met the following criteria: (1) published between 1995 and 2020, with a natural focus on more recent articles, (2) full text available in English, and (3) referenced policy achievements or failures of the PRR in national government coalitions.

In this review, 58 articles were found to meet these criteria, but only 17 of the 58 articles focused specifically on the health policies of PRR in government. Of these 17 articles, three focused specifically on the Austrian radical right, two were dedicated solely to the Swiss radical right, two articles were found pertaining to Central and Eastern Europe, and one article was written about the Danish radical right. The other six articles covered several of the relevant countries as a way of comparing or contrasting the various successes and failures surrounding radical right-wing health policy decisions in national government.

This review shows a tremendous asymmetry in the literature. There is a large and growing volume of original research evidence on the motivations of voters, public opinion, and political psychology with regard to populism. Social scientists are putting a lot of effort into working out why people vote for populists and into understanding the successes of populist parties. There is almost no complementary research literature on the *effects* of populist governments on health policies in developed countries. Articles published in public health and medical literature, for example, often argue that the populist right is uniquely anti- or unscientific, but the evidence is at best anecdotal and lacks rigorous comparisons (e.g. to the use of science by other parties).

In short, we started out hoping to do a review of the literature on the impact of populist parties on health and rapidly learned that what we had instead found were a number of serious gaps in the literature just where we would have hoped for a conversation with health policy research. There was a great deal of research on populist parties and their voters but very little on their effects on policy, and what was there was often more of a hypothetical or an assertion in an editorial. Amazingly, at the intersection of two of the biggest bodies of literature today, we find very little. We do not know what populists do to health or health policy when they are in government.

This is the gap we address in this book. In this introduction, we argue that more precision about populism and more study of the effects of populist parties (especially the populist radical right) are needed if we are to understand populism and health.

Populism

Populism is a common word, but as almost every author notes, it is a very problematic term. Populism clearly refers to something, but that something seems to come in infinite combinations, mix promiscuously with everything from nationalism to communism, and predict the actions of different populist leaders poorly. What is the core of something named after a workers' movement in nineteenth-century America (Woodward 1959) that spans from left parties like Podemos in Spain and Syriza in Greece to people of uncertain ideology such as Czech President Andrej Babiš to very right-wing parties such as the French National Rally or the Austrian Freedom Party? Certainly not a coherent ideology. Historian Anton Jaeger sums this point up: "The ideological and empirical deficits of the original sources of this widespread conceptualization are far from being resolved, and its initial contradictions continue to bother contemporary populism research on both sides of the Atlantic" (Jaeger 2016; Woodward 2017).

Rather, populism is a political logic (Laclau and Mouffe 1985), a rhetorical or performative style (Speed and Mannion 2020), and way of doing politics (Weyland 2001). Jan-Werner Müller defines populism with regard to two characteristics: it is *anti-elitist* and *anti-pluralist* (Müller 2016). It is anti-elitist, appealing to the people against elites who are seen as distanced, too intellectual, too foreign, too plutocratic, or something similar that marks them as an outgroup. It is anti-pluralist, meaning that the people themselves cannot in a populist worldview be divided. The people, not the elites, agree on what is good.

Mudde and Kaltwasser define populism to similar effect as "A thin centred ideology that has three core concepts (the people, the elite and the general will) and two direct oppositions (elitism and pluralism)" (Mudde and Kaltwasser 2017). Perhaps the most important attribute Mudde and Kaltwasser underline is the "thin-centeredness" of populism, which accounts for its "chameleon-like" character (Ruzza and Fella 2009). That is how they can appeal to sentiments conventionally regarded as being of the left or the right.

Overall, though, populism is a political style, a practice, of politics rather than an ideology or party family. Thus, it severely underdetermines analysis. Given the pejorative way in which it is frequently used, the enormous variation in things that can reasonably be labelled populism, and the thin-centeredness of its ideological content, there is very little there to be studied. Furthermore, almost any politician will say something "populist" at some point, which is unsurprising but makes it too easy to accuse one's enemies of populism.

It follows that populism almost always can fit with elements of other political philosophies, but it entails very little about the actual motivations and actions of its voters and leaders. Depending on context, "elites" can be defined as intellectuals, as the media, as bankers, as big companies, or as particular ethnic or religious groups such as Jews. Populist leaders generally have little trouble finding "elites" against whom they can direct animosity or shifting targets. Thus, we find the Polish PRR politician railing against a "world of bicyclists and vegetarians" on behalf of the

people they supposedly repress (Müller 2016, p. 56). They also can direct attention to other, nonelite, outgroups whose elite status is not so clear, such as immigrants, which enables alliances with some elites by marginalizing some people (Judis 2016).

One implication of this chameleonic thin-centeredness is that the extensive literature tracing the ideologies and ideological heritages of populist parties, let alone looking for the nature of populist politics, is probably of limited value. Insofar as parties are populist, it seems unlikely that they will be confined to a permanent ideology or even a fixed set of putative enemies. In essence, populists will not be troubled by their failure to conform to the standards of ideological coherence intellectual "elites" would expect. A broader implication is that the political approach of populism does not lend itself to much further study. The irreducible core that Mudde and Kaltwasser, Müller and others found does not tell us much and offers little further opportunity for research.

One point does seem to have strength: there is an elective affinity between populism and the democratic backsliding (Albertazzi and Mueller 2013; Kendall-Taylor and Frantz 2016; Norris 2017) that is also worrying many analysts. The most extreme case in Europe at the moment is Hungary, where populism amplified the consequences of elite polarization leading to an "illiberal democratic regime" (Enyedi 2016). Similar dynamics are at work in Poland. The link between democratic backsliding and populism is almost definitional: anti-elitism fits poorly with the necessary elitism of representative democracy, while anti-pluralism fits poorly with the basic pluralism and contestation of interests of democracy.

In particular, for students of health policy and public health, the thin-centeredness of populism is a problem. Particular populist parties and leaders adopt distinct strategies with regard to health issues, and there are patterns and affinities between subsets of populist parties, but logically a populist health policy could be almost anything, from expanded healthcare access to state-endorsed quackery. This chameleonic persona of both the populist and populism is ultimately too underdetermining to be helpful. Instead, we shift our attention to the practice of a very particular kind of political family, namely, the populist radical right (PRR), within very distinct settings.

Populist Radical Right

While there have been some strong and emerging populist left parties in Europe, notably Podemos in Spain and Syriza in Greece, there is little disagreement that most of the populist force today is on the right. In seeking a more practically and politically relevant object of study, and one likely to affect health policies, it seems fruitful to focus on, specifically, parties of the right. There are two kinds of such parties: One is the parties of the populist radical right (PRR), discussed in this section. The other is "mainstream" right parties discussed in the next section.

PRR parties and politicians:

> …share a core ideology that includes (at least) a combination of nativism, authoritarianism and populism (Mudde 2007: Chapter 1). By nativism, I mean a xenophobic form of nationalism in which a mono-cultural nation-state is the ideal and all non-natives (i.e., aliens) are perceived as a threat to the nation. Authoritarianism entails a strict belief in order and its stringent enforcement within society through discipline, law and order-based policies. Finally, populism is defined as a thin ideology that considers society to be essentially divided between two antagonistic and homogeneous groups, the pure people and the corrupt elite, and wants politics to reflect the general will of the people (Mudde 2014).

Noteworthy PRR parties include the French Rassemblement National (RN),[2] the United Kingdom Independence Party (UKIP) and British National Party (BNP), the German Alternative for Germany (AfD), the Austrian Freedom Party (FPÖ), the Italian League (Lega), the Hungarian Jobbik, the Polish Law and Justice party (PiS), the Finns Party, the Danish People's Party (DPP), the Vlaams Belang in Flanders, the Swiss People's Party (SVP), and the Dutch Freedom Party (PVV). These parties have dense enough international contacts to show that they view themselves as a coherent party, though others, such as Hungary's Fidesz party, are PRR parties that formally belong to and benefit from belonging to other party families.

These parties clearly do not have a monopoly on PRR rhetoric, policies, or style. Boris Johnson, Donald Trump, and Jair Bolsonaro are particularly high-profile PRR leaders whose parties are not historically PRR parties, but they are not alone. Many politicians within "mainstream" parties will use PRR rhetoric and advocate for PRR policies. We should expect that the success of PRR parties will be explained in large part by electoral systems – for example, the majoritarian, first past the post-electoral systems, such as those of the United States and the Westminster parliament in the United Kingdom, create incentives for PRR advocates to operate as party factions within the Republican and Conservative parties. Other electoral systems make it easier for small parties to win representation (it is amusing but no accident that UKIP did best in the proportional representation elections held for the European Parliament). The presence of a PRR party is therefore an imperfect guide to the actual support for PRR ideas and politics; France has a well-known PRR party that governs very little, while the United States, with no conventionally designated PRR party, had Donald Trump as president and a nearly ideal type PRR politician.

We, therefore, look at PRR politics and politicians, not just PRR parties. If the impact of the populist radical right depended on parties that clearly belong to the PRR family, its impact in most countries would be very limited. But since the phenomenon of PRR politics extends beyond particular parties, it is necessary to include politicians as well.

A longstanding literature looks at PRR parties themselves, examining members, doctrines, and promises. This literature, typically European and broadly constructivist and historical, looks at party doctrines and changing organization, tracing the parties and what they espouse as well as, in many cases, interviewing members. Fine examples include Mudde (2016b), Camus and Lebourg (2017), Shields (2007),

[2] Pre-2018, this party was known as the Front National (FN).

Ford and Goodwin (2014)). Overall, it has some limitations. First, many of the parties, especially further back in history, were quite marginal. Studies of today's PRR parties when they were small, or of their ancestors, are of unclear usefulness. Is studying the defunct UK National Front, the near-defunct British National Party, or the active but marginal English Defence League a good way to understand the direction of British politics? At best (e.g. Winlow et al. 2017), these parties and their members' perspectives can be understood as data on views, and perhaps malaise, in some part of society. Further, insofar as the focus of this research was often on ideologies, the inconsistencies of populists created problems. It is always difficult to demonstrate that parties of any kind have such a dedication to ideological coherence as to repay study of their ideologies.

One reason ideology is studied is that a small enough party will offer little else to study. Most of the PRR is made of small parties (and much else that could be called PRR is to be found in factions of larger parties). A look at literature about the PRR shows research on a galaxy of groupuscules and a publication bias (worse still in the mass media) towards focusing on their successes rather than their many failures and high overall mortality as parties (Glynos and Mondon 2016; Mudde 2013). If we are interested in mass political behaviour or public policy, we can disregard many of these parties, except for noting their potential as incubators for political violence (e.g. Belew 2018).

It is rare for a PRR party to actually command anything like a plurality of votes. Even in the cases where major national parties have been led by PRR politicians, such as the UK Conservatives or the US Republicans, those parties did not gain a majority of the popular vote. That leaves for study the more successful PRR parties – the ones that have entered governments in Italy, Austria, the United Kingdom, Switzerland, Poland, Hungary, and Belgium and the ones that have done well in elections such as the Dutch PVV and the German AfD. The literature here is more typical of the literature on political parties in general, looking at their strategies, places in party systems, and voters. With regard to their behaviour in office, it finds that they do generally adhere to their programmatic goals, even if they tone down their rhetoric (Afonso 2014; Tjitske Akkerman et al. 2016; Akkerman and De Lange 2012; Albertazzi and McDonnell 2015; Albertazzi and Mueller 2013; Bobba and McDonnell 2016; Kriesi and Pappas 2016). The hypothesis of Mény and Surel (2002) that populist parties are necessarily most successful as opposition parties is clearly not supported. They can and do govern.

This literature might nonetheless be of limited use to those who are concerned about the relationship between the PRR and policy. Survival in government, and even consistency on key issues, still does not tell us much about their health policy and effects.

In short, there is remarkably little literature on any policy effect of PRR parties and even less on health as a specific topic. The literature has instead focused on PRR parties' ideologies and voters even when there were policies available to study. Up to 2016, it also had a strong tendency to focus on PRR parties rather than grapple with the phenomenon of PRR *politics* and *politicians* in the context of established parties – meaning, that it was more sensitive to the evolution of a UKIP or fringe

white supremacist groups than to behaviour of leading politicians in big parties that fit the definition of PRR or to the interaction of big and fringe parties that leads to major party adoption of PRR ideas (Twist 2019).

Emblematically, there are two Oxford Handbooks on the topic: *The Oxford Handbook of the Radical Right* (Rydgren 2018) and *The Oxford Handbook of Populism* (Kaltwasser et al. 2017). Between them they have 68 chapters. Only one is about policy effects. This lack of interest in policy consequences is a research opportunity.

Populist Radical Right Parties and the Mainstream

The marginality of many PRR parties means that much of the actual practice of populist radical right politics today is being carried out by the "mainstream" right – whether the US Republican Party, the UK Conservative Party's approximation to key UKIP stances on immigration and the EU, or the widespread adoption of harsh and restrictive stances on immigration and migrant policy by parties across the spectrum. In order for PRR policies to be executed, they typically have to be adopted or supported by parties that actually hold office, and PRR parties rarely control entire governments. If, for example, leading Conservative Boris Johnson had not agreed with UKIP about the desirability of Brexit, it would likely narrowly have failed (Clarke et al. 2017). If Republican elites had not put party loyalty above their views of Trump, it is likely that they could have fatally damaged his candidacy (Levitsky and Ziblatt 2018). If the Austrian Christian Democratic People's Party (ÖVP) had not decided to go into coalition with the FPÖ, the PRR would not have been in office in Austria.

In other words, studying the development and deployment of PRR politics and policies among mainstream parties might be a more effective way to understand policy outcomes than focusing on often-marginal PRR parties. It was Conservatives, after all, who became the party of Brexit and the French mainstream right, including President Emmanuel Macron, that have taken a very hard line on immigration.

The French term for the adoption of populist radical right positions by mainstream parties is *droitisation* (which would overly literally translate to rightization, or, less literally, a pull to the right). The term could usefully be imported into English language literature in order to capture the gravitational pull of the populist radical right, whether as a threat from a separate party (as with the FN in France) or as a force within an established party (as with the Trump movement within the US Republicans). The presence of PRR parties can cause the leaderships of other parties towards the populist radical right by changing agendas and activating previously dormant or suppressed political currents (Williams 2006).

It is also worth noting one point, which is that there are little discussed linkages between liberal (pro-market) parties, or parties occupying the pro-market liberal space of politics, and the far right (Afonso and Rennewald 2017). This can be quite overt in cases such as the Austrian FPÖ, which was founded by ex-Nazis as a

national liberal alternative after World War II and has since shifted between explicit radical right populism under Jörg Haider and a more liberal approach post-Haider, or the mainstream German Free Democratic Party, which has been accused of flirting with PRR stances and in 2017 caused the breakdown of coalition talks with its demands for very restrictive immigration policies. Two major PRR parties, UKIP and the AfD, were in fact founded by liberal anti-EU economics writers and drifted towards the PRR over time (to the dissatisfaction of their founders).

The research agenda would then focus on *droitisation* – the adoption of PRR rhetoric, based on authoritarianism, nativism, and populism, and its transfiguration into policy by mainstream parties. Given this frame, there should be an abundance of potential health policy case studies, particularly surrounding access to health care and public health for migrants and vulnerable groups, since it is possible to portray health as a zero-sum conflict over resources or a giveaway to the undeserving.

Populist Radical Right Politics and Health Policy

The decisions that politicians in power make shape the conditions in which people live and the choices that are available to them (McKee et al. 2020). Most of these choices and conditions, described as the political determinants of health (Bekker et al. 2018; Greer et al. 2017), directly impact people's health and quality of life and are therefore necessary to consider.

In what, to our surprise, was the first work picked up by the review, Greer wrote in 2017 on the likely public health consequences of 2016s PRR victories. Greer argued that PRR politicians are "a threat to core values of medicine and public health even when they hold office in a functioning democratic system" (Greer 2017). This publication was followed closely by an issue supplement in the *European Journal of Public Health* pointing to the fact that PRR policies might have significant implications for unequal access to welfare benefits and increasing health inequalities (Greer et al. 2017). The following year, Falkenbach and Greer looked at the impact of PRR parties on policy, what PRR parties have done to implement their views, and whether they make a difference. Their findings included that PRR politicians tend to de-emphasize the issue, preferring to focus on migration, crime, and security rather than health and welfare, and they prefer to pursue exclusionary policies. In addition, they found that it is unclear whether PRR politicians increase or decrease benefits for the "native" populations they claim to represent (Falkenbach and Greer 2018).

The latest study attempting to look at the impact PRR politicians have on health came in the form of a scoping review. The authors established that there is little research "about the direct relationship between PRR parties and health" (Rinaldi and Bekker 2020). In fact, they found the research surrounding health policies to be so thin that they had to expand their scope to include social policies. This combination of social and health policies led them to the conclusion that PRR parties impact welfare policies by implementing a welfare chauvinistic agenda that restricts access

and eligibility to provisions for outsider groups such as immigrants and minorities (Rinaldi and Bekker 2020). All previous studies on the actual political impact mentioned health as part of the welfare system but focused their efforts more on the social and migration policies passed by the PRR.

Thus, it is established that the research surrounding what radical right populists actually *do* in office is limited. This is a pressing question since what they do in office naturally shapes their impact and political survival and it is one where policy researchers in health can complement more process-focused political scientists. We develop six hypotheses from our review.

The first two hypotheses are about the impact of the PRR on the welfare state's decommodifying and egalitarian properties. We can think of programmes such as health care and public health along two axes: generosity and the exclusiveness of benefits (Table 2 presents them as a schematic four-cell for simplicity). The *generosity* of benefits is a longstanding preoccupation of the welfare state literature. Conceptually, it is the extent to which a welfare state decommodifies by reducing people's dependence on money, e.g. the extent to which access to health care is independent of income (Esping-Andersen 1990; Marshall 1950). For health, the generosity of benefits can be and is measured in a variety of ways, e.g. out-of-pocket expenditures, prevalence of catastrophic healthcare expenditures, financial barriers to access, or resource-based barriers to access such as the adequacy of facilities.

The *exclusiveness* of benefits is and is not a longstanding preoccupation of the welfare state literature. It is, insofar as inequalities in access and benefits *within* systems have long interested analysts. It is not, however, insofar as the access of outsiders such as migrants to benefits is a newer and largely separate field. Conceptually, the exclusiveness of benefits is the extent to which access is restricted on grounds of, for example, citizenship, residency, or participation in a social insurance scheme. The least exclusive benefits are available to all. The most exclusive benefits are those which require membership in some scheme that involves having money, legal residency, and an established labour market position. Exclusion can also be directed at particular groups; for example, if reproductive health services such as abortion are illegal, unfunded, or made difficult to access, that is a form of exclusion of women, and if services relevant to transgender populations are unavailable, that is an exclusionary policy directed against them. The health inequalities literature is rich in examples of exclusion in policy and practice.

We can look at PRR politics in practice by studying changes in exclusiveness and generosity. There are two main hypotheses about which cell a given PRR party will land in. The first, which we can call *liberal chauvinism* (Falkenbach and Greer

Table 2 Welfare politics

	Increase or maintain access to benefits	**Reduce access to benefits**
Increase or maintain generosity of benefits	Social democratic universalism	Welfare chauvinism
Decrease generosity of benefits	Liberal universalism	Liberal chauvinism

Source: authors

2018), combines racial and ethnic animosity with a class conservative preference for a small state. In their classic study, Kitschelt and McGann found that PRR parties were essentially liberal or conservative parties who shared those parties' animus towards welfare states, extensive welfare programmes, labour unions, and non-contributory benefits (Kitschelt and McGann 1997). The PRR parties were distinguished largely by their stances on policies towards immigration (policies about border control and entry) and migrants (immigrants' benefits and responsibilities once in the country). In other words, Kitschelt and McGann identified PRR parties as essentially liberal but with a special animus towards immigrants and other minorities. *This hypothesis predicts that the PRR in power will reduce generosity and increase the exclusiveness of benefits with a special emphasis on migrants.*

The second hypothesis, *welfare chauvinism*, was first introduced by Andersen and Bjørklund as the view that "welfare services should be restricted to our own" (Andersen and Bjorklund 1990, p. 212). The term has since evolved to imply that "welfare benefits should be both generous, indicating a strong support for economic redistribution, but at the same time the benefits should be restricted to the native population" (van der Waal et al. 2010; Keskinen et al. 2016). PRR parties do indeed often make welfare chauvinist claims (Norris 2020; Schroeder 2020). This hypothesis predicts that the PRR, in power, will increase the generosity of benefits and their exclusiveness or dilute coalition partners' efforts to decrease the generosity of benefits (Röth et al. 2017). They will create generous welfare states for the "people" and vigorously exclude outsiders. This was the agenda many attributed to Donald Trump, who spoke forcefully about defending the Medicare programme that helps so many of his core elderly voters. It could also be seen in the promise painted on the side of the Brexit campaign bus that Brexit would free up millions for the National Health Service (NHS). In neither case is it clear that the promise of welfare chauvinism will or can be matched with actual expenditure, which is a key empirical question. *This hypothesis suggests that the PRR increases generosity and exclusiveness.*

The third hypothesis is that they adapt a *Conservative* direction from their, more than likely, centre-right coalition partners as a result of insufficient power to move in their direction of choice (see earlier section on "Populist Radical Right Parties and the Mainstream). When PRR politicians come to power, it is often in the form of a coalitional government, wherein they assume the role of minority partner. This Conservative/Liberal approach is shaped by traditional family values and a preference for a small state that only steps in when absolutely necessary. This implies that generosity is reduced across the board and exclusivity is increased across the board, no exceptions. *This hypothesis predicts that when a PRR politician joins a coalitional government wherein s/he assumes the minority role, the PRR will adopt the Conservative position of reducing generosity for all.*

The fourth is *welfare populism* (de Koster et al. 2012; Michel 2017), a combination of egalitarianism with critical views of the welfare state. PRR politicians that follow this welfare strategy argue that the welfare state no longer functions as it was meant to, supporting the "common man" in need of social assistance, and has

instead turned into an instrument catering to self-serving bureaucrats and those undeserving of assistance. *This hypothesis proposes that when in power, PRR politicians will communicate their animosity towards the welfare state and create policies that are beneficial to the "common man" as opposed to bureaucrats or migrants.*

The fifth hypothesis is that populists, PRR or otherwise, will engage in *clientelism* (Müller 2016) when in government. The direction of state resources can change regardless of whether the overall quantity of state resources is increasing. Decreasing resources can even trigger greater importance for the distributors of clientelistic benefits as their clients bid for continued support. For example, in what was billed as a public health policy, the Hungarian government created a state tobacco monopoly and thereby was able to distribute concessions for tobacco sales de novo. This move redistributed tobacco sales revenue – and sometimes all the revenue from general shops that needed tobacco sales to survive – from their previous owners to the party's clients. As a result, the Hungarian retail tobacco sector is now made up of clients of the governing party (Lendvai-Bainton and Szelewa 2020; Magyar and Vasarhelyi 2017). Against this analysis, there is Cas Mudde's contention that there is no necessary relationship between clientelism and populism. As he points out, plenty of politicians and regimes use clientelism and there is no particular reason to believe that the two have an affinity (Mudde and Kaltwasser 2017). Part of the analytic problem is the term "mass clientelism" (Müller 2016), which would require a precise definition to distinguish it from public policies targeted at large groups. The presence or absence of clientelism can, of course, be tested in addition to the previous two hypotheses as clientelism can be present within a governmental structure irrespective of changes in exclusiveness or generosity; thus, the hypothesis: *the administration of programmes would become more clientelist under PRR politicians*. This can, of course, be the case in addition to also pursuing welfare chauvinist, populist liberal, or conservative policies.

The final hypothesis is that the PRR will be distinctively *antiscientific* in their rhetoric and actions (McKee 2017; McKee et al. 2017). This hypothesis certainly seems plausible, given the long record of many populist leaders of questioning basic science (e.g. Nigel Farage, leader of the Brexit campaign, has questioned the link between smoking and cancer, while Donald Trump has repeatedly suggested that vaccination can cause autism) (Bienkov 2017; Buncombe 2018) and the appeal to common sense intrinsic to anti-elitist PRR politics. The pro-Brexit UK politician Michael Gove confirmed the people's impatience with experts (Mance 2016).

Despite this anti-intellectual style, which is almost definitionally part of any anti-elitist and anti-pluralist ideology, it is not actually clear that the PRR is systematically more antiscientific than other parties, and it is perhaps noteworthy that political scientists generally do not find this issue worthy of a focus. Donald Trump has vigorously questioned the link between carbon emissions and climate change, but all of the 2016 Republican presidential primary candidates did, as do most elected Republican officials and a large share of their voters (Davenport and Lipton 2017). Likewise, the Austrian PRR party FPÖ undid a 2015 ban on smoking in public places agreed by their coalition partners ÖVP (conservative) party. Austria has the third highest percentage of smokers (over 30%) in the EU (Eurostat 2016), and over

25% of deaths were caused by tobacco in 2016 (The Tobacco Atlas 2018). Despite these facts, one of the conditions that the FPÖ presented during coalition talks with the ÖVP in late December 2017 was to drop the smoking ban set for enforcement on May first, 2018, directly linking this decision with the FPÖ entering government. This decision is certainly not good public health policy, but is it antiscientific, or is it a belief about rights and trade-offs held by the FPÖ?

The literature on the use of science in policy-making is full of discussions of how politicians of all kinds ignore, misuse, attack, or try to hijack scientific findings and procedures in pursuit of their interests. The first and strongest hypothesis to be tested here is that in some identifiable way, *the PRR is still more likely to act on arguments with no scientific validity than other parties* (Trump called for a major reduction in science funding, but the Republican congress declined to enact the cuts). The second, weaker, version of the hypothesis is that *the PRR will undermine science more than other parties, above all, by starving research and education of resources but also by misusing scientific resources like advisory positions*.

The Coronavirus Test

With the COVID-19 pandemic, the world has been exposed to the biggest public health crisis to date providing researchers with a new and perhaps more direct chance of studying PRR politicians and their impact on public health and health policy (Greer et al. 2021). We conducted an additional systematic review intended to identify literature discussing the impact of the PRR on the politics of the COVID-19 pandemic.

COVID-19 has produced an even larger volume of scholarly publication than populism: as of 30 September 2020, 9 months after the very first publications, a search in Google Scholar found no variant on COVID-19 (e.g. coronavirus, COVID-19) that received fewer than half a million hits. Populism was the topic of a paltry 14,500 Google Scholar entries in 2020 as of the same date. It is hard to imagine that there would be any islands left uncovered by such a flood of scholarship. Indeed, there was a significant amount of publication on the topic, which shed light on (and often confirmed) existing theories of PRR politics, though public health and health policy received just a light drizzle of scholarship compared to some other fields.

The goal of the search was to find articles that showed how PRR politicians in government or in opposition were reacting to the corona pandemic. Electronic bibliographic databases (i.e. Political Science Complete, JSTOR, and Google Scholar) were used to conduct this search from January to September 2020 using the following search terms: “coronavirus” and “populist radical right”. The result was sixty-seven hits. Published articles in peer-reviewed journals were chosen if the full text met the following criteria: (1) published in 2020, (2) full text available in English, and (3) actively discussed and analysed the reaction of PRR politicians to

the corona pandemic. In this review, thirteen articles were found to meet these criteria. Of these thirteen articles, five (Bambra and Lynch 2020; Clark and Patterson 2020; Falkenbach and Greer 2020; Lendvai-Bainton and Szelewa 2020; McKee et al. 2020) came from commentaries reflecting on Rinaldi and Bekker's 2020 scoping review of PRR parties' influence on welfare policy and its implications for population health. One article discussed Australia's PRR politician Pauline Hanson's political communication on Facebook. It found that she used the pandemic to indulge in nativist policies such as immigration (Sengul 2020). Three articles look at populism in general and how it has impacted reactions to the pandemic (Greer et al. 2020; Widmann 2020). One article introduces the notion of "medical populism" as it pertains to the usage of the pandemic to pit people against the establishment in Brazil, the United States, and the Philippines (Lasco 2020), and two other articles talk about the increased authoritarianism and antiscience rhetoric, particularly in Eastern Europe and South America (Bergmann 2020).

Together these findings produce three concrete results: (1) At least some PRR politicians have increased their antiscience rhetoric during the pandemic, justifying this approach by pointing to the crumbling economies and denied personal freedoms; (2) if in government during the pandemic (Bolsonaro, Trump, Johnson, Duterte), hypotheses have been made that PRR politicians have performed poorly in handling the threat in an efficient and effective manner; (3) PRR politicians have blamed migrants, institutions, and other countries for the pandemic, thereby reinforcing the "us" (common people) vs "them" (out-of-touch elites and foreigners) sentiments.

Faced with a pandemic, PRR politicians' key strategies, whether in or out of power, were denial and distraction (Davis 2020; Falkenbach and Greer 2020; McKee et al. 2020). Denial can be explicit, as with Trump's claim that coronavirus was a "hoax" (Epstein 2020) or Bolsonaro's statement that it was nothing but a "little flu" (Borges 2020), but it can also be implicit. Demands to reopen countries before containing the outbreak as were made by the PRR in Austria and Lega in Italy were sheer economic strategies that had little scientific backing. Distraction meant blaming somebody else, be it the EU, World Health Organization (WHO), or foreigners, and led to damaging border control policies as well as the US decision to leave the WHO mid-pandemic. Both strategies undermine public health and cost lives, making the corona pandemic an interesting and important occurrence to contemplate when thinking about the PRR and health.

The Book in Brief

This book will identify PRR politicians as an independent variable (based on their expressed nativism, populism, and authoritarianism) and then look to see what health policies they promoted and/or implemented while in government. The health policies will then be characterized according to the book's hypotheses, thereby determining if there is a distinct characterization that PRR politicians in a given country follow when it comes to health policies.

The country cases were chosen to allow for a diverse and holistic picture of active PRR politicians across the globe. Italy and Austria have the longest history of PRR politicians in government. The Netherlands's longstanding consensual, "pillarized" party system has been massively disrupted by PRR parties. The PRR parties of Hungary and Poland have driven democratic backsliding, producing authoritarian regimes within the EU. The United States and Brazil provide current examples of PRR politicians in systems without established PRR parties, while the Philippines showcases the most well-known case in Asia. While the focus is on PRR politicians either currently in government or with previous governmental experience, we found it important to include one PRR party that has only been in opposition to showcase the influence of opposition parties. The AfD in Germany has never been in government, but the case has many useful insights highlighting how the PRR works in opposition and how the PRR influences policy despite being in the opposition.

Each case chapter follows a similar structure. The introductions will briefly touch on the PRR politician's history, the acceptance in the country and among other parties, and why the party can be considered populist radical right. This information will be gathered through a literature review. The core of the chapter will encompass the PRR politician's health policy focus. Policy proposals, decrees, regulations, and laws having to do with health will be analysed to acquire a holistic picture of what PRR politicians actually support in terms of health policies. As a current, specific and direct example of the politician's attitude towards health, a section in each case chapter will be contributed to the coronavirus wherein actions and reactions of the country's PRR politician will be noted and analysed. The chapter's conclusion will highlight what kind of health policies PRR politicians prefer given the book's framework and under what conditions they prefer them. In addition, the conclusion will provide an outlook for further research regarding health policy and the PRR.

Chapter 2 "The Austrian Freedom Party in Government: A Threat to Public Health?" on Austria tells us that a welfare populist approach was followed pre-2013 after which it was replaced with a tendency towards welfare chauvinism. This case also highlights that when a PRR party is in a coalition with a dominant and more right-leaning conservative party (i.e. the new ÖVP) a combination of liberal chauvinism, welfare chauvinism, and a generally conservative approach towards health care can result. In addition,this case presents a clear example of PRR parties acting on arguments that have little to no scientific backing (see renege on the smoking ban).

Chapter 3 "The Alternative for Germany (AfD) and Health Policy: Normalization or Containment of Populist Radical Right Tendencies?" on Germany showed us that PRR politicians do not have to be in government to influence health policies. The features that characterize PRR parties – nativism, authoritarianism, and populism – can be transported in more subtle ways such as framing widely acknowledged policy problems through nativist and populist lenses.

Chapter 4 "Populist Radical Right Influence on Health Policy in the Netherlands: The Case of the Party for Freedom (PVV)" on the Netherlands made apparent that

being the weaker party in government often implies trade-offs. The PVV's agenda on health care is welfare chauvinistic; favouring increased government spending (primarily for older adults) combined with the exclusion of certain immigrants. During its time supporting a centre-right coalition, the PVV faced a trade-off between pursuing its electoral agenda and maintaining its position in office. The party maintained a strong focus on immigration and elderly care but conformed to the coalition at the expense of its welfare chauvinistic healthcare agenda.

Chapter 5 "The Evolution of the Populist Radical Right and Their Impact on Health in Italy" on Italy shows how external pressures can dictate governments' health policies no matter where on the political spectrum, the parties in power lie. The health policies passed or supported by Lega politicians can be summarized as being (1) Conservative due to the strict debt containment measures during the Berlusconi coalitions (II–IV) and (2) welfare chauvinistic as there were several attempts to decrease healthcare access and social benefits for migrants. It must, however, be concluded that health policies in the country might be better studied on a regional level seeing as the devolution of the health system has left the national competencies rather sparse.

Chapter 6 "The Populist Radical Right and Health in Hungary" on Hungary presents the case of a PRR politician that has been the head of the largest party in parliament since 2010, dominating politics by holding a supermajority. This implies that the party has been relatively unconstrained in the types of policies it formulates and implements and has therefore been able to systematically undermine democratic checks and balances to further its grip on power and its control over policies. The party has had a negative indirect impact on population health through its promotion of statist, liberal chauvinistic reforms and reforms marred by clientelism.

Chapter 7 "Is the Polish 'Law and Justice' (PiS) a Typical Populist Radical Right Party? A Health Policy Perspective" on Poland is illustrative of the tenuous link between traditional neoliberal right-wing health policies and the PRR agenda. PiS's health policies share some of the traditional Western PRR parties' stances in that they combine left-wing redistributive policies with right-wing socially conservative stances. However, in health policy, PiS does not subscribe to welfare chauvinism, which is typical of PRR parties. Instead, they can be characterized as promoting "conservative welfare state populism" (culturally conservative, welfare state expansionist populism). Thus, while PiS has been described as a "textbook" PRR party in the context of its migration policy or attitude to the rule of law when it comes to health policy, it diverges from this description.

Chapter 8 "The Case of the United Kingdom Independence Party (UKIP)" on the United Kingdom shows us how UKIP has employed welfare chauvinist narratives to elevate anxieties over "health tourism" and abuses of the national healthcare system by "outsiders." This has placed pressure on mainstream parties to adopt aspects of its platform reflected, for example, in the adoption of immigration health surcharges by the Conservative government. By co-opting UKIP positions, the Conservatives have enabled PRR ideas to influence health policy in the United Kingdom.

Chapter 9 "Rhetoric and Reality in the United States of America: Trump, Populism, and Health Policy" on the United States shows that a PRR politician does not have to be supported by a PRR party. While health policy under the Trump administration has delivered few concrete policies, it has had success through its implementation of welfare and liberal chauvinistic policies seeking to rein in the role of government in the welfare state while denying benefits to out-groups, such as minorities and immigrants.

Chapter 10 "Ruling Through Chaos in Brazil: Bolsonaro's Authoritarian Agenda for Public Health" on Brazil shows public health policies that reflect a combination of increasing authoritarianism and high levels of economic liberalism wherein Conservative policies and cuts in public investments are the Bolsonaro government's signature. In addition, Bolsonaro simplified the severity of the COVID-19 pandemic and used it as a stage to enhance social division and polarization to surpass the crisis unharmed and maintain his electoral support base.

Chapter 11 "An Authoritarian Reaction to COVID-19 in the Philippines: A Strong Commitment to Universal Health Care Combined with Violent Securitization" on the Philippines showcases an authoritarian populist leader whose welfare programme combines a progressive and inclusive social policy – such as the introduction of universal health care – with the PRR rationale of exclusion and excessive use of political violence against single vulnerable groups and political opponents.

It should be trivial to say that politics matters in public health, but it isn't. Public health scholarship has a profound culture of apolitical expertise, which impoverishes our conceptual tools for understanding how, when, and why politics shapes health policy and health outcomes. This book certainly shows that politics matters, with a global tour of the populist radical right and its impact on health that should inform public health scholarship and action. At the same time, it remedies one of the characteristic deficiencies of political science research: a lack of interest in policy. The finding that there have only been a few dozen publications on the populist radical right and health is stunning, even more so when we compare it to the thousands of publications on populist radical right politicians, strategies, and voters.

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The Austrian Freedom Party in Government: A Threat to Public Health?

Michelle Falkenbach and Raffael Heiss

Introduction

The Federal Republic of Austria, located in the heart of Europe, bordered by Switzerland, Germany, Italy, Hungary, the Czech Republic, Slovenia, and Slovakia, has had a long-standing history of being governed by a "grand coalition" made up of the conservative Austrian People's Party (ÖVP) and the Social Democratic Party (SPÖ). In fact, there were only a handful of years where there was not a grand coalition on the federal level,[1] which is to say that these two parties dominated much of the post-war government. The other party that found itself in government three times was the Austria's Freedom Party (Freiheitliche Partei Österreichs, FPÖ). Today this party is considered to be one of the most successful populist radical right (PRR) parties in Europe (Ennser-Jedenastik 2016), but that was not always the case.

The FPÖ's first years in government as a PRR party (2000–2005) were marked by internal arguments and scandals wherein their policies, mostly social, generally took the back seat. By their third round in a governmental coalition (2017–2019), the FPÖ was much better prepared and able to implement (with the support of the ÖVP) many pivotal health and social policies. We include social policies in this

[1] In 1966 the ÖVP was in government alone. Between 1971–1983 the SPÖ was in government alone. From 1983 until 1986, the SPÖ formed a coalition with the FPÖ – at this point the FPÖ was not yet considered PRR, rather a liberal democratic party (Pelinka 2002). From 2002 until 2006, the ÖVP was in a governmental coalition with the FPÖ/BZO. In 2017 until 2019, the ÖVP formed a coalition with the FPÖ, and in 2019 the ÖVP joined forces with the Greens.

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chapter as social determinants of health (SDH), factors, aside from solely medical components, that are influenced by social policies and indirectly influence health (Braveman and Gottlieb 2014). Such social policies were actively pursued by the FPÖ and had an indirect impact on health. While the focus of this chapter as well as the entire book is on the health policies pursued by PRR politicians, we find it important to shed light on the importance of the SDH, specifically in a case like Austria where the social impact on health is significant.

This chapter will begin with the history of the FPÖ tracing their transition from a party with primarily welfare populist policy goals (2000–2005) into one that adapted a welfare chauvinist approach to governing (2017–2019). Health-related policy decisions, both indirect, through social policies, and direct, through health policies, will be traced back to the year 2000 when the FPÖ entered into the national government coalition.[2] A short section will reflect on the FPÖs reaction to the coronavirus, and the conclusion will summarize the findings. The goal of this chapter is twofold: (1) to lay out what the FPÖ actually does in government with regard to social and health policies and (2) to establish what type (welfare populist, chauvinist, liberal, or conservative) of health and social policies the FPÖ pass when in government.

History of the FPÖ

The Freedom Party was founded in 1956 as a successor party to the Federation of Independents (VdU) by former national socialist Anton Reinthaller as an alternative to the red-black coalition governments of the SPÖ and ÖVP (Ellinas 2010). The party was formed by both a liberal and a nationalist wing making the creation of clear political strategies difficult seeing as the former was interested in free enterprise and the preservation of individual liberties while the latter found its hold in the former Nazi philosophies. By 1958, upon the death of Reinthaller, Friedrich Peter took over the party and led it towards increased ties with the SPÖ. Under Norbert Steger, Peter's successor, the FPÖ entered into a governmental coalition with the SPÖ in 1983. By 1986, however, after just three years in government, one internal crisis led to the next and Steger lost support within his party. He was replaced by the charismatic Jörg Haider.

Haider brought with him neo-Nazi tendencies that appealed to the party's conservative nationalists, an oratorical gift that united him with his voters, and an authoritarian grip that held together his party. His ascension to leadership marked the FPÖ's turn to the PRR party family (Ennser-Jedenastik 2016). Under Haider the FPÖ achieved great success in both national and provincial elections and was finally seen as a viable alternative to the ÖVP and SPÖ (Fig. 1). His most popular political

[2] The FPÖ was in a governmental coalition with the SPÖ between 1983 and 1986, but at that time the FPÖ was plausibly classified as a liberal party (Huber 2009).

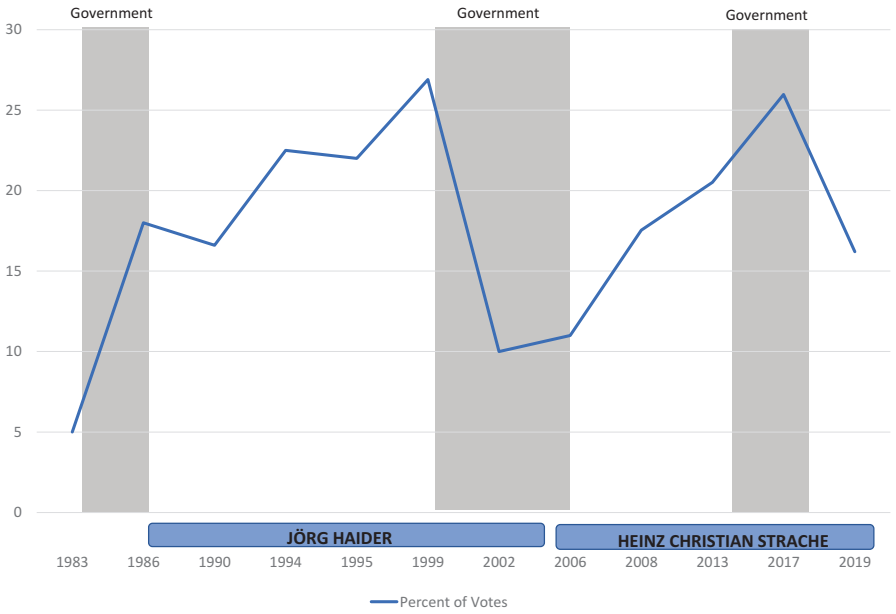

Fig. 1 FPÖ vote share at parliamentary elections 1983–2019. (Adapted from Ennser-Jedenastik 2016)

goal was to cut down the number of foreigners allowed to live in the country. In 1991, he was able to pass a law stating that no more than 10% of the country's workforce could be made up of foreign workers.[3] This antiforeigner sentiment is what would lead to increased tensions between the liberal and conservative factions of the party, resulting in the liberal faction leaving to form their own party in 1993.

From Welfare Populism to Welfare Chauvinism

The Haider period of the FPÖ (1986–2005) followed two main goals: (1) breaking the SPÖ/ÖVP dominance within the Austrian political party system and (2) solidifying the FPÖ as a votable party fit to take part in a government coalition. The first point was a success as the SPÖ and ÖVP parties were forced to broaden their political party spectrum. The second point turned out to be more problematic for the party ultimately resulting in a new party leader and a complete rebranding of the FPÖ.

The FPÖ under Haider marked the party's turn from liberal to PRR (Bailer and Neugebauer 1998). This was not only made visible through party members' extreme right and neo-Nazi sympathies but also through Haider's policies which offered

[3] This was reduced to 9% in 1993 under the Resident Alien Law (Austrian Parliament 1993).

simple solutions to complex problems. Haider presented his party as a new "workers party". Under this banner he sought to (1) decrease the power of the bureaucracy (trade unions, institutional structures, SPÖ), which he accomplished by passing the pension reform in 2000 wherein the social partners' role was significantly decreased (Schludi 2005; Talos and Kittel 2001), and (2) increase welfare benefits for the average worker while trying to simultaneously reduce these same benefits for bureaucrats[4] and immigrants (Hacklerregelung in Ennser-Jedenastik 2016). These were probably contradictory goals. On the one hand, he presumably wanted to decrease the generosity of the welfare system for bureaucrats by first and foremost removing their overwhelming influence on welfare policies while on the other increasing welfare benefits for the native working class. The policies passed during the FPÖ's time in government under the leadership of Haider, however, resulted in benefit cuts for all leading to a loss in support for the FPÖ in 2000 (see Fig. 1). What started out to be a desire to engage in welfare populist policies quickly turned to liberal chauvinistic ones.

Following FPÖs stint in government, leading to a massive decrease in support, the FPÖ went in yet another direction; this time under the leadership of Heinz Christian Strache. When Strache took over the party in 2006, he rebranded it as "die soziale Heimatpartei" (the social homeland party) (Austrian Press Agency 2005), thereby increasing its anti-immigrant, anti-Islam, and pro-welfare state messaging. This approach, known as welfare chauvinism, emphasizes generous welfare benefits for "the people" and reduced benefits for "foreigners" (Falkenbach and Greer 2018; Mudde and Kaltwasser 2017), which found great appeal with the socially disadvantaged native population (Ennser-Jedenastik 2016). Whereas Haider's main policy points were immigration and pension reforms, under Strache the FPÖ made immigration their core issue while finding a moderate tone on socioeconomic issues. This change in both leadership and policy focus paid off as the party under Strache began recovering, reaching former heights by 2017 (Fig. 1). The FPÖ under Strache was exceptionally successful until the 2019 "Ibiza affair"[5] that led to a dismissal of the ÖVP-FPÖ government and the removal of Strache from the party. Since that point the FPÖ has been struggling to find a charismatic leader to turn the party's luck around at the polls.

The FPÖ and Their Social Policies

Haider and Strache had several things in common: charisma, dedicated followers, and a drive to implement strict immigration policies to limit the number of foreigners residing in Austria. One of Haider's greatest accomplishments in this realm was

[4] Attacks against bureaucratic privileges stopped once the FPÖ entered government (Ennser-Jedenastik 2016).

[5] See Oltermann (2019).

maintaining one of the most restrictive regimes on family reunions for foreigners (Heinisch and Hauser 2016), consistent with his aversion to European integration. Strache's greatest anti-immigrant feat was the passage of the Family Equalization Law (see Strache 2017–2019). Among their differences, however, was the way in which they pursued social policies.

Haider (2000–2005)

Surprisingly, when the FPÖ was asked to join the ÖVP as junior partner in the 2000 governmental coalition, Jörg Haider, the head of the party at the time, opted to stay in Carinthia as governor saying that he would only go to Vienna as chancellor (Badzic 2008). Instead, Susanne Riess-Passer assumed the role of vice chancellor for the FPÖ until 2002 when she was replaced by Herbert Haupt. Although Haider did not assume the role of vice chancellor, a move that many argue weakened the party (Austrian Press Agency 2003), he did still try to assume control of the ongoings in Vienna (Austrian Press Agency 2004). Therefore, although Haider was not vice chancellor in the national governmental coalition, he was still head of the FPÖ and very much controlled the party's direction.

As previously mentioned, the FPÖ under Haider would have ideally followed a welfare populist path with regard to social policy; however, his coalition partner (ÖVP) prevented this. The coalition pushed him more onto a typical conservative path wherein cuts were made across the board without regard for "in" or "out" groups. This can be seen through the pension reform passed in 2000 and fully implemented by 2002. All FPÖ manifestos between 1986 and 1999 called for cuts to or the abolition of politicians' pension privileges or severance rights (Ennser-Jedenastik 2016), whereas the ÖVP wanted to abolish the early retirement scheme, increase financial penalties for each gap year in contributions, lower the conversion rate for each year of contribution, and substantially change how pensions were calculated (Afonso 2014). In an effort to reach a zero deficit three years ahead of schedule (politically important for both coalition parties), the compromise that ensued was an increase in the early retirement age of 1.5 years for both men and women, an increase in the statutory age of retirement for public employees, increased penalties for people retiring sooner than the statutory age of 60 for women and 65 for men, and the abolition of all newly granted widows' pensions for retirees, whose own pension entitlements exceed a certain income limit (Schuldi 2005). Consistent with the FPÖ's desire to dismantle the traditional social partnership system (Greer and Falkenbach 2017) from which it was excluded, the FPÖ notably tried to condition its support for the pension reform on a 40% cut in the mandatory contributions of individuals to the Austrian Chamber of Labour, thereby decreasing the union's institutional influence and satisfying a promise to its core voters, but the ÖVP rejected the demand. The result was that the FPÖ essentially went along with the ÖVP's Conservative plans, garnering them much backlash from their core voters (this may have also influenced the drop in voter support during this period) (Fig. 1).

The social policies passed during the FPÖ's governmental stay under Haider's leadership from afar can be summarized as having been primarily influenced by the ÖVP as they were generally in line with conservative policy changes in other countries (Heinisch 2003), but they also served to weaken institutional networks and break ties with the traditional corporatist structures (Röth et al. 2017). The radical and oft populist tendencies that shone through every once in a while were eloquently contained by the ÖVP (or the constitutional court) and therefore not particularly noticeable in implementation. In essence, the FPÖ helped to enact a series of classical conservative reforms and fiscal measures that ended up being felt most acutely by the very same people the party had wanted to protect – workers (Heinisch 2003). This, along with the split of the FPÖ,[6] may have contributed to the radical decline in the polls (see Fig. 1) until Heinz-Christian Strache's leadership, coupled with Haider's death, gave the party a new wind.

Strache (2017–2019)

The former Health and Social Minister Beate Hartinger-Klein (FPÖ) summarized the FPÖ agenda during their 2017–2019 governmental period as "new" and advocated for "social justice" (Austrian Parliament 2019b). This fit well with the nativist stance the "new" ÖVP (Schultheis 2017) under chancellor Kurz was taking (Gady 2017). Both the ÖVP and FPÖ supported cuts for foreigners, whereby refugees marked the starting point for broader cuts sealing their governmental programme as politically neoliberalistic and welfare chauvinistic (Becker 2018). During their 2-year stay in government, several different social policies were passed, three of which were distinctly welfare chauvinistic in practice.

Beginning with the Family Bonus Plus regulation (Austrian Parliament 2018c), every family would receive a tax credit of €1500 per child per year up until the children's eighteenth birthday, thereby reducing that tax burden of parents. Upon first glance this seems to be a very generous, pro-welfare move. However, upon closer examination, the tax credit applies only to families whose children live in Austria or EU countries (including Switzerland). This regulation was heavily criticized by the opposition because it lacked differentiation between the various socioeconomic groups implying nativist rather than redistributive motivations (Austrian Parliament 2018a). For example, the new regulation cut benefits for families from Eastern European countries, which tend to have more children than Austrian natives. In addition, the credit would be less if a child lived in an Eastern European country[7] (Seidl 2018), therein increasing the welfare chauvinistic style of the reform.

[6] In 2005, Haider split with the FPÖ to form the BZÖ (Alliance for the Future of Austria), which immediately took the place of the FPÖ in the coalition with the ÖVP.

[7] Childcare money is matched to the amount the child would receive in the country where it resides. So, while a 0–2-year-old Austrian child would receive €114, a 0–2-year-old child living in Bulgaria

In November of 2018, Health and Social Minister Hartinger-Klein (FPÖ) proposed the new minimum income law which would standardize the minimum income across the country while also tightening eligibility rules. The minister claimed that the law would promote general cost-efficiency and decrease the dumping "of immigration into the Austrian social system" (Austrian Parliament 2019a). The law was proposed, in particular, to increase the fairness for Austrians wherein Chancellor Kurz argued that there are more minimum-income recipients than the entire population of Burgenland and that every second person that receives this money is not an Austrian citizen (ORF 2019). The proposal stated that a single person would receive €863 per month, which is the same as in the current law. The difference is if that single person does not speak German well or at least speak English, that amount would be reduced to €563 per month. In addition, the proposal sees that families with children would no longer receive the same amount of money per child. Instead, after the second child the amount received per subsequent child would decrease substantially. This additional condition targets, in particular, families with many children – i.e. migrant families. Excluded from any benefits according to the legislation are criminal offenders, foreigners without residence permit, and asylum seekers – in short, minority groups at the bottom of the social hierarchy, according to the PRR. Health and Social Minister Hartinger-Klein (FPÖ) summed up the proposal nicely: fairness for Austrians, others have to wait (Krutzler 2018). While the proposal was never implemented due to the government's premature termination resulting from the Ibiza scandal, this is certainly an example of welfare chauvinism at its best.

The last social policy change, the Family Equalization Law Amendment, was implemented on January first 2019 wherein child support for parents working in Austria whose children live outside of the country would be adjusted to the child support standards of the country in which the child resides (Austrian Parliament 2018b). This implied that Austrian employees whose children reside in Eastern and South-Eastern European EU countries would receive reduced benefits. The desired effect of the policy was to prevent the abuse of welfare payments by other EU nationals that live in Austria and would be, under European law, eligible for social security provisions for their children, even if those children live in another country. The hidden agenda herein is to make Austria less attractive for economic migrants, thereby creating friction between the richer Western European countries against the poorer Eastern ones. This amendment could very well be categorized as being welfare chauvinistic seeing as the government wanted to prevent the welfare state from being seen as an instrument catering to those "undeserving of assistance", i.e. economic migrants.

While the FPÖ ran on and promised welfare populist social policies in the late 1990s, what ensued were ÖVP-led conservative policies that ended up hurting the FPÖ voter base resulting in decreased support for the party by the early 2000s. The

whose parents work in Austria would only receive €51,30. Similarly, a 0–2-year-old child living in Luxembourg whose parents work in Austria would receive €134,52.

FPÖ government under Strache between 2017 and 2019 generally advocated for, and at times was even able to pass, welfare chauvinistic social policies with the help of the ÖVP. The reason that the FPÖ under Strache was able to play more towards its own agenda of welfare chauvinism was because his coalition partner, the "new" ÖVP under Sebastian Kurz, was not only seen as being more right-leaning (Austrian Press Agency 2017) than his predecessors (i.e. Wolfgang Schüssel) but also because the party moved away from its values surrounding Catholicism and tradition and more towards a value base that was situationally elastic and ideologically undefined (Wodak 2018). In fact, many political scientists and commentators feel that the new ÖVP was taking on the role of the FPÖ (Bartlau 2019; Bodlos and Plescia 2018; Lackner 2017; Liebhart 2019; Löffler 2020). These characteristics made the governing coalition that formed between the new ÖVP and the FPÖ particularly precarious seeing as both parties favoured welfare chauvinistic policies accompanying an anti-immigrant political discourse.

The FPÖ's Role in Shaping Health Policies

In two of the three times that the FPÖ participated in coalition governments, they controlled the health ministry (2000–2005 and 2017–2019). The 2000 ÖVP-FPÖ coalition did not introduce deep systemic changes to the healthcare system; however, smaller regulations, such as a partial renunciation from the free co-insurance for couples without children or a new law to raise private patient contributions, were introduced (Tálos and Obinger 2019; Unterthurner 2007). As part of the national government, the FPÖ also contributed to major structural reforms, which began to take shape between 2000 and 2005 and were consolidated in the second ÖVP-FPÖ coalition between 2017 and 2019 (Hofmarcher 2019) (see Table 1). What is particularly interesting in light of these structural reforms is that while the ÖVP-FPÖ governments in both 2000 and again in 2017 aimed at reconstructing the social insurances, the SPÖ/ÖVP government between 2007 and 2017 attempted to strengthen the coordination and cooperation between the different actors within Austrian healthcare system (Hofmarcher 2019). Furthermore, the FPÖ positioned itself as a harsh opponent of tobacco regulations, thereby pushing and succeeding to overturn a planned smoking ban in bars and restaurants in 2018.

The Social Insurance Merger

The ÖVP-FPÖ governmental coalition in 2000 attempted but was unsuccessful in restructuring the main umbrella organization of the social insurance system through the introduction of a "supervisory board". One consequence of such a board would

Table 1 Overview of key FPÖ health policies

PRR health policy	Implemented	Coalition partner	Clientelistic nature	Outcome/comments	Classification
Overturning the smoking ban (2017)	Smoking ban was overturned in March 2018	New ÖVP	No	The ÖVP-FPÖ government was dismissed in spring 2019; smoking ban was reinstated in November 2019	Antiscience
Financing reform of private hospitals (2018)	2018	New ÖVP	The FPÖ allegedly received payments from the private hospitals it helped by passing the new law	Private hospital clinics receive an additional €73 million in the next few years via cost reimbursements from the social insurance contributions of workers	Clientelism
Health insurance merger (2019)	21 insurances were merged into 5 in 2020	New ÖVP	Yes – many former SPÖ health positions were now given to FPÖ/ÖVP	This unification promised to bring €1billion in savings to be used to serve the Austrian people. Instead, it brought millions in losses (Egyed 2020), even more with corona (Austrian Press Agency 2020a)	Conservative / Liberal chauvinism
New electronic health insurance card (2019)	2019–2022	New ÖVP	No	All e-cards are required to have a photo identification on the card by 2022 costing about €18 million	Welfare chauvinism

have been a balance of power between labour and employer organizations (thus, weakening the workers).

The reshaping of the social insurance system was a key target in the 2017–2019 ÖVP-FPÖ government. One of the declared goals was to reduce the administrative costs (Hofmarcher 2019) by 1 billion euros (Jungwirth 2018). In December 2018, the Austrian parliament adopted the Social Insurance Organisational Act (SV-OG), which merged the pre-existing 21 social insurance institutions into only five institutions. These five institutions are now represented by an umbrella organization (Dachverband) instead of the former "Federation of Social Insurance Institutions" (FSII). Despite the fact that the European Commission approved the reduction of

social insurance companies in Austria, the implementation and consequences of this massive structural change are worth a closer look.

On its home page, the FPÖ-led the Federal Ministry of Health described the reform as "ensuring an efficient and modern social insurance system, which is closer to ordinary people" (Austrian Ministry of Social Affairs Health Care and Consumer Protection 2020). To achieve this goal, the plan was to reduce costs through a merger. Thus, the nine regional insurance institutions for privately employed citizens were merged into one national "Austrian" health insurance fund (Österreichische Gesundheitskasse, ÖGK). In addition, the insurance institution for public sector employees (BVA) and the insurance institution for the railways and mining industry (VAEB) were merged into the insurance institution for public sector employees and railways and mining (BVAEB), and, finally, the insurance institutions for trade and industry and for farmers were merged into a common social insurance institution for the self-employed (SVS).

The most criticized components of this reform were: (a) the proportional representation of employer and employee organizations within the newly merged insurance institutions; (b) the emergence of a three-tiered medical system (privately employed, state employed, and self-employed citizens) depending on what type of profession you work in; and (c) the projection that the reform would essentially cost more to execute than it would save, which was one of the main reasons for the reform in the first place. While the first ÖVP-FPÖ coalition already introduced proportional representation at the FSII level, this reform would see a proportional representation system also within the newly merged social insurance institutions. The proportional representation led to a further power shift in favour of employer organizations and a degradation of the role of labour unions (Hofmarcher 2019). Furthermore, even though the reform targeted a merger of the health insurance institutions, the differentiation between professions remains an integral part of the Austrian social insurance system. As a consequence, existing inequalities were not resolved because the reimbursement is still different depending on which institution citizens are assigned to.

Private Hospitals Financing Fund

Besides the reform of the insurance system, another structural reform gained attention: the Private Hospitals Financing Fund (PRIKRAF).[8] The PRIKRAF, established in 2002, distributed finances from public healthcare institutions to certain private hospitals. In 2018, the fund received an additional 15 million euros (representing an 11.5% increase). This not only marked a shift towards strengthening private providers in the healthcare system, but media reports also suggested that

[8] For more information pertaining to the relevance of private hospitals in Austria, see Verband der Privatkrankenanstalten Österreichs (2020).

both FPÖ and ÖVP supporters benefited from the new funding (Thalhammer 2020). According to the reports, the head of a private hospital in Vienna approached his long-time friend HC Strache, head of the FPÖ at this time, asking him if his hospital could be added to the PRIKRAF list. A text message went public in which Strache explicitly asked his friend which law should be changed (Thalhammer 2020). Shortly after this conversation, the hospital was included in the PRIKRAF.

The initial PRIKRAF regulations were quite simple: private hospitals in Austria were eligible to receive money from the PRIKRAF if they provided medical services to publicly insured citizens. Following the principle of "self-administration", the health insurance institutions, which provide the money for the PRIKRAF, decide which hospital should receive money from this fund. Thus, the list of hospitals that are eligible to receive money are discussed and debated by the social insurance institutions (which used to represent primarily the insured) and the professional association of healthcare companies ("Fachverband der Gesundheitsbetriebe"). The problem, aside from the clientelistic aspect of the deal, was that the ÖGK, which pays 70% of the additional money from this PRIKRAF (Kucher 2020), was not informed of the new deal until after the draft law. Another problematic aspect is that the financing of the PRIKRAF comes almost entirely from the three public insurances (ÖGK, BVAEB, and SVS), which is problematic seeing as only patients with a separate private insurance policy can have access to private hospital services (Holley-Spiess 2020). For additional information regarding this ongoing debate, see Anschober (2020).

A New E-Card

In 2019, the FPÖ introduced a new form of the "e-card", the electronic health insurance card, wherein all e-cards would be required to have a photo identification on the card by 2022. The idea of the photo was, according to the government, to prevent the misuse of e-cards, most importantly the illegal use of an e-card by a third person, i.e. an uninsured person. According to Chancellor Kurz, this was costing Austrian taxpayers dearly and around 200 million euros could be saved (John 2020). Despite lacking actual evidence as to the scope of the misuse, the FPÖ pushed for changing all e-cards in Austria to the new photo e-card, which former chairman of the FSII, Alexander Biach, estimated to cost about 18 million euros (Kleine Zeitung 2017). Before the implementation of the new law at the beginning of 2019, the FPÖ released a video wherein the law's intention became very clear (see Fig. 2). The Austrian regulatory authority for broadcasting and audio-visual (KommAustria) decided that the video violated the Austrian law against discrimination (Austrian Press Agency 2019) and was therefore quickly removed from the Internet. Not only is the cost for reissuing e-cards exceptionally high, but the amount of money saved in terms of misuse also is comparably low (Austrian Press Agency 2020b).

Fig. 2 FPÖ video (In the video released by the FPÖ, uninsured fez-wearing Ali, who appears to be a Muslim, wants to use healthcare services with the e-card of another person (his cousin Mustafa). Because of the newly introduced picture on the e-card, he fails to do so). (Source: FPÖ TV 2018)

The Austrian Smoking Ban

The prevalence of smoking in Austria is among the highest in Europe. On average, around 25% of the Austrian population report to be daily smokers (European Social Survey 2014). This is one of the highest scores in the EU (only Hungary has a higher prevalence of daily smokers). Furthermore, the smoking rate is particularly extreme among the Austrian youth (Berger and Neuberger 2020). One reason for this high rate might be the liberal smoking regulations. In fact, until recently, Austrian citizens were allowed to smoke in bars and restaurants, despite overwhelming scientific evidence that smoking bans in bars and restaurants were able to reduce smoking behaviour and limit initial smoking habits among youth in particular (Mackenbach and McKee 2013; Siegel et al. 2005). Despite this evidence, the Austrian road towards stricter tobacco regulations has been rocky (see Table 2). Some observers see close links between the tobacco industry and Austrian politics (Burki 2018).

In 2015, the Austrian parliament, at this time dominated by the two traditional parties, the SPÖ and the ÖVP, adopted a general smoking ban in bars and restaurants, which was to come into effect by May 2018. There was, however, another election between the adoption of the ban and its actual enforcement. In 2017, the FPÖ joined the new ÖVP in government wherein one of their campaign pledges was to scrap the scheduled smoking ban law (Burki 2018). Even though the conservative coalition partner was not fond of this decision, it relented to the pressure of the FPÖ and voted to overturn the smoking ban. Media reports speculated that this was a

Table 2 A rocky road of smoking regulations in Austria

Year	Policy
1974	Smoking ban in school buildings (with exceptions)
1993	Mother protection
1994	Smoking ban for bus drivers (while driving)
1995	Smoking ban with exceptions/ employee protection law
2001	Smoke-free workplace regulation
2006	Smoking ban in school buildings
2007	Smoking ban in trains
2009	Smoking ban in restaurants and bars with many exceptions
2015	General smoking ban in bars and restaurants as of May 2018
2018	Repeal of the 2015 general smoking ban
2018	Smoking ban in schools (including school yards)
2019	Repeal of the 2015 general smoking ban
2019	General smoking ban comes into effect as of November 1st

political horse-trade, in which the FPÖ agreed to sign the EU-Canada Comprehensive and Economic Trade Agreement (CETA) in exchange (Neuberger 2018).

The key arguments used by the FPÖ in overturning the smoking ban were framed in terms of (a) individual freedoms (the "ordinary" people's right to smoke in their bars) and (b) economic consequences (the survival of bars). The individual freedom framing followed the argument that bar and restaurant owners should be able to choose freely as to whether or not smoking should be allowed within their establishments. Furthermore, they argued that customers would be free to go to smoking or non-smoking bars based on their personal preferences. In this context, the FPÖ often spoke of the so-called Zwangsverordnungen or coercive regulations imposed by the government. The economic consequences frame identified a negative impact for bar and restaurant owners, especially for "small" bars, wherein regular customers that were used to smoking indoors would no longer frequent the bars.

The FPÖ and the Coronavirus

After the September 2019 re-election, the new ÖVP formed a new coalition government with the Austrian Green Party wherein Rudolf Anschober (Green Party) assumed the role of Health Minister. This implies that the FPÖ was not in

government and had to therefore establish itself as an effective oppositional force. When the coronavirus broke out in early 2020, the FPÖ supported the national government's course stating mid-March that the "direction of the government in the last few days was correct". However, FPÖ club chairman Herbert Kickl added:

> However, FPÖ club chairman Herbert Kickl added that "many sensible measures were started much too late as valuable time was lost with the government concentrating on crisis PR instead of focusing on crisis management" (Freiheitlicher Parliamentsklub, 2020). The FPÖ was the first party to demand a comprehensive lockdown during a press release on March 13th (Freiheitlicher Parliamentsklub, 2020), the government passed this 3 days later on the 16th. At the end of March, Kickl demanded that asylum seekers in Austria not only be quarantined, but also that their right of asylum should be suspended: "We will need all of our resources for our own population in the coming months. Period. Everything else is a slap in the face of the Austrians, who are already being asked a lot by the rigid measures against the coronavirus" (Freiheitlicher Parlamentsklub - FPÖ, 2020).

By the end of April, the FPÖ began heavily criticizing the national government calling for normalization and even going so far as to launch a campaign for a petition called "Jetzt reicht's! – Allianz gegen den Corona-Wahnsinn" (It's enough! – alliance against the corona madness). In their campaign, they demanded that the government take back all measures that reduce personal freedoms (Falkenbach and Greer 2020), especially those related to the freedom of movement (including travel) and anything pertaining to the economy. They also called for a quick opening of educational institutions and a withdrawal of any general restrictions to public events. Despite existing evidence of the effectiveness of face masks, the campaign claims: "Too many citizens suffer from the entirely useless coercion to wear face masks…even though face masks evidently provide no protection" (Freiheitliche Partei Österreichs 2020).

By the end of October, in the midst of the second wave of the pandemic, Kickl called for a change in strategy arguing that instead of curfews, asymptomatic people should no longer be tested. The FPÖ, as well as the other parties in opposition (SPÖ and NEOS), were asking why all of the necessary preparatory measures were not taken over the summer, such as expanding hospital capacities and implementing better measuring and counting instruments (Kurier 2020). The critic of all opposition parties, but particularly that of the FPÖ, intensified when the government announced a complete lockdown including school closures to go in effect on November 17 at midnight. Not only did the FPÖ accuse the government of creating a "lost generation" through continued school closures (Austrian Press Agency 2020c) but also stated that this new lockdown "would carry Austria to the grave" (ORF 2020c). Taken together, the FPÖ followed a pragmatic political approach, tracking public opinion and often contrary to the scientific discourse.

The FPÖ also mobilized against a COVID-19 vaccination. They published a press release in which they clearly positioned themselves against a mandatory vaccination (Freiheitlicher Parlamentsklub 2020). Norbert Hofer, head of the FPÖ, announced that he would not get vaccinated trusting instead his "good immune system" (ORF 2020a), and on September 9, FPÖ TV released a spot on YouTube

reinforcing their viewpoint that compulsory corona vaccinations are wrong and that they are doomed to fail (FPÖ TV 2020).

Conclusion

This analysis suggests that the FPÖ influenced health outcomes via indirect (social) and direct (health) policy choices. We first looked at social policies. A wealth of research on the social determinants of health shows the importance of social and economic policies to health (Braveman and Gottlieb 2014). The FPÖ's social policies indicated that the FPÖ moved from a populist welfare approach under the leadership of Haider to one based more on welfare chauvinism when Strache took over the party. The pension reform in 2000 can be seen as welfare populist in character as it not only broke the unions hold on pension reforms but also increased the retirement age for many bureaucrats. The reduction of the minimum income for foreigners or the discriminatory "family bonus" could be interpreted as manifestations of a welfare chauvinist approach since the bonus increased the welfare benefits of natives while simultaneously decreasing those of foreigners. While these are all social policies that were passed, they significantly impact the health of the individual. Lengthening working careers is not beneficial to everyone; much depends on a person's health and more importantly their willingness to continue working (Ilmakunnas and Ilmakunnas 2018). In addition, a lack of income severely impacts a person's participation in society and subsequently their ability to receive the necessary services (health care) (Marmot 2002). Thus, the social policies passed by the FPÖ negatively impacted public health and led to an increase of inequities within health care.

Next, we looked at how the FPÖ influenced health outcomes via direct health policy choices. These policies can be divided into two categories: (1) structural reforms of the health system such as the social insurance merger and the introduction of a private hospital financing fund and (2) policy choices targeting behavioural outcomes, such as the introduction of new e-cards and the reversal of the smoking ban. The structural health reforms took on welfare chauvinist and liberal chauvinist characteristics wherein the liberal chauvinist approach was more prominent, very likely due to the close involvement of the new ÖVP. The reforms targeting individual behaviour, however, can be classified as welfare chauvinist with regard to the e-card changes and antiscience with respect to the overturned smoking ban.

While several of the health policy reforms passed were done so with the help of the ÖVP, the FPÖ distinguishes itself from its conservative coalition partner by also putting forth policy decisions that sharply contrast scientific evidence. The most important example is the FPÖ's role in overturning the smoking ban which had been introduced by the former SPÖ-ÖVP coalition. Against overwhelming scientific evidence, the FPÖ portrayed itself as the protector of small business owners and "ordinary" people propagating individual choice over top-down regulations. The lack of respect for scientific evidence also became apparent during the COVID-19

epidemic. While the FPÖ supported a comprehensive lockdown at the beginning of the crisis, it changed its position as infection numbers went down and initiated a campaign against what they called the "corona madness". Contrary to scientific advice, the FPÖ have been in favour of rolling back key measures of containment, have denied the effectiveness of face masks, and have openly made their scepticism towards vaccinations known.

Just as in other domains, health policy reforms led by the FPÖ were overshadowed by accusations of clientelism. Most recently, in the case of the private hospital reforms, these accusations were also geared towards the new ÖVP, implying that clientelism is not only a PRR problem, rather one that also is deeply imbedded within the structures of the political system in Austria, as well as in other countries no doubt. The major problem with the FPÖ's tendency to engage in such behaviour is that it fundamentally goes against their claims in representing the "ordinary" people, which when uncovered leads to a decrease in votes.

In summary, the FPÖ's policy choices incorporate both clear markers of well-known PRR characteristics and elements influenced by its conservative coalition partner. Favouritism towards the native "ordinary" people and the systematic exclusion of foreigners from the eligibility of health and social services are the predominate FPÖ policy mantra. Examples can be found in the introduction of a photo-based e-card, the new Minimum Income Law, or the Family Bonus Plus regulation. Also, in line with conceptualizations of PRR parties is the liberal chauvinist approach coupled with anti-elitist sentiments, which became apparent in the structural reform of the healthcare system. The legitimization of this reform, which the ÖVP actively supported, was to create a system "closer to the ordinary people". Interestingly enough, however, it decreased the representation and thus the self-administrative power of the worker group, represented by established labour organizations. The short-term "aims" appeared to decrease bureaucratic costs and relieve the SPÖ of their monopoly in all things health. The long-term aim will presumably result in more bureaucracy (we are seeing this already), which will lead to higher costs to run the health insurances (already happening – need governmental support) and will very likely result in a decrease in services for the insured.

The anti-elitist/antiscience nature of the FPÖ's policy preferences also manifested in its harsh opposition to stricter anti-smoking laws. In fact, this type of "science populism" is common in PRR parties, which often position themselves against theories of climate change and are more prone to support conspiracy theories (Mede and Schäfer 2020). In this case, the FPÖ propagated the interest of particularistic groups (smoking customers and small bar owners) while ignoring the advice of public health authorities. This same tendency can be seen when looking at the FPÖ's reaction to the coronavirus: "Corona isn't' dangerous, the Koran is more dangerous my dear friends", said Norbert Hofer (ORF 2020b, translated by the authors) in April while demanding an end for restrictive measures and terminating the mandatory mask policy.

Welfare chauvinism, particularly in social policies, along with conservative and liberal chauvinist structural health policies supported by the ÖVP and a general antiscience approach to health, can be seen as the characteristics of FPÖ health and

social policies. With the FPÖs current political standstill, however, further research would do well to look into the new ÖVP's health and social policies as they creep further to the right on the political spectrum.

Summary Box

1. The FPÖ under Strache (2017–2019) promoted health policies that can be characterized as welfare chauvinist and conservative coupled with a liberal chauvinist structural touch. In addition, elements of clientelism and a general disregard for science can be found as well.
2. The FPÖ led rollback on the smoking ban in 2017 highlighted the FPÖ's ant-scientific approach to health policy-making.
3. During, and after, the 2017–2019 ÖVP-FPÖ government, the new ÖVP played an active role in supporting the FPÖ's anti-immigrant campaign and even took over some of their rhetoric.
4. Considering the FPÖ's current political standstill, further research would do well to look into the new ÖVP's health and social policies as they creep further to the right on the political spectrum.

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The Alternative for Germany (AfD) and Health Policy: Normalization or Containment of Populist Radical Right Tendencies?

Philipp Wacker and Katharina Kieslich

Introduction

Germany's post-war experience with populist radical right (PRR) parties has, until recently, been marked by the rise and fall of right-wing movements and parties. Some of these parties, for example, the National Democratic Party of Germany (Nationaldemokratische Partei Deutschlands, NPD), pursued clear right-wing extreme tendencies from the beginning, while others such as the Alternative for Germany (Alternative für Deutschland, AfD) moved towards the right-wing political spectrum over a course of time. Most of these movements never managed to establish themselves as a significant parliamentary and electoral force, apart from gaining a few seats in the parliaments of federal states, especially in the east of Germany. This changed with the federal election of 2017 in which the fairly new AfD managed to attract 12.6% of the votes and now forms the biggest opposition party in the 19th German parliament, the *Bundestag*. For the first time in Germany's post-war history, a party that is now commonly characterized as populist and radical right (Berning 2017; Arzheimer and Berning 2019) has the opportunity to shape the parliamentary debate, policy agenda, and national mood in a way that was previously difficult to imagine, given Germany's significant efforts, and arguably success, at containing and addressing radical right political tendencies against the background of its Nazi history.

Its status as the strongest opposition party in the 19th German *Bundestag* is also what distinguishes it from the other PRR practitioners covered in this volume. Most of the other parties have governed or have been part of governing coalitions, in

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national or state governments. The fact that populist radical right movements or parties had not had significant electoral successes until 2017 has been attributed to Germany's mainstream public and political policy of containment, which is a public discourse against radical right tendencies that is embraced by politicians, the media, and civil society alike (Art, 2018). Given this long period of containment of radical right forces, the question arises if Germany's AfD can be viewed as the party whose success ushers in a period of normalization of radical right views (Art, 2018), that is, a period in which AfD views gradually become normalized as one of several political platforms in a pluralist party system.

One way to begin addressing this question is by analysing policy initiatives brought forward by the AfD in select parliament committees such as the Committee on Health (Gesundheitsausschuss), as a proxy for examining the direction and the likely impact of the AfD's role as the largest opposition party. The fact that such initiatives arise from the AfD's position as an opposition group does not minimize its potential impact. On the contrary, scholars such as Minkenberg (2001) have shown that opposition parties can shape policy-making by influencing policy agendas and shaping debates. In the following sections, we begin with a brief history of the rise of the AfD and provide an assessment of the ways in which it can or cannot be characterized as a populist radical right party following Mudde's (2010) definitions of the term. In the second part of the chapter, we use four cases of AfD policy initiatives in the Committee on Health of the *Bundestag* to exemplify not only the likely impact of AfD on health policy but also the challenge of characterizing some of these initiatives as reflecting populist radical right tendencies.

The History of the AfD

The AfD was established in 2013 by a professor of economics, Bernd Lucke, in response to the Eurozone debt crisis and the German government's ensuing decision to provide bailouts for Greece and other Eurozone countries, despite having previously ruled out such bailouts (Art, 2018). As such, the AfD's early days can be characterized as providing an economic liberal platform that centred on criticisms of the common currency zone within the European Union (EU) rather than on criticism of, or even opposition to, the EU per se, as now seems to be a unifying feature of PRR parties in Europe (bpb 2018). Initially, the AfD under Bernd Lucke was seen as a competitor to liberal parties such as the Free Democrats (Freie Demokratische Partei, FDP) rather than as threat of establishing PRR tendencies, although there are ambiguous accounts of the extent to which nativism, for example, was part of the party's platform from the start (Art, 2018).

Fighting within the party over the ideological and programmatic direction of the AfD eventually led to the election of Frauke Petry as head of the AfD at the party's conference in 2015 (bpb 2018). This paved the way for the AfD rebranding itself not only as a Eurozone-sceptical party but also as a party sceptical of, and opposed to, further EU integration, migration, and the acknowledgement of Islam as being a

part of a multicultural Germany. Under the leadership of Frauke Petry, the AfD started to embrace a more nativist rhetoric that is also reflected in its election manifesto of 2017 and the policy programme that can be found on its website. In other words, it slowly transformed into a party with PRR characteristics. Following this, the AfD experienced significant electoral gains in 2017 (12.6% in 2017 compared to 4.7% in 2013). In addition, it gained mandates in all 16 state parliaments over time. Its success can at least in part be attributed to the refugee crisis of 2015–2016 during which the German government decided to grant entry to Germany for over a million refugees (Art, 2018). The AfD was able to harness public opinion and fears over the ramifications of Germany's decision, now openly employing tools from the PRR playbook.

The AfD as a PRR Party

Lewandowsky (2015) outlines that scholars are still debating whether the AfD can be classified as a right-wing party. However, the policies the AfD promotes according to its election manifesto and its policy programme share important hallmarks with other PRR parties discussed in this book. The election manifesto and policy programme reflect nativist views. That is the xenophobic view of nationalism in which only a monocultural nation-state should be aspired to. In that, large sections cover issues such as culture, language, and identity in which the German cultural heritage is foregrounded, and other cultures and religions such as Islam are being rejected as foreign and as not being a part of German culture and identity (AfD 2016, 2017).

The party's policies can be described as featuring authoritarianism in that they focus on domestic security and the strengthening of police forces, often coupled with statements of an alleged increase in crimes following the refugee crisis. Last, but not least, the extant literature seems to agree on the populist characteristic of the AfD (e.g. Lewandowsky 2015; Art, 2018). A reading of its election manifesto, its policy programme, and its press statements gives further support for the AfD's characterization as deeply populist. The will of the people is at the centre of its policy direction as the AfD advocates for more direct democracy and referendums, explicitly naming the Swiss system as the model to be emulated within the German context (AfD 2016, 2017). Its party rhetoric and policies are targeted against the corrupt political elites, exemplified in its promotion of populist policies such as making the waste of taxpayers' money, for example, as a result of delayed infrastructure projects financed through the public purse, a prosecutable offense (AfD 2017).

A more complex picture emerges in relation to health policy, both regarding the AfD's classification as a PRR party and its impact in this policy field. The AfD positions on health policy issues are marked by one striking feature: its absence. That is to say that health policy received little attention in the AfD's election manifesto in 2017 and virtually no attention in its general policy programme. Only little more insight about AfD positions on health policy can be drawn by the Berlin declaration,

which was put forward by the party's parliamentary group. The ten positions are vaguely stated on one page. In its election manifesto, the AfD focused on the healthcare access in rural regions of Germany (AfD 2017), which has been marked by a decrease of the availability of physicians and number of doctors' surgeries in recent years. The AfD also focused on improving investments in hospital infrastructure and on improving the status of professional careers through better pay and better working conditions (AfD 2017). As in other countries, these issues are widely acknowledged challenges in the German healthcare landscape, and there is nothing uniquely nativist or populist about focusing on them. However, one of the paragraphs in the health section of the AfD's election manifesto frames healthcare financing challenges as addressing increased spending on health care for refugees and asylum seekers that are covered by the sickness funds (AfD 2017: 60). The fact that increased healthcare expenditure was already a concern before the refugee crisis in 2015/2016 is omitted, thus demonstrating the AfD's more subtle ways of framing policy problems with a nativist undertone. Explaining the apparent lack of attention on health policy is challenging and requires more research in the future.

The AfD and Its Response to the Early COVID-19 Crisis

The previous lack of attention to health policy seems to be reflected in the AfD's uncertain and ambiguous positions during the early stages of the COVID-19 pandemic. They ranged from criticizing the absence of early lockdown measures in the beginning, to silence, to criticisms surrounding the economic consequences of lockdowns, and to ambiguous messaging around the appropriateness of face masks as a pandemic containment measure (Fiedler 2020). Thus, the AfD shifted constantly in order to accuse the German government of mishandling the crisis. While at first the AfD criticized the lack of strict early lockdown measures and closure of borders, it later criticized too strict and uniform lockdowns as Germany fared comparatively well through the first wave in the beginning of 2020 (Weiß 2020).

Infighting seems to continue between the moderates and pragmatists on a variety of topics, which apparently stifled the party's response to the pandemic at the beginning. As a result, the AfD employed similar kinds of responses to the pandemic as other PRR parties discussed in this book. For example, strategies such as questioning the effectiveness or the need for mandatory measures such as the wearing of face masks, social distancing rules, and lockdowns, as well as labelling them undue and authoritarian restrictions of civil liberties, have been popular political frames employed by AfD politicians.

Along with the questioning of government measures comes a scepticism about the evidence base of such measures that culminated in outright denials of the existance of such, like the denial of scientific evidence in relation to climate change. As the pandemic evolved, the AfD reverted to familiar PRR territory, suggesting that scientists as well as the members of government make up the country's elite, wanting to restrict the freedom of the people. As befits a party whose political

stance on the COVID-19 pandemic can be described as chaotic at best and opportunistically populist at worst, the AfD frequently employs the rhetoric of far-right conspiracy movements that are at the heart of the so-called anti-corona (measures) demonstrations, for example, by accusing the German government of a "corona dictatorship". As the second wave of the pandemic continues to hold Germany in a tight grip in November 2020, the AfD's uncertain position seems to have given way to a PRR comfort zone that is characterized by denial (e.g. of the scientific evidence), non-compliance (e.g. of mandatory mask-wearing in Parliament and lawsuits against mandates for party conventions), protest (e.g. attending anti-corona measures demonstrations), and rhetorical scaremongering (Weiß 2020). Exemplary for the aforementioned populist methodologies employed by the AfD is an affair receiving broad national coverage and causing widespread outrage amongst the established parties in November 2020. AfD members of parliament allowed four right-wing activists to enter the *Bundestag* through a side entrance. These individuals publicly harassed lawmakers within the *Bundestag* on the day that amendments to infection control legislature aimed at boosting governmental authority during the pandemic were voted on. The AfD's party whip later apologized (Deutsche Welle 2020); however, the occurrence clearly demonstrates the AfD's utilization of the PRR playbook, leveraging its populist messaging to disturb regular political proceedings while ignoring previously set rules of good conduct and distracting from the lack of solid health policies they are able to present.

The Health Policies of the AfD

In comparison to other countries with active PRR practitioners, the AfD has not held a government position to this date and has only focused on opposition work. Given this situation, we focus on policy initiatives brought forward in the *Bundestag* Committee on Health by the AfD as the largest opposition party. Our analysis will thus focus on the political "supply side".

Federal health policy in Germany is developed through joint efforts of committees and the full parliament. The seats in the committee are allocated according to electoral strength of the parties in the *Bundestag*. As per the rules of procedure, committees prepare the decisions of the *Bundestag*. Committees debate and discuss draft bills and revise them until it can be passed in the committee. Results from the committee are usually a recommendation to the plenary for decision. In a general proceeding, bills may be introduced by the government or any parliamentary part, which are first read in the plenary and are then forwarded to the committees for deliberation. Nonetheless, committees may act at their own initiative (Deutscher Bundestag n.d.).

In order to establish PRR patterns in the AfD's health policy, we focused on more subtle observations through a qualitative examination of bills introduced into the *Bundestag* by the AfD. We extracted health policy-related bills (*Anträge*) introduced by the AfD in the 19th electoral term (2017–2021) with a cut-off date of

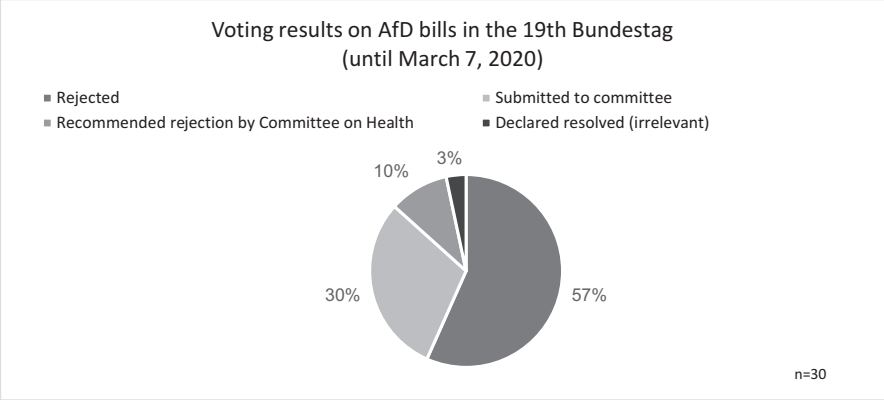

Fig. 1 Analysis of AfD bills introduced in the German Bundestag

March 7, 2020, from the *Bundestag* data base with search criteria of 19th electoral term, subject area health, and AfD as initiator (see Fig. 1).

Until then, the AfD had brought forward 30 bills with the subject area of health. Of these, 17 were rejected, three were recommended to be rejected by the committee to the plenary, one was declared resolved (not relevant anymore), and nine were sent to the respective committee for further discussion. This shows that so far, the AfD has received no support from other parties in the *Bundestag*. However, the introduced bills show that while broad in topics, the AfD is willing to move away from a solely populist approach and frequently makes technical suggestions. Bills are characterized by liberal and conservative themes, such as the removal of budgets for ambulatory care or more competition between statutory sickness funds and private health insurances. Such policy directions are in line with some of the proposals other conservative or liberal parties have made (e.g. FDP). However, the party distinguishes itself from other conservative and liberal parties by nationalist themes and frames, commonly referred to as nativism in this volume. We illustrate this nativist element in our analysis in order to establish its right-wing characteristic.

We focus on two themes the AfD has tried to address in the course of its parliamentary work: (1) dependency on foreign pharmaceuticals and (2) immigrant influx of foreign health professionals. AfD bills carry the common theme that quality is increased if international dependency is reduced, and therefore the generosity of the benefit scheme in Germany increases by a definition of quality. In the first theme, three bills address the German dependency on foreign pharmaceuticals and import regulations.

The first bill demands the introduction of a notification obligation for pharmaceutical companies in case of a 14-day unavailability of prescription medication, an export ban on scarce pharmaceuticals and the revision of rebate contracts in the statutory health insurance (SHI) scheme to award two manufacturers rebate contracts of which one must produce agents as well as the medication within the EU (Deutscher Bundestag 2019b). The AfD criticizes that due to the price competition

induced through the rebate contracts, domestically produced pharmaceuticals are sold to other countries with higher prices, creating gaps in pharmaceutical supply. The AfD also links competition over prices with drug safety, suggesting that foreign-produced active pharmaceutical agents are of bad quality (Deutscher Bundestag 2019d).

The welfare chauvinist theme in this bill is based on the ideology of increased benefit generosity for SHI beneficiaries expressed through the improved quality and availability of medication. At the same time, the AfD utilizes its populist capabilities to put a spotlight on the shortages of the current system within the country. The party creates fear of inadequate treatment due to the current setup of the welfare system that does not help the general population (welfare populism). The use of the word "dependency" on foreign imports in the bill illustrates how the AfD frames its initiatives in ways reminiscent of a welfare populist undertone. Dependency is a strong word that suggests a systemic misalignment between goals (e.g. generating savings through rebate contracts on the one hand and ensuring adequate domestic supply of pharmaceutical products on the other), leading to an alleged situation in which the German population receives pharmaceuticals of suboptimal quality from abroad. It is this choice of framing that distinguishes the AfD's bill from the positions of other parties on the effects of pharmaceutical rebate contracts that are not uncontroversial in political and health policy circles. Framing the issue as a dependency issue that suggests an overreliance on products from abroad regardless of other issues such as expenditure control is an example of the AfD's narrow understanding of the challenges in pharmaceutical policy.

The second bill targets import quotas imposed by the Federal Government through payer and pharmacist associations on local pharmacies. To reduce pharmaceutical expenditure in the SHI scheme, pharmacies must currently generate 5% of their end-product revenue from imported pharmaceuticals. The bill demands a removal of the mandate on pharmacies to dispense imported pharmaceuticals should no specific product be prescribed by a physician. The AfD argues that savings achieved through the current import quota are slim while introducing safety risks such as dubious procurement channels. The AfD also suggests that domestically produced and marketed pharmaceuticals are superior compared to imported medications. While the bill includes a thin health economics perspective, it becomes clear that the AfD sees fraud opportunities in the import regulations as a core issue, since import quotas allows for "qualitative inferior, stolen or counterfeit medication" to be dispensed to the public, thus posing a threat to the country (Deutscher Bundestag 2018a). In its plenary presentation, the AfD stated that import quotas result in the import of safety issues and risks (Deutscher Bundestag 2019c). Additionally, AfD states that these effects could potentially expose the German SHI system to illegal activity from abroad and suggests that existing control mechanisms are ineffective. In summary, the welfare chauvinist theme emerges again, as generosity increases are defined through improved quality and a safer pharmaceutical care supply to the general public. It can also be argued that there is a financial increase in generosity to the SHI beneficiaries, as the removal of the import mandate could theoretically result in increases in SHI pharmaceutical expenditure.

The third bill regarding the dependency on foreign pharmaceuticals aims at restricting the influence of EU online pharmacies on the German market. A decision by the Court of Justice of the European Union (CJEU) paved the way for the market entry of online pharmacies in 2016 (Deutsche Welle 2016). EU online pharmacies in other countries are not bound to the German pharmaceutical price regulation and may offer bonuses and discounts to customers. EU online pharmacies are also subject to VAT (value-added tax) regulations of their originating country, which may be lower compared to the German tax code. The AfD criticizes the "unfair competition" between foreign and domestic pharmacies, which threatens the existence of pharmacies across Germany. This conservative theme of reducing generosity across the board for SHI beneficiaries, who may receive rebates on their prescriptions, also demonstrates the theme of nativism, in which the monocultural state is ideal. The perceived threat in this case are foreign EU online pharmacies that allegedly endanger the adequate supply of pharmacies across the country (Deutscher Bundestag 2019a). In turn, the AfD argues that both patients and domestic pharmacies would benefit from a ban on foreign online pharmacies, with the provision of pharmaceuticals being ensured and domestic pharmacies losing unfair foreign competition. While this AfD bill was rejected by the parties in parliament, other parties on both sides of the spectrum have recognized the issue and are working to resolve this discrepancy in fairness. This emphasizes the reluctance of established parties in the *Bundestag* to vote in favour of AfD bills, with no AfD bills accepted in the committee on health and the *Bundestag* plenary.

These three bills targeting the foreign influence on the pharmaceutical supply demonstrate the AfD's interest in increasing the assumed qualitative generosity for the beneficiaries of the SHI insurance programme while being prepared to accept increases in expenditure. The PRR party sees the dependency on international non-EU suppliers as a threat to the pharmaceutical care of the German population and aims at reducing this threat through a refocus on national capabilities and structures, thus decommodifying the people's dependence on international manufacturers and distributors. It speaks to the party's embrace of welfare chauvinist policies in which the reduction of so-called dependency on "foreign" pharmaceuticals is portrayed as a benefit for the German population and in which international imports are seen as threats to healthcare quality and local economic competition.

We have already demonstrated the conservative, welfare chauvinist, and in parts welfare populist characteristics of AfD bills. Similar tendencies can be identified in other areas of health policy, such as the accreditation of foreign health professionals. As other developed countries, Germany is experiencing a shortage of healthcare professionals, especially in rural areas. In a bill proposing the increase of accreditation standards of foreign health professions, the party describes dangers that have occurred and may occur through an insufficient assessment of technical skills and language capabilities. In its reasoning, the bill mentions the alleged inferiority of foreign physicians and shows the common PRR theme of non-natives endangering the healthcare system. The relatively short bill (1.5 pages) lacks detail and reliable evidence undermining its proposal (Deutscher Bundestag, 2018b). The suggestions and themes outlined in the bill are underlined by the discussion in the General

Assembly of the *Bundestag*. The AfD blames the established parties for failures in health policy, which supposedly led to a shortage of physicians, now needing to be filled with foreign health professionals. The AfD stresses that forged certificates, insufficient capabilities, and language barriers lead to significant risk of malpractice (Deutscher Bundestag 2018c). The AfD thus implies that the currently existent accreditation system threatens the safety of care provision to the benefit of migrant physicians seeking employment in Germany. The alleged acceptance of safety risks by the established parties to the detriment of the common citizen is criticized by the AfD, thus establishing a welfare populist pattern. These remarks add to the growing, qualitative evidence that AfD bills, while attempting to contribute to the resolution of policy problems, exhibit nativist and authoritarian characteristics with a thin ideology.

In summary, the AfD blames the established German parties with failures, which lead to problems in the provision of care for its citizens. Many of the targeted structures were introduced as a response to shortages in financial and human resources. Interestingly, the AfD relies on a definition of generosity through quality, as the reliance on international markets is seen as a negative impact factor on the quality of pharmaceutical provision. The provision of health services is in turn subject to growing foreign influence without the necessary control and enforcement strategies in place, again a clearly authoritarian theme utilized by many PRR parties across Western Europe.

Conclusion

The AfD provides an interesting case study when examining the impact of PRR parties on health policy, both because of its role as an opposition party and because of its ability to frame known policy problems in a nativist, populist, and authoritarian way. The apparent lack of attention on health policy in its election manifesto and policy programme notwithstanding the AfD has brought forward several bills in the *Bundestag* Committee on Health, none of which have been accepted by the other parties. The topics covered in the bills are not necessarily nativist or populist in character because they frequently refer to widely acknowledged health policy issues. However, what distinguishes the AfD from its parliamentary counterparts is its framing of the issues as nativist, populist, or authoritarian. This is hardly surprising, given that framing is at the heart of the policy process, with every party and policy-maker engaging in some form of framing. Still, it is surprising in the context of the German political system which has thus far been credited with success in containing PRR tendencies. It is too early to tell what the impact of the AfD's framing of common policy problems will be on the parliamentary and national debate, but it is likely that the AfD is already having an impact in putting topics on the policy agenda that would have otherwise perhaps not reached it.

More generally, the AfD case raises interesting questions about how to conceptualize and measure a PRR party's impact, or any party's impact for that matter. One

way to conceptualize and operationalize it is through hard outcomes such as votes and seats gained. On that measure, the AfD has had a large impact on the German policy landscape. Another measure would be to look at the way other parties meet the challenge of the rise of PRR parties, with the literature suggesting that often PRR topics and frames are co-opted by other parties to regain votes. To a certain extent, this has been visible in Germany with the CDU and the CSU being embroiled in discussions about their programmatic directions and with many members calling for a reorientation of the parties to more conservative and less liberal values.

Finally, our analysis of AfD bills in the *Bundestag* Committee on Health to examine the AfD's impact on health policy has underlined that opposition parties play a role in agenda-setting and in moving the debate. Our analysis has also shown that the features that characterize PRR parties – nativism, authoritarianism, and populism – do not have to be visible in equal measure in every parliamentary or other activity but that PRR messages can be transported in more subtle ways such as framing widely acknowledged policy problems through nativist and populist lenses. If these subtle, but powerful, framing efforts do not continue to be met with opposition by the other parties in the German system, it is more likely that the AfD's role and positions will become more normalized and less contained over the years.

Summary Box

1. The AfD in Germany is distinct from other PRR parties covered in this volume because it has not been a part of a governing coalition to date.
2. The AfD's positions on health policy are marked by thinness with regard to coverage in the election manifesto and the policy programme.
3. In the *Bundestag* Committee on Health, the AfD introduces bills on widely acknowledged health policy problems that are not characteristic of PRR topics per se.
4. AfD's parliamentary work can be characterized as incorporating conservative, welfare chauvinist, and populist themes in their bills while covering nativist, authoritarian, and populist issues of health care.
5. For a party or practitioner to be classified as PRR, the PRR features do not have to be present in every activity, bill, statement, or publication. PRR themes can be subtle, and attention needs to be paid to how issues are framed.

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Populist Radical Right Influence on Health Policy in the Netherlands: The Case of the Party for Freedom (PVV)

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Introduction

Research on the political determinants of health, "how different power constellations, institutions, processes, interests, and ideological positions affect health within different political systems and cultures and at different levels of governance" (Kickbusch 2015, p.1), has increasingly focused on the health impact of populist radical right (PRR) parties in office (Falkenbach and Greer 2018; Rinaldi and Bekker 2020). While PRR parties share a common ideology based on populism, nativism, and authoritarianism, both the health policies they propose and their influence in the implementation of these policies vary considerably, partly due to the characteristics of the national political system in which they act (Rinaldi and Bekker 2020). In this chapter, we will take a closer look at the Party for Freedom (Partij voor de Vrijheid, PVV), the only Dutch PRR party that has participated in a national coalition government in the past 40 years (2010–2012). We will analyse the influence of the PVV on Dutch health policy, with a particular focus on elderly care, curative care, and public health policy. The analysis will first look at the influence of the PVV on health policy between 2010 and 2012 when it supported the Dutch coalition government through a so-called Tolerance Agreement. We will then expand to the influence of the PVV in opposition. We will end with a brief discussion of the PRR response to the COVID-19 pandemic, looking at the standpoints and actions of the PVV and the newer PRR party Forum for Democracy (FvD).

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History of the PVV

The PVV was founded in February 2006 by Geert Wilders after he had left the liberal-conservative People's Party for Freedom and Democracy (VVD). During his early days in politics, Wilders was a conservative-liberal inspired by the former leader of the VVD, Frits Bolkestein. This position slightly changed at the beginning of the 2000s when he could best be described as an 'American-style' neoconservative, critical of the Netherlands' progressive political culture and its consensual consultation economy (Vossen 2011). Wilders was also critical of the Dutch welfare state and favoured a smaller government with a free market economy. On the cultural front, Wilders is conservative, but particularly radical in his rejection of Islam, which he sees as a threat to Dutch society. Only after having founded the PVV, Wilders made a shift towards a more populist position, starting with a more hostile position towards Muslims and immigrants in general, and stronger Euroscepticism (Vossen 2011). He also changed his stance on the welfare state, which shifted from hard neoliberalism to a more interventionist position. Scholars were initially somewhat hesitant to categorise the PVV as a populist radical right (PRR) party due to its distinct ideology that was described as "right-wing half hearted-liberal nationalists and populists" p.181 (Lucardie 2009) or as being a liberal-democratic, anti-Muslim mainstream party lacking the traditional PRR ethnic nationalism (Mudde 2010). However, the PVV is now considered one of the leading examples of PRR politics in Europe. Indeed, after being omitted from Cas Mudde's classification of PRR parties in 2007 (Mudde 2007), the PVV was later included as the main PRR party in the Netherlands between 1980 and 2014 (Mudde 2016).

Taking a closer look at the PVV's standpoints today, the three main characteristics of the PRR ideology – populism, nativism, and authoritarianism – can clearly be distinguished. An important aspect to note here is that the PVV is not a democratic party, as Wilders has always been its only member. The party's standpoints are therefore a reflection of Wilders' personal positions, which are mostly, but not wholly characteristic of other PRR parties' views. Starting with populism, Wilders is a strong opponent of the liberal political elite (especially 'in Brussels', i.e. the European Union), which he argues is not concerned with the will of the people (PVV 2012b, 2017b). Wilders has, for example, accused mainstream parties of clientelism (PVV 2015), a characteristic that is sometimes attributed to PRR parties but it is not very relevant to the PVV itself. Secondly, nativism is central to the PVV's most important standpoint: the 'de-Islamisation' of the Netherlands, described in its latest manifesto as the protection of Dutch culture and values against mass immigration, asylum seekers, terror, violence, and insecurity (PVV 2017a). In line with this, the PVV also aims to protect the welfare state from immigrants, who are deemed to be less deserving of support than the Dutch (PVV 2012b). On the authoritarian front, the PVV calls for greater investment in defence and the police force to protect the Dutch borders from 'outsiders' (PVV 2017a). While Wilders is a protector of traditional Dutch values, he partly diverges from the conservative

cultural values that are often associated with PRR parties. Wilders is, for example, pro-LGBTQ+ rights, abortion, and euthanasia (Vossen 2011).

The 2010 general elections, in which the PVV received 15.5% of the total vote share and 24 seats in the House of Representatives, were the first big success for the party. This was mostly at the expense of the largest mainstream parties VVD, Labour Party (PvdA), and Christian Democratic Appeal (CDA) (Vossen 2011). After initial refusal by the CDA to collaborate with Wilders, the PVV supported the centre-right VVD-CDA minority government Rutte I through a so-called Tolerance Agreement, an exceptional arrangement in Dutch coalition politics. Through this arrangement, the parties agreed on several issues regarding immigration, national security, elderly care, and finances, but the PVV did not formally take part in the coalition (Rijksoverheid 2010a). Nevertheless, the Rutte I cabinet fell in April 2012 after the PVV refused to support €14,4bn worth of austerity measures in the wake of the 2008 financial crisis (Parlement.com n.d.). The main point of disagreement was the proposed increase in retirement age, which the PVV deemed 'unacceptable' – most likely in the light of a 2010 poll which revealed that 86% of the PVV electorate were against this reform (Afonso 2015). This triggered a snap election in September 2012. The PVV lost nine of its 24 seats as voters blamed Wilders for having political power interests prevail over the public interest (Bunnik 2012).

In the increasingly fragmented Dutch multiparty system with 14 parties currently holding seats in Parliament, the PVV has been a fierce opposition party since 2012. As of 2020, the party holds 13.1% of the seats in the House of Representatives and 6,5% in the Senate. However, the PVV has recently lost supporters to the newer PRR party Forum for Democracy (FvD), founded in 2016 by Thierry Baudet. In the 2019 provincial elections, the FvD emerged as the biggest party with 86 seats (out of 570), while the PVV won 40 seats – a loss of 26 seats compared to the previous provincial elections (Kiesraad 2019b). The 2019 European Parliament elections were similarly a defeat for the PVV, which saw its vote share decrease to a mere 3.53%, while the FvD received 10.96% of the votes (Kiesraad 2019a). The FvD now holds two seats in the House of Representatives and nine in the Senate (it lost three seats due to conflicts within the party). A study into the motivations for voting FvD revealed that a large majority (79%) did so to vote against the existing coalition government and especially its 'moderate' standpoints on climate change mitigation and immigration (NOS 2019). About a quarter of FvD voters in 2017 previously supported the PVV (Ipsos 2018), which has sparked speculations about whether the FvD will become the new PVV (Boersema 2019; Kleinpaste 2019; Margulies n.d.).

The PVV and FvD have several similar standpoints. Like the PVV, direct democracy through referenda is one of the most central agenda points for the FvD. The FvD also opposes increasing multiculturalism, which it believes will lead to a loss in Dutch norms and values. Even more so, Baudet has said that the Netherlands is currently threatened by 'an existential crisis' caused by mass immigration and the loss of our sovereignty to the 'undemocratic' European Union (FvD 2017). On socioeconomic issues, the FvD takes a more neoliberal position than the PVV, however, with a strong exclusionary focus towards immigrants (a position that is also known as liberal chauvinism). When it comes to the healthcare system in particular,

the FvD recognises that the 'marketisation' has gone too far and has led to worse and more expensive health care (FvD n.d.). However, the FvD is far less ambitious than the PVV on the topic of elderly care (FvD n.d.).

While the PVV and FvD share similarities, their leaders differ in significant ways. FvD leader Thierry Baudet has a law degree and wrote a PhD thesis on 'The significance of borders: why representative government and the rule of law require nation states' (later translated into the more populist title 'Attack on the nation state') before he set up the FvD. Baudet has attracted votes from a more white-collar, mostly male, conservative electorate. Indeed, the FvD sees itself as an alternative to the liberalist right (i.e. VVD). Wilders, a 'professional politician' with an unclear educational record and a very brief work history outside politics, has a predominantly working class support base (NOS 2019). The FvD has also attracted more support from older voters; 31% of its electorate is 65 years and older, compared to only 14% for the PVV (NOS 2019).

Since November 2020, the FvD is facing significant internal turmoil after Baudet refused to distance the party from its official youth division (JFvD) after a series of anti-Semitic and homophobic messages had emerged. Several prominent members on the party's list have resigned and it is unclear whether Baudet will remain as leader of the FvD. It is now uncertain how electoral support for FvD or PVV will develop in the run-up to the March 2021 general elections. We will now continue the analysis of PVV influence on healthcare policies.

The Influence of the PVV on Dutch Health Policy

In this section we will describe and analyse party and government documents, policy proposals, and voting behaviours to shed light on the PVV's influence on elderly care, curative care, and public health (Table 1). The analysis will primarily focus on the time period 2010–2012, when the PVV supported the coalition government through a Tolerance Agreement. However, given the PVV's prominent role in advocating for elderly care as an opposition party, the time period of this analysis was extended to also include the PVV's influence after it ended its support for the VVD-CDA coalition. We will end with a brief reflection on the PRR's reaction to the policies implemented in response to the COVID-19 pandemic throughout 2020.

Health and health care are not the main focus of the PVV's (or FvD's) political actions and achievements in the past decade, as observed through the limited amount of health-related policy proposals in favour of immigration and law and order proposals. As for their political agenda, however, health care is clearly featured in the PVV electoral manifestos. This includes calls for better elderly care and against the further privatisation, 'managerialism' and 'Islamification' of the Dutch healthcare system (PVV 2010a). The key points of the electoral agenda that helped the PVV win a position in government in 2010 included: a halt to the increase of excess out-of-pocket contributions for health care, an increased mandate for primary health care, improved rights for older adults and disabled people in care homes, no further

Table 1 PVV's healthcare policy proposals

PRR policy	Implemented	Coalition partners	Outcome/ comments	Classification
'Agema monies' to be spent on the training of healthcare workers and 12.000 additional jobs in long-term elderly care	Yes, through the Tolerance Agreement in 2010	VVD, CDA	The PVV believed that the money was not spent as intended. The budget was dismantled by the new government in 2012	Welfare chauvinism (i.e. favouring the 'common' healthcare worker)
Keeping walking aids in the basic health insurance package	The proposal was accepted in November 2010	VVD, CDA		
Restriction of eligibility for free health care for asylum seekers	No	VVD, CDA	The proposal was not supported by the coalition	Welfare chauvinism
Radical reform to improve the quality of elderly care/ care homes	The proposal was unanimously accepted in December 2016. The plan was implemented in 2017	None, PVV in opposition	The proposal led to a reversal of 2017 austerity measures and, among others, a €2.1bn yearly budget for care homes starting in 2021	Welfare chauvinism
Increasing pay for healthcare workers (in response to COVID-19 pandemic)	No	None, PVV in opposition	The proposal was rejected by a small majority after coalition MPs had left without voting	Welfare chauvinism (i.e. favouring the 'common' healthcare worker)
Creating a structural national reserve of healthcare workers and hospital beds in intensive care units (in response to COVID-19 pandemic)	Yes	None, PVV in opposition	The proposal was unanimously approved in the House of Representatives	

marketisation in health care, and no 'favouring' of foreigners and asylum seekers in health care. Together these standpoints represent a rather left-of-centre and welfare chauvinistic position on health care. Welfare chauvinism refers to the expansion of welfare provisions for the native population while at the same time restricting eligibility or access for 'undeserving' foreigners (Ennser-Jedenastik 2016, 2018). The strong focus on older adults, a population group that is praised and respected for their previous contributions to society, can be considered welfare chauvinistic and authoritarian as this group is deemed more deserving of generous welfare support than other groups (predominantly non-native 'foreigners'). The PVV also argued for decreasing the autonomy of large provider and insurance companies in the Dutch healthcare system, and the amount of managers in healthcare institutions (PVV 2010a). This highlights the populist disapproval of the elite in favour of the 'common' healthcare worker (e.g. nurses and general practitioners [GPs]) (Otjes et al., 2018).

A stark contrast emerges when comparing these welfare chauvinistic standpoints with the PVV-supported health policy that was implemented during 2010–2012. In light of the financial crisis, the centre-right coalition and VVD Minister Edith Schippers prioritised reducing costs and increasing 'efficiency' in the 2011 budget policy for the Ministry of Health, Wellbeing and Sport, thus favouring a more market-based approach (Rijksoverheid 2010b). Much of the health policy that was implemented in this period appears to have taken a conservative and sometimes liberal chauvinistic direction instead of the welfare chauvinistic one championed by the PVV. What these positions have in common is that they both aim to exclude 'outsiders' from receiving welfare benefits. However, where where welfare chauvinism expands services to the native population, liberal chauvinism cuts welfare spending for the entire population, with a particular focus on minorities, immigrants, and migrants (Falkenbach and Greer 2018).

Elderly Care

In 2010–2012, elderly care was one of the four areas of compromise in the VVD-PVV-CDA Tolerance Agreement and clearly shared commonalities with the PVV winning agenda on the issue. Through this agreement, €1bn was allocated to the improvement of the quality of elderly care and care personnel, as the government considered itself responsible to care for those who have built up the country (Rijksoverheid 2010a). A part of this budget was reserved for the training of healthcare personnel and the creation of 12.000 additional jobs in long-term care. These 'Agema monies' were a significant achievement by Fleur Agema, the PVV MP responsible for public health and health care (Table 1).

While the elderly care provisions in the Tolerance Agreement have been criticised for being unspecific and less ambitious than they appear, the PVV seems to have had a highly influential role in the prioritisation of elderly care by the Rutte I Cabinet (Schols, 2011). The Tolerance Agreement set out measures to prioritise

community care and allow for collaboration between care professionals to mitigate problems of home care in a competition-based healthcare system while also increasing the effectiveness and affordability of care. Another key measure is the emphasis on smaller care institutions for greater efficiency, higher client satisfaction, and better care (e.g. by giving the Healthcare Inspectorate a mandate to enforce a split-up of care institutions for quality safeguard) (Rijksoverheid 2010a). Finally, the agreement also includes an expansion of patient rights under the Healthcare Institutions Principles Act (e.g. the right to daily showers and time outside) and increased accountability and sanctions for care home boards of directors (Rijksoverheid 2010a). This seems to stem from the PVV's authoritarian tendencies, for example, comparing the rights of people in nursing homes to those of prisoners who, according to Wilders, 'unjustly' receive better treatment.

The PVV, under the leadership of MP Fleur Agema, took ownership of the issue of elderly care though their proposals to the House of Representatives between 2010 and 2012. These include the accepted proposal to keep walking aids in the basic health insurance package (Tweede Kamer der Staten-Generaal 2010c). Interestingly, the PVV was much less generous when it comes to youth care – it advocated for more efficient youth care (PVV 2010a) and voted against proposals to retain the legal right to youth care (Tweede Kamer der Staten-Generaal 2010d) and to counteract rising waiting lists (Tweede Kamer der Staten-Generaal 2010a).

A noteworthy point is that the PVV did not follow the VVD and CDA in its voting on issues regarding elderly care, but instead voted in accordance with left-wing parties, such as the green party GroenLinks (GL) and the Socialist Party (SP). It thus seems that once 'in office' (albeit under a Tolerance Agreement), the PVV prioritised its electoral promises on elderly care rather than adopting 'office-seeking' behaviour and compromising with its coalition partners. The PVV's special favouring of older adults (aged 65 and above), which form a large share of the electorate and are especially likely to consistently vote (CBS 2017), was therefore likely for electoral reasons. However, despite older adults being a key target for the PVV, this population group does not show great support for the party. At the 2012 general elections, only 7% of those aged 65–75 years and 4% of those aged 75 years and older voted for the PVV (CBS 2019). Instead, older adults preferred traditional parties such as the VVD and CDA, or 50PLUS, which was founded in 2009 to represent the interests of older voters. This is consistent with earlier findings that younger voters are more likely to support radical and extreme right parties, possibly because they feel personally threatened by competition on the labour market from immigrants (Arzheimer 2009).

Curative Care

As opposed to elderly care investments, the curative healthcare policies implemented by the VVD-CDA coalition between 2010 and 2012 are marked by austerity. In accepting those conditions, the PVV diverted from its initial promise to make

health care more affordable and less profit-driven (PVV 2010a). The maximum excess out-of-pocket contribution for insured health care, which was increased from €170 to €210 with PVV support, is the most notable example. In 2011, the PVV followed the VVD and CDA in voting against amendments to roll back the increase of these out-of-pocket contributions (Tweede Kamer der Staten-Generaal 2011a) or to remove them altogether (Tweede Kamer der Staten-Generaal 2011n). In addition, PVV, VVD, and CDA also voted against exempting GP visits and mental health care from out-of-pocket contributions (Tweede Kamer der Staten-Generaal, 2011m) and against a 'social maximum' that would make care more accessible for chronically ill people with low incomes (Tweede Kamer der Staten-Generaal, 2011h).

Despite its agenda standpoints against austerity measures, the PVV acted in support of overall budget cuts in health care. Surprisingly, the PVV supported budget cuts to, among others, patient, disability, and elderly organisations (Rijksoverheid 2010b). The PVV also voted in support of the further privatisation and market orientation of the Dutch healthcare system, for example, by supporting experimentation with paid priority care (SOS doctors) (Tweede Kamer der Staten-Generaal 2010b).

A unique contribution of the PVV in healthcare policy is its nativist ideology, which is in line with the general tougher stance on immigration that was set out in the Tolerance Agreement. While exclusionary policies were rejected by most opposition parties in the House of Representatives, VVD-CDA support (or 'tolerance') was enough to reach a majority in favour of such policies. For example, the VVD-PVV-CDA majority blocked proposals to allow healthcare practitioners to legally continue providing care to illegal immigrants (Tweede Kamer der Staten-Generaal 2011d) and to introduce a more in-depth analysis of whether asylum seekers in need of care would be able to access appropriate care services in their country of origin in order to facilitate and possibly re-evaluate their return (Tweede Kamer der Staten-Generaal 2011i, j, k). The PVV policy proposal to limit the healthcare services available for asylum seekers to acute care only and to stop the reimbursement of asylum seekers' healthcare payments (Tweede Kamer der Staten-Generaal 2011g) was too radical for the coalition and not supported by any party. This is a clear example of welfare chauvinism, arguing that in the current system of solidarity, 'Henk and Ingrid' (the Dutch 'John and Jane Doe') pay for 'Ali and Fatima' (the 'foreigners') (PVV 2010a). The coalition was not withheld by a more indirect form of welfare chauvinism (or liberal chauvinism) and decided to stop compensation for interpretation and translation services in health care from 2012 (Rijksoverheid 2010b). This policy was targeted at the entire population but disproportionally affects non-native patients by posing additional barriers to seeking and receiving the care they need.

While the PVV took a 'vote-seeking' position on elderly care, thus prioritising the interests of its electorate based on the 2010 manifesto, this cannot be said for health care in general. The PVV largely diverted from its welfare chauvinistic promises to invest in health care and reverse further 'managerialism' and privatisation of the healthcare system. The PVV also took a more passive role when it comes to submitting policy proposals about health care and tended to vote in concordance

with the VVD-CDA coalition, as suggested by its supporting role for the minority government. This evidence indicates that the PVV employed a more 'office-seeking' strategy to maintain its role in the Rutte I Cabinet. However, the PVV did not consistently vote the same as the VVD and CDA due to its nativist position that was only to a certain extent accommodated by its coalition partners.

Who Are 'Henk and Ingrid'?
The term 'Henk and Ingrid' was popularised by Wilders in 2010 when he positioned himself as the politician who stands up for the average Dutchman and -woman. Throughout the years, Henk and Ingrid have gained considerable attention from the media, all trying to answer the same question: Who are 'Henk and Ingrid'? This has led to descriptions of these archetypal Dutch citizens as people who are homeowners, have young children, and earn an average income. According to Wilders himself, Henk and Ingrid might have voted for the Labour Party in the past but now vote PVV (n.a. 2010). Henk and Ingrid are furthermore 'threatened' by the political elite and mass immigration (PVV 2010b). Henk and Ingrid have become the subject of mockery from comedians, and various 'searches' for the real people Wilders' stereotype was based on have led to excessive phone calls to couples with the same name (Wanders 2010).

Public Health

The PVV does not have clear standpoints on public health but takes a libertarian approach that emphasises personal responsibility, with exceptions for a minimalamount of issues that require government intervention, such as infectious disease prevention and screening and vaccination programmes (PVV 2011). This seems to follow the PVV's populist, anti-elitist agenda that opposes (perceived) paternalistic public health policies and 'government propaganda' (PVV 2010a). However, the PVV does not use anti-vaccination rhetoric, a standpoint that is often associated with PRR parties and voters (Kennedy 2019). In this sense, public health is the health area with most alignment between the VVD-CDA government and the PVV. In a statement on the PVV website (PVV 2011), Wilders was indeed very supportive of the four-year preventative health plan set by health minister Schippers in 2011, which focused on encouraging healthy individual lifestyle choices with the participation of the private sector, civil society organisations, schools, and health providers (Tweede Kamer der Staten-Generaal 2011b). The PVV also supported a €18 m budget cut for lifestyle interventions between 2011 and 2014 and the removal of smoking cessation programmes from the basic health insurance package (Rijksoverheid 2010b; Tweede Kamer der Staten-Generaal 2011f). It even proposed – without success – to replace insured smoking cessation aid with walking aids, arguing that while smoking is a personal choice, walking problems are not (Tweede Kamer der Staten-Generaal 2012a). A few years prior, the PVV published

a statement against a smoking ban in the hospitality sector that only allowed smoking in designated smoking areas, as it would harm small businesses (PVV 2008). After backlash, businesses smaller than 70m^2 without employees were exempted from this ban in 2010 with PVV support (a full smoking ban in the hospitality sector has since been implemented) (Tweede Kamer der Staten-Generaal 2010e, 2011e). During its time in office under the Tolerance Agreement, the PVV thus exerted influence on the public health agenda to some extent, but this has also been observed after the government coalition fell and the PVV returned to their opposition benches.

The PVV in Opposition

After the resignation of Rutte I over a disagreement about the 2013 National Budget plan, the PVV strongly opposed the new health policy that was negotiated by VVD, CDA, and several other parties before the snap election in September 2012. One of the greatest concerns, which it shared with radical left-wing party SP, were increases in excess out-of-pocket contributions. After having supported increased out-of-pocket contributions in 2011 and 2012, the PVV now proposed to roll back a further increase in 2013 arguing that it would not result in much financial benefit. This proposal was rejected in the House of Representatives (Tweede Kamer der Staten-Generaal 2012b), and tactics by both PVV and SP to delay its implementation failed (NOS 2012). The PVV also proposed to block the expansion of extramural elderly care plans, which they believed would lead to the eventual abolishment of nursing homes. This proposal was rejected (Tweede Kamer der Staten-Generaal 2011c).

After the inception of the new VVD-PvdA coalition (Rutte II) in September 2012, PVV MP Agema took a critical stance towards the new budget plan of the Ministry for Public Health, Welfare and Sport. Agema accused the Ministry of completely dismantling elderly care with their proposed budget cuts of €6.8bn (PVV 2012a). She also contested the governments' deviant use of the budget that was originally reserved for additional training and care personnel in the 2010 Tolerance Agreement (the 'Agema monies'). A call to ensure that this budget would be spent as intended did not reach a majority (Tweede Kamer der Staten-Generaal 2013a), as well as a call to retain this budget in the context of the government's budget cuts (Tweede Kamer der Staten-Generaal 2013c). New PVV proposals to reintroduce extra funds for training and care personnel were again rejected in 2015 (Tweede Kamer der Staten-Generaal 2015a), like their renewed efforts to roll back the extramuralisation of elderly care and safeguard the institution of care homes between 2012 and 2017 (Tweede Kamer der Staten-Generaal 2012c, 2013b, d, 2014, b, 2017).

Then, in 2016, the PVV was finally successful in its strides for better elderly care. Their proposal to implement improvements in elderly care was unanimously accepted in the House of Representatives (Tweede Kamer der Staten-Generaal 2016) – thus recentring the focus on elderly care that was lost after the Rutte I cabinet. The government presented a plan, including a commitment to a €2.1bn yearly budget for care homes from 2021 (Ministry of Public Health 2017). Other measures

were, among others, the reversal of the planned €500m cuts on long-term care in 2017, a yearly €200m investment in training for care personnel and daytime activities for elderly, and the establishment of improved patient-oriented quality standards for care homes and care personnel (Rijn 2017). The PVV managed to receive full Parliamentary support for an unprecedented mandated elderly care budget because of two recent public contestations exposing how nursing homes were operating below moral and quality standards. The first one was a (initially anonymous) protest letter by the father of the then-State Secretary of Public Health Martin van Rijn about the quality of care provided to the State Secretary's mother in a nursing home (Landeweer 2014). This letter was followed by a manifesto presented by public opinion columnist Hugo Borst (and Carin Gaemers) based on personal experiences with the quality of care to his mother earlier that year. This manifesto contained several recommendations to improve and 'depoliticise' long-term elderly care (Borst and Gaemers n.d.) and was the direct trigger for the successful elderly care proposal by the PVV and the subsequent reform.

The Dutch PRR and the COVID-19 Pandemic

The PRR response to the COVID-19 pandemic in the Netherlands was in conflict with the response of the VVD- and CDA-led government (Rutte III). Initially, the PVV and the FvD were more radical in their proposed measures. Both parties called for a lockdown weeks before it was eventually implemented nationally on March 23, 2020. Wilders was the first to criticise the governments' approach to the crisis in early February In mid-March both the PVV and FvD refused to support the milder measures that were introduced by the government, including the decision to ban gatherings of more than 100 people and encourage people to work from home, but to keep schools open. Wilders accused the Minister of Healthcare of not taking enough measures compared to other countries, questioning whether there was enough healthcare capacity (and PPE) and why Dutch borders remained open (Tweede Kamer der Staten-Generaal 2020c). Indeed, the PVV made several proposals to control the inflow of people from abroad, including a proposal to ban flights from 'risk areas', which was only supported by the PVV, FvD, and radical left Dutch Socialist Party (SP). Baudet similarly criticised the initial herd immunity strategy the government seemed to be taking and called for a stricter lockdown (FvD 2020). While the FvD, unlike the PVV, eventually supported the governments' 'intelligent lockdown', it also called for increased border controls to curb risks from abroad.

During the early days of the crisis in the Netherlands, support for the VVD and trust in the Prime Minister Mark Rutte increased. On the other hand, the PVV and FvD lost support for advocating for stricter lockdown rules (Kester 2020). It is possibly for this reason that both Baudet and Wilders changed their position on the lockdown during the following months, now stating that it was too strict and would cost too many jobs in the hospitality sector (Yannis and Giorgos 2020). Wilders

criticised the '1.5 [meter] society' which is considered the new normal and made proposals to abolish 1.5 m distancing rules outside immediately. This proposal was only supported by the party itself and the FvD (Tweede Kamer der Staten-Generaal 2020a). Similarly, when new 'partial lockdown' measures were announced and implemented in October, both the PVV and FvD made proposals to keep hospitality open and to avoid mandatory mask-wearing mandates. The FvD was the only party to support the contested 'herd immunity' strategy whereby older and more vulnerable people are shielded while restrictions are lifted for the rest of the population (Tweede Kamer der Staten-Generaal 2020d). This is surprising given Baudet's initial criticism of natural herd immunity in the context of COVID-19 (FvD 2020).

Despite a change in standpoint by Wilders and Baudet, they have not openly opposed science and experts. For example, Wilders has said that he believes in 'experts' and the National Institute for Public Health and the Environment (RIVM), but decisive political action is also needed. This in itself contrasts with the standpoints taken by populist leaders in other countries, such as the United States and Brazil, which consistently dismissed scientific expertise during the pandemic (Yannis and Giorgos 2020). While Wilders is firmly against making COVID-19 vaccines mandatory, he has not engaged with the anti-vaccination (or 'anti-vax') movement and the conspiracy theories that have emerged in response to the pandemic. However, Baudet has allegedly made statements in private that suggest he believes in conspiracy theories regarding the emergence of COVID-19 (NOS 2020).

Throughout the pandemic, the PVV showed support for healthcare workers (especially nurses). For example, Wilders proposed to increase pay in the healthcare sector, which was rejected by a small majority after several coalition MPs had left before voting (Tweede Kamer der Staten-Generaal 2020b). This was met with anger by Wilders himself, who found it unfair that healthcare 'heroes' earned less than 'runaway' MPs (populism) and that the government was willing to spend millions of euros for corona-related relief in other EU countries while not having enough money to increase salaries for healthcare workers (nativism) (PVV 2020). Later in the year, Wilders made several successful proposals to the House of Representatives, including those to investigate the creation of a national reserve of healthcare workers and to maintain a structural reserve of intensive care beds for future emergencies (Tweede Kamer der Staten-Generaal 2020e, 2020f). While the PVV and FvD had similar standpoints on the coronavirus measures, including the treatment of healthcare workers, Wilders was much more contentious and critical of the government than Baudet. This has been suggested to be linked to the leaders' prospects for office, which are smaller for the PVV than the FvD given its more ostracised position in Dutch politics (Yannis and Giorgos 2020). Wilders' approach seems to have been successful, as after an initial drop, the PVV's approval rating has risen again. In the summer months of 2020, the PVV was polling as second largest party at the national level, after the VVD (Heck 2020a). The FvD only saw a small increase in support during the same time period, despite its successes in the 2019 provincial and European election. While the PVV kept its position as second largest party, support for the FvD has dropped again in October 2020 (Heck 2020b).

Conclusion

While the PVV did not make health or health care its central issue when 'in government' (through a Tolerance Agreement), the evidence in this analysis indicates that the PVV had a positive influence on the improvement of long-term elderly care. Indeed, elderly care was to a certain extent exempt from the severe austerity measures that were introduced by the VVD-CDA coalition Rutte I (Rijksoverheid 2010b). While the new government quickly dismantled some elderly care measures that were introduced with the Tolerance Agreement in 2012, the PVV's continuous efforts eventually led to significant investments in elderly care and care homes from 2017 (Tweede Kamer der Staten-Generaal 2016). However, due to the State Secretary's personal involvement and the public awareness that was created around this topic, it remains the question whether some of these changes would have happened anyway without PVV initiative. In this sense, the proposal that led to the renewed elderly care budget was an easy win for the PVV.

It also becomes clear that the PVV broke its electoral promise to make health care more affordable and less 'elitist' and market-driven, instead favouring a more libertarian approach that was championed by the VVD in particular. Rather than a change in ideology, this appears to have been an opportunistic decision given the trade-off the PVV faced between securing and retaining a place in office and representing the interests of its voters (Afonso 2015; Rinaldi and Bekker 2020). As evidenced by the Tolerance Agreement, the PVV decided to prioritise the issues of law and order, immigration, and elderly care in its negotiations with the VVD and CDA (Rijksoverheid 2010a) while sacrificing the health-related issues that were present in its electoral manifesto. This suggests that the PVV engaged in office-seeking behaviour rather than vote-seeking behaviour when it comes to health during its time 'in government', in order to achieve its main (mostly immigration-related) agenda points. It is therefore unlikely that the PVV had much influence on the curative care policy that was implemented between 2010 and 2012, which seems to be more in line with the retrenchment ambitions of the VDA-CDA government.

At the same time, the VVD and CDA were willing to accept exclusionary and authoritarian measures to gain a majority in government and pursue their own agenda. This provides evidence for accommodation to PRR standpoints by Dutch mainstream parties, which is believed to be a consequence of electoral threat by PRR parties and/or need for PRR support in government (Rinaldi and Bekker 2020). While the PVV's nativist agenda was more successful in leading to immigration policy reforms, their electoral manifestos and their health policy proposals suggest a welfare chauvinistic position that favours the native population (mostly older adults) over immigrants and asylum seekers in access to healthcare provisions. However, in combination with retrenchment in health spending during the 2010–2012 period, the position taken by the government resembles more what is called liberal chauvinism. Early evidence suggests that welfare chauvinism in health care is indeed more common in countries with a tax-based healthcare system compared to the Dutch system based on private insurance, which is believed to be less

susceptible to public scapegoating (Ennser-Jedenastik 2018; Rinaldi and Bekker 2020). Nevertheless, there is evidence that in countries with insurance-based healthcare systems, PRR parties use a form of exclusion based on financial contribution (Ennser-Jedenastik 2018). This is what the PVV has done by attacking asylum seekers' access to health care, a group that does not contribute through premiums. The PVV also directed its attention towards long-term elderly care rather than the healthcare system in general, as this is a publicly financed sector and thus politically more opportunistic.

The decline in support for the PVV in favour of the FvD in the 2019 provincial and European elections might mean that the FvD will become the most prominent-PRR voice in the Netherlands – although the 2021 general elections could take a very different turn because of the multiple impacts of the coronavirus policies and regulations and the ways in which PVV and FvD position themselves towards these policies. Besides, the FvD is facing significant internal challenges, which could result in a change in leadership and direction in the next elections. The most recent polls at the time of writing show that the pandemic might have positive consequences for Wilders in the 2021 general elections. Given the electoral loss that was faced by the PVV after its withdrawal from the Rutte I cabinet in 2012, it seems unlikely that Wilders would use the same office-seeking, liberal chauvinistic strategy if his party were to be elected in government. This can, for example, be seen through his advocacy for increased government spending on salaries for healthcare workers during the COVID-19 pandemic. However, this depends on whether Wilders has learned from his mistakes in diverting from his political agenda on health.

Summary Box

1. The PVV diverted from its welfare chauvinistic political agenda after lending its support to the centre-right government coalition.
2. While the PVV pursued its voters' preferences on the issue of elderly care and exclusion of 'foreigners' (vote-seeking behaviour), it chose to compromise with its coalition partners on health policy (office-seeking behaviour).
3. Influence was exerted in different ways: through the Tolerance Agreement (which contained accommodation on both ends) and through policy proposals (seizing momentum caused by public contestation to gather political support).
4. As of 2019, the PVV is in competition with the newer PRR party FvD which has similar standpoints on immigration and European integration but takes a more liberal chauvinistic position towards the welfare state and is less ambitious on the topic of elderly care.

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The Evolution of the Populist Radical Right and Their Impact on Health in Italy

Michelle Falkenbach

Introduction

The parliamentary republic of Italy is the fourth most populous country in Europe with over 61 million inhabitants. According to the most recent OECD report, Italy has the fourth highest life expectancy in the world (OECD 2019) but sees the largest internal differences of GDP/capita for health of any European country (Health Consumer Powerhouse 2019). Over the last 25 years, the Italian National Health Service (NHS) has transformed from a centralised to a regionalised and semi-federalised system (see Pavolini and Vicarelli 2012; Lynch and Oliver 2019 for more detailed information) wherein the 19 regions and two autonomous states (Vatican City and San Moreno) provide universal health coverage. The central Italian government controls the distribution of tax revenue for health care and defines the essential levels of health services.[1] While much of the health competencies have devolved to the regions, the goal of this chapter is to identify health policies directly or indirectly passed by the populist radical right (PRR) Lega Nord (LN).

While the main policy areas prioritised by the Lega Nord (LN) have always been immigration and fiscal autonomy through either federalism, secessionism or devolution (Bull 2011), there are instances when they attempt to frame health policies to fit into these realms. The LN has been in national government over the course of

[1] Statutory benefit packages that are offered to all residents in every region (Donatini n.d.).

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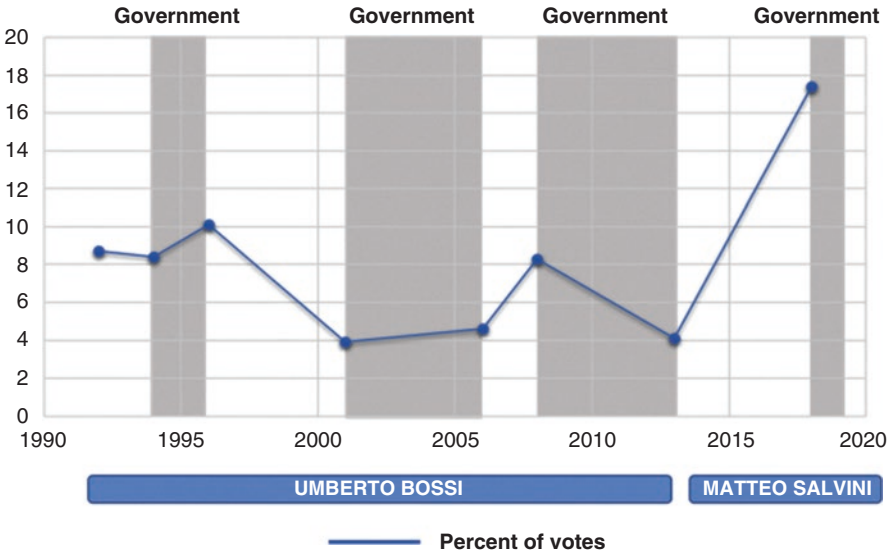

Fig. 1 General Elections (Chamber of Deputies) Results; Source: (Governo italiano Ministero dell'interno 2018)

several different election periods: 1994, 2001–2005 and 2008–2011[2] (Fig. 1), wherein they participated in Berlusconi's right-wing coalition government briefly in 1994, were in another Berlusconi led coalition from 2001 to 2006 and formed another coalition with Berlusconi's People of Freedom party in 2008. During this time, the healthcare system was plagued with efforts to contain public health spending. Naturally, this led to retrenchment measures in health care typical of conservative governments. After a name change leading up to the 2018 elections, the Lega made their last appearance in government through a coalition with the populist, anti-establishment party Movimento 5 Stelle (M5S; Five Star Movement). During this period, the party's new leadership becomes apparent through increasing anti-scientific rhetoric coupled with indirect welfare chauvinistically motivated health policies.

The chapter will continue with a history of the Lega Nord establishing that it does belong to the populist radical right party family. Starting from 2001, when the LN was in government, the health policies (direct) or policies relating to or impacting health (indirect) passed and/or addressed will be looked at in detail. Then, a section on the corona pandemic and the PRR response to it will follow leading into the chapter's conclusion.

[2] With the respective coalition partners: Forza Italia (FI), United Christian Democrats (CCD-CDU) and the National Alliance (AN); FI and AN; The People of Freedom (PdL) (Mudde 2013). In 1992, the Lega made it into Parliament but was not part of a governing coalition.

History of the Lega Nord

Founded in 1991 by Umberto Bossi as a regionalist populist party (see Mazzoleni and Mueller 2016; Spektorowski 2003), the Lega Nord (LN; Northern League) was born out of the success of several regional leagues[3] (Veneto, Lombardy, Piedmont, Liguria, Emilia-Romagna and Tuscany). At this time, the Lega Nord was considered a 'a populist movement with protest and identitarian features' (Tarchi 2008 pg 91) whose goal it was to protect the Northern region's economy and culture (Giordano 2001; Nord n.d.). Much support was garnered due to citizens increasing resentment of economic and political problems, which the party used to criticise the South for being lazy and profiting from the transfer of hard-earned Northern resources (Betz, 2001). During this time, the LN focused primarily on two political issues: (1) the 'northern question' (Diamanti 1996), implying a break between the wealthy North and the much poorer South, and (2) increased regional power because of the increasingly corrupt political and institutional elites (Bulli and Tronconi 2011).

The LN's evolution into a full-fledged PRR party can be observed in how it participated in government and what issues became most pressing for them. Always being part of the centre right coalition, Casa della Libertà (CDL; House of Freedom) led by media tycoon Silvio Berlusconi's[4] Forza Italia, the Lega initially chose to concentrate its efforts on regional topics, specifically, advocating for the independence of the North and thus showing little presence on the national stage.[5] By the time the party entered into its second coalition with Berlusconi's' Forza Italia in 2001, the LN began solidifying its national issues: anti-immigration, devolution through constitutional reform, protectionism and a strong aversion to the EU's (European Union) single currency (Albertazzi et al. 2011). At this point, the party took on more nativist and authoritarian positions (Mudde 2007; Norris 2005) although not entirely dropping its ethnoregionalist (Spektorowski 2003) ideology. The party's success during this period can be attributed to its passage of both the Bossi–Fini immigration law and the Constitutional Reform bill (devolution). While both of these laws had their faults (see Albertazzi et al. 2011), they allowed the Lega to establish 'issue ownership' (Albertazzi et al. 2011) through their proactive participation in government.

The third and final coalition with Berlusconi, now head of the Il Popolo della Libertà (PdL; The People of Freedom),[6] came in 2008. By this time, the LN had become the oldest party in Italy's parliament (Albertazzi et al. 2018). Rather than dissipate or be consumed by other parties, as happened to many other Italian parties, the LN became a primary force within Italian politics (Biorcio 1999) because it was able to change and adapt its rhetoric thereby adjusting to the changing political

[3] For more information pertaining to regionalism in Italy, see (Tarchi 1998).

[4] Forza Italia is a populist party on the right, but not on the radical right (Bobba and McDonnell 2016).

[5] In fact, the party was only in government for 6 months.

[6] This party resulted from the merger of Berlusconi's Forza Italia and the AN.

situation in Italy.[7] The two pillars of discourse and themes were still greater northern autonomy coupled with the immigration of people from outside the EU; but the rhetoric of the party started to intensify with slogans such as 'Let's close our borders' and the number of policies that were passed increased. LN Minister of Interior Roberto Maroni saw to the passage of two very strict security packages, the first of which, Law n. 94, went into effect in August 2009 and the second became law in 2010. Both laws increased the barrier of entry for immigrants specifically tightening the controls on convenience marriages and allowed for citizens to patrol the streets to help fight crime (Brunazzo and Roux 2013). In addition, the government implemented eight decrees that supported further devolution and federalism (see Brunazzo and Roux 2013).

With the issues immigration, security and devolution at its core combined with the classic populist (Taggart 2000) manner in which its leader, Umberto Bossi, justified its actions and policies, the Lega Nord was in government three times – 1994, 2001 2008 – and becoming increasingly radical.

From Bossi to Salvini

After a corruption scandal, Bossi had to step down as the leader of the LN, handing the party over to Roberto Maroni in 2012. Maroni's leadership ended shortly after it begun as Matteo Salvini took hold of the party reigns in 2013 thereby moving the party even more to the right on the political spectrum. According to scholars, Salvini's aim was to transform the LN from a regionalist party to one centred in anti-immigration and anti-EU policies, thereby following the sentiments of the population (Albertazzi 2016; Brunazzo and Gilbert 2017; Mancosu and Ladini 2018). He went so far as to create a sister party to the LN known as 'Noi con Salvini' (Us with Salvini) in 2014 in order to amass more support from the Southern regions (Perrone 2018) and subtly dropped the 'Nord' from the parties name (Albertazzi et al. 2018), thereby officially putting an end to the Lega's regionalist ideology. Although Bossi had always proposed strict immigration policies (Brunazzo and Gilbert 2017), Salvini took this a step further embracing the unconditional rejection of foreigners (Albertazzi et al. 2018) emphasising the defence of the Italian people against external pressures such as the European Union (Caiani 2019), and thereby appealing not only to neo-fascists but also to the many Italians fearing increased migration into the country. Both Bossi and Salvini are charismatic leaders, typical of populist parties; however, Salvini was able to increase his popularity, communication range and political influence through the use of social media (particularly through the use of Facebook and Twitter) (Albertazzi et al. 2018). While Bossi was most known for his alliance with Berlusconi, securing three government terms in a centre-right coalition and his more conservative governing style (Brunazzo and

[7] For more history on the changing geographical phases of the Lega, see Giordano 2001.

Roux 2013), Salvini shifted the Lega's direction towards radical right-wing populism (Brunazzo and Gilbert 2017).

PRR Lega?

While many scholars classify the Lega Nord, before Salvini (pre 2013), as PRR (Betz and Johnson 2016; Ruzza and Fella 2009; Stefano and Ruzza 2009; Verbeek and Zaslove 2015; Zaslove 2011), arguing that its ideology, political organisation and voter profile match other 'third wave' PRR parties that emerged in the 1970s (Zaslove 2011 pg 5–6). Others disagree stating that while the LN was certainly always a populist party, its qualification as radical is more difficult to establish (Bartlett et al. 2012; Mudde 2009). They argue that it does not meet the PRR criteria of having a nationalist, populist and authoritarian ideology and is instead nationalist, populist and regionalist with secessionist aims, an ethnoregionalist position and a preference for decentralisation (Zaslove 2011). Others attest that the party did not move into a radical direction until Salvini took over in 2013 (Caiani 2019; Newth 2019). For the purpose of this chapter, the health and social policies passed by the Lega or with the help of the Lega will be investigated starting in 2001. The parties first term in government will be left out because it was too short (6 months).

It is also important to note that in addition to the Lega, there are several Italian parties that have been interpreted as being PRR by scholars over the years. While some scholars include the Alleanza Nazionale (AN; National Alliance) in the PRR family (Gómez-Reino and Llamazares 2006; Norris 2005), they provide no reasoning or justification for doing so. The AN, born out of the Movimento Sociale Italiano (MSI; Italian Social Movement) in 1995, had its roots in fascism (see Griffin 1996), evolved into a modernisation party 1998–2000 (Tarchi 2003) and then settled into the position between the Forza Italia and the Lega on the political party spectrum, also identifiable as 'proto-conservative party' (Ignazi 2005) or 'post-industrial far right' (Kopecek 2007). In 2009, the AN as well as Berlusconi's Forza Italia merged into the newly formed Berlusconi led Il Popolo della Libertà (PdL; The People of Freedom). Currently, the AN is considered to be a part of the Fratelli d'Italia (FdI; Brothers of Italy), a former faction of the PdL.

The Fratelli d'Italia (FdI) can, since their founding in 2012, very much be classified as PRR (Gattinara and Froio 2018) as it is a hard-right, nationalist, conservative and populist party that has origins in neo-fascism (Bruno and Downes 2020). Although the party has never been in government, it is one worth looking out for in the coming years as it is gaining increasing momentum under the leadership of Giorgia Meloni (Bruno and Downes 2020; Nadeau 2018).

In addition to the PRR party family in Italy, there is also another type of Italian populism that has influenced the choices of the not only the Lega but of other parties as well (Caiani and Padoan 2020). The populist radical left led by the M5S is a relevant player in the Italian party system not only because the party has been in government over the course of two periods but also because it has pushed for institutional

reforms securing their biggest accomplishment through the 2020 referendum to reduce the size of parliament (Balmer and Fonte 2020).

Health Policies of the Lega

Berlusconi Government II and III (2001–2006)

The Italian Welfare state, including health and social policies, in the 2000s can best be described as an almost 'frozen' (Naldini and Saraceno 2008) landscape as all national healthcare reforms (decentralisation, managed competition and different forms of privatisation) took place in the 1990s (Legislative Decrees no. 502/1992 and no. 517/1993); see Maino and Neri 2011; Neri 2019 for more detailed information. There was however an attempt by the centre-right Berlusconi coalition, fuelled by pressures from the LN, to dismantle some provisions of the constitutional health reforms (Constitutional Law no. 3/2001), such as those regulating doctors and managers in the public sector. The national government wanted to further increase opportunities for private sector involvement within the healthcare system at all levels, particularly in financing, through private health insurance. In addition, the LN presented a bill aimed at changing the constitutional reform approved just before the 2001 elections. According to the new proposal, the regions were supposed to be granted exclusive – instead of shared – legislative power in the health sector (Fargion 2006). While decentralisation continued, the proposed reform was rejected per referendum.

Between the years 2001 and 2006, Umberto Bossi (LN Minister of Institutional Reforms and Devolution) took on the task of introducing a stricter law on immigration; Roberto Castelli (LN Minister of Justice) promoted a controversial reform of the judicial system; and Roberto Maroni (LN Minister of Labor and Social Security) was at the forefront of efforts to restructure the pension system (Tarchi 2008). The policies implemented by the Berlusconi government from 2001 to 2006 did not satisfy the voters as many of these policies turned out to be more moderate than those originally proposed by the LN. While the Bossi-Fini law introduced more stringent procedures for checking up on and expelling illegal foreigners by linking employment to the ability to obtain a work permit or visa (Zaslove 2004), it also led to the regularisation of hundreds of thousands of immigrants already resident in the country (Albertazzi and Mcdonnell 2008). In fact, regional governments were to provide health care for 650,000 regularised immigrants with no extra funding (Fargion 2006). This reality was in stark contrast to the one presented in the LN pre-election manifesto, where the party asserted that immigrants would have to contribute to the national wealth before asserting the right to health insurance (Zaslove 2004).

Compared to the previous centre-left government, the Berlusconi government had a different attitude towards operational agreements between public administrations and/or with representatives of the private sector. As it became clear with the

publication of the White Paper on the Labour Market in October 2001, the centre-right government and, particularly, the Minister of Welfare, Roberto Maroni, wanted to create new forms of 'social dialogue', wherein the role of the government and civil society would be more distinct, thereby also splitting the trade union front (Maino and Neri 2011). The consensus of social actors would no longer be considered necessary in order to promote structural reforms (Maino and Neri 2011). While it was very active in labour market and pension policies (see Laws no. 30/2003 and no. 243/2004 and Ascoli and Pavolini 2015), the Berlusconi government did not promote any structural reforms in health care.

Berlusconi IV Government (2008–2011)

In 2009, the Berlusconi government began removing competencies for health care from the Ministry of Welfare transferring them instead to the Economic Ministry as cost containment in the Italian NHS became the primary goal (Pavolini et al. 2015). This left the Health Minister, Ferruccio Fazio (Independent), with little to no powers to plan, coordinate and monitor regional health services. The result was cost-containment programmes that began in 2009 (Law Decree No. 39/2009) and 2010 (Law Decree No. 78/2010) and increased after 2011. These programmes put spending caps on pharmaceutical expenditures, strictly controlled staff expenditures in public services (i.e. reducing the number of NHS employees, a suspension of collective bargaining and wage stagnation), increased patients co-payments and decreased the expenditure allotted to purchase goods and services (Neri 2019). In addition, while public spending for health stagnated at around 6.3% in terms of GDP and per capita expenditures, private health expenditure (predominately in the form of out-of-pocket-payments) as a percentage of total health expenditure significantly increased from 22.5% in 2007 to 25.8% by 2018 (OCPS Report 2018). These measures cannot be specifically attributed to any party in government, rather they were a direct result of the economic and financial crisis and the subsequent controls the EU imposed on Italy due to its high debt (the relationship of GDP and public debt has been over 100% since the early 1990s, surpassing 130% by 2014) and healthcare spending (Neri 2019).

What can however be linked directly to the LN is the security package (Pacchetto Sicurezza) designed by Lega Minister of Interior, Roberto Maroni. This package was made up of five laws grouped together essentially characterising immigrants as security risks (Meyer 2015). While the package certainly contained several desperately needed revisions to security in Italy such as provisions making it easier to address crimes of human trafficking or increased collaboration with worldwide agencies (Maccanico 2009), some articles (Law 94/2009, article 10 or Law 286/1998, article 35) impacted health care in a very negative way. The Pacchetto laws (or security package), as they are commonly known, most directly impacted the health of immigrant care workers (Meyer 2015) (see Table 1). Article 10 made the status of being an undocumented immigrant a criminal offence, and article 35

Table 1 Lega health policies

PRR Health policy	Implemented	Coalition partner	Outcome/comments	Classification
'Security package' law 94/2009, article 10 and modification to law 286/1998, article 35	Yes	Forza Italia	Article 10 made the status of being an undocumented immigrant a criminal offence and article 35 declared that undocumented immigrants could receive only emergency and essential medical care from the Italian National Health System	Welfare chauvinism
'Salvini Decree' Law 132 (2018) modifying the Legislative Decree of 25 July 1998, n. 286	Yes	Five Star Movement	Abolish the humanitarian protection status for migrants, weakens the public services available to them	Welfare chauvinism

declared that undocumented immigrants could receive only emergency and essential medical care from the Italian National Health System. These laws had two different effects on immigrants: (1) Some immigrants felt scared deciding not to even come to Italy or the ones already in Italy decided to return to their home countries; (2) more experienced immigrants would simply ignore the laws knowing that they would continue to receive care. See Meyer (2015) for the detailed interviews with immigrants regarding the security package.

By the end of 2011, the Berlusconi IV government was replaced by a technocratic government (Monti government) because international markets as well as the European Union no longer believed that the government could contain the countries debt. At this time, the cost-containment programmes increased, and a spending review on public administration was put into place in 2012 (Law Decree No. 95/2012, converted into Law No. 131/2012) (Neri 2019). Severe inequities, stemming primarily from geographic differences in health systems,[8] in health status and healthcare provision across the various Italian socioeconomic population groups resulted from these measures. Increased waiting times, and inequities in specialist care, favouring wealthier patients over poorer ones made access increasingly difficult (Ferré et al. 2014).

The LN's resume in government up until this point with regards to health can be seen as consistent with their coalition partners and the technocratic governments that replaced them. Governments across the board, whether technocratic, PRR or conservative had the same approach to health – classic conservative cuts for the entire population. While the LN tried to mark some of their policies with a Liberal

[8] In most Northern and Central Italian regions (excluding Liguria and Piedmont), the attainment of fiscal equilibrium allowed these regions to push for autonomous regional health policies, in spite of the strictly nationally determined austerity policies (Neri 2019).

chauvinistic – cuts for all, but specifically for immigrants – characteristic, the general message was clear: public health expenditure was cut for all in order to adhere to the debt-containment measures.

Conte I Government (2018–2019)

At the general elections held in March 2018, the Lega gained over 17% of the national vote – i.e. 7% more than its previous best result in a general election back in 1996 (10.1%) and secured its fourth term in a coalition government with the populist left M5S as a coalition partner (Albertazzi et al. 2018). During the election campaign, Salvini said that he and his party would put 'Italians first' and that he would begin cracking down on illegal immigration, but he also had things to say in terms of health and health policy.

One of the first things M5S and Lega politicians did was prepare a proposal to eliminate the mandatory vaccinations for preschool children (Lorenzin decree No. 73 of 2017) against ten diseases including measles, tetanus and polio (Davenport 2018) put forth by the centre-left government in 2017. The new populist coalition argued that vaccinations benefited pharmaceutical companies (5SM) and claimed they could cause autism (Lega) (Harris and Monella 2018). On the other hand, the coalition said that they were in favour of vaccines but were against coercion (Rezza 2019) with the Lega insisting that the Lorenzin decree violated Article 2 of the Italian Constitution seeing as it opposed the freedom of care for minors (Casula and Toth 2018). Despite vehemently arguing to overturn the decree, this was never done. Instead the government passed a measure allowing children to stay in school as long as their parents affirmed that they had been vaccinated; no proof was required (Horowitz 2018). The problem with this decision was that already in 2017, the WHO reported a spike in measles cases due to misinformation about vaccines, with the greatest surges being in Europe and the Eastern Mediterranean regions (WHO 2018), hence, the Lorenzin decree. Mandatory vaccinations in countries with declining coverage, such as Italy, have proven to produce positive effects (Rezza 2019), which is why members of the scientific community have doubts that the changes made to the Lorenzin decree were guided by scientific evidence (D'Ancona et al. 2019).

The next attack on the scientific community came in December 2018 only months after the new government was elected. Health Minister, Giulia Grillo, dismissed the entire health advisory board wanting to signal that this government would be doing things differently, thereby discarding some of the biggest names in Italian medicine (Giuffrida 2018). Political opponents presumed that the decision was made to suppress scientific opinions (Dyer 2018). Shortly thereafter, Walter Ricciardi, President of the Italian National Institute of Health and internationally recognised expert on vaccinations resigned stating 'representatives of the government (by which he explicitly meant Salvini) have endorsed unscientific or frankly antiscientific positions on many issues' (Day 2019 pg 1). In addition, Ricciardi claimed that this

populist government was 'playing politics with public health by pressuring health officials to adopt policies favorable to antimigrant views'[9] (Day 2019 pg 1).

In December 2018, the Decree-Law on Immigration and Security aka 'Salvini Decree' (Corsi 2019) pushed forth by Salvini came into effect (Law no. 132) as a modification of the previous Legislative Decree of 25 July 1998, n. 286 (see Table 1). Migrants had been accused of exploiting the Italian welfare system and taking advantage of its services such as social housing and universal health care. Thus, the decree saw to it that not only the humanitarian protection status for migrants would be abolished, but it would also become easier to strip migrants of Italian citizenship, stops asylum seekers from accessing reception centres designed to combat social exclusion and generally weaken the public services available to them (Carlotti 2020).

Anti-scientific rhetoric and actions were best displayed during this short-lived governmental coalition. No specific implemented health policies can be tied to the Lega during this time; however, observations as to how the party dealt with health discussions and policy proposals point to a fundamental PRR characteristic, namely, pursuing policies and making arguments without scientific evidence. In addition, the 'Salvini Decree', although labelled as a security or immigration law, had profound effects on the health of undocumented migrants and continues to negatively impact public health throughout the corona pandemic.

The Corona Pandemic

The 'Salvini decree' caused additional stress with the outbreak of the corona pandemic[10] as both health care and support for housing are two pressing needs for migrants, particularly during a pandemic (Carlotti 2020). If an undocumented migrant is not able to have a residence,[11] then they are unable to register for the Italian National Health Service thereby impeding their access to services (Carlotti 2020). No measures were adapted under the new Conte government[12] to ease the access for undocumented migrants to attain services or provide other useful measures to protect the migrant communities from the virus.

Aside from the latent impact previous Lega policies had during the pandemic, as a member of the opposition, Salvini greatly influenced the discourse surrounding

[9] In his role as Minister of Interior, Matteo Salvini proclaimed that there is a connection between migration and the spread of diseases such as tuberculosis and scabies. Italian doctors and the WHO vehemently negated this claim (ANSA, 2019).

[10] See (Falkenbach and Caiani 2021) for details on the corona pandemic in Italy.

[11] A significant number of the homeless population is made up of undocumented migrant and refugees (Kluge et al. 2020).

[12] In August 2019, Salvini pushed forward a vote of no confidence against the government resulting in a reformulation of the government in which the Lega was no longer present. The Democratic Party (PD) and the Five Star Movement (M5S) reached an agreement and were sworn into office with their new ministers at the beginning of September forming Conte II.

the coronavirus. Initially, he used the pandemic to continue his anti-immigrant rhetoric going so far as to blame them for bringing the virus to Italy. Then, he was silent only to emerge again with attacks on the scientific community (regarding masks) advocating for a quick return to normality.

When a boat carrying several hundred migrants from Africa was granted access to the Sicilian harbour in late February, Salvini accused Prime Minister Conte of being unable to shield Italians from a disease outbreak in Italy (Thrilling 2020) claiming that allowing migrants from Africa to land in Italy was thoughtless (Smith 2020). Salvini used this humanitarian act to further his agenda against immigration in the middle of the pandemic advocating to tighten security along the Italian border (Nugent 2020). By March, when it seemed the virus was spiralling out of control in Italy, Salvini stayed quite content to let the government make the difficult decisions. At the end of the month however, when he noticed increased frustrations due to the lockdown, Salvini found his voice again and started firing critique towards the Italian government and the EU. In April, he staged a 2-day occupation of the Italian parliament to protest the lockdown demanding the restoration of full liberties (Roberts 2020).

In a time when politicians should be holding together, making and propagating decisions that are best for their populous, Salvini, like many other PRR politicians, chose to follow their own agendas (Falkenbach and Greer 2020) adding to the confusion revolving around the virus and increasing the scepticism towards governing officials and scientists alike.

Conclusion

The health policies passed or supported by Lega politicians can be summarised as being typically conservative due to the strict debt-containment measures during the Berlusconi coalitions (II–IV) and welfare chauvinistic coupled with anti-scientific rhetoric during the Conte government (I). While the LN was not in the position to directly pass health policies during the Berlusconi coalitions, they did support the retrenchment measures proposed during Berlusconi II. During the third Berlusconi government, the LN also supported further healthcare retrenchment efforts and attempted to reduce access to health care for undocumented migrants indirectly through the security laws.

During Conte I, the anti-scientific vaccination rhetoric and the welfare chauvinistic policies passed in the Salvini decree dominated the short-lived government. The already difficult situation surrounding the corona pandemic in Italy was made even more difficult due to the Lega's consistent criticism of the government, their attempt to uphold anti-immigrant sentiments by blaming migrants for importing the disease and their inconsistencies regarding the wearing of masks.

PRR politics in Italy, and elsewhere, can generally be summarised as having a lot of bark, but no bite. This was formulated more eloquently by Anna Cento Bull when she described the politics of the Lega as 'a form of political communication that

articulates demands which are not supposed to be taken seriously and implemented, but which are nevertheless constantly rearticulated' (Bull 2010, 431). This is to say that manifestos and rhetoric are filled with action points; however, when it comes to implementation policies, these can be counted on one hand. In fact, 'policy proposals and even detailed legislative initiatives are made as mere instruments of political communication' (Ruzza and Fella 2009, 231–32).

Future research on the PRR in Italy should continue to follow the Lega but also keep an eye open for Giorgia Meloni's Brothers of Italy. In addition, health policies in the country might be better studied on a regional level seeing as the devolution of the health system has left the national competencies rather sparse.

Summary Box

1. The Lega, formally known as the Lega Nord, is the oldest party in the Italian parliament.
2. The health policies supported or passed by the Lega can generally be categorised as conservative although they all have a distinct anti-scientific rhetoric and an anti-immigrant undertone.
3. The social policies passed by the Lega that have an indirect impact on health can generally be categorised as welfare chauvinistic.
4. Health policies in the country might be better studied on a regional level seeing as the devolution of the health system has left the national competencies rather sparse.

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The Populist Radical Right and Health in Hungary

Alexandru D. Moise, Gábor Scheiring, and Olga Löblová

Introduction

Populist radical right (PRR) parties generally hold a peripheral position in national politics in Western Europe. They cater to a small electorate and form their policy positions based on the logic of welfare chauvinism, by attempting to expand access to benefits of the local population while excluding immigrants and other vulnerable groups. PRR parties do this by leveraging their influence over centre-right and centre-left parties in order to promote their policies.

Hungary does not fit this mould. In contrast to its Western counterparts, the Hungarian PRR party, Fidesz has been the largest party in parliament since 2010, dominating politics by holding a supermajority. Because of this, the party has been relatively unconstrained in the types of policies it could formulate and implement. Moreover, it has systematically undermined democratic checks and balances in order to further its grip on power and its control over policies. However, the fact that Fidesz has had such broad electoral support meant that it also had to adapt its policy positions to the broader Hungarian electorate. What resulted was a mix of policy approaches towards health care, including what can be considered statist, liberal chauvinistic reforms and reforms marred by clientelism. Fidesz's direct impact on health care is mixed. However, the PRR party has had a clearer indirect impact on health, through its undermining of other elements of the Hungarian welfare state. These reforms increased social insecurity and therefore negatively impacted the

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health and livelihoods of individuals. Welfare reforms by the party more clearly follow the mould of conservative and liberal chauvinistic reforms.

What sets Fidesz apart from other PRR parties are its statist policies, which we emphasise more than its putative welfare chauvinism when it comes to health policy. Statist policies structurally increase the state's role in administrating health care. These can be seen in contrast to policies that privatise financing or real estate, or that decentralise administration and decision-making. In the case of Hungary, statist policies returned hospitals and financing under state control and gave the central government more direct control over administration.

This chapter begins by examining Fidesz's ideological transformation from a centrist liberal party into a PRR party. It then examines its indirect impact on health through its regressive welfare reforms. The chapter then considers the health reforms implemented by the party since 2010. Since Fidesz did not qualify as a PRR party during its 1998–2002 cabinet, this chapter focuses on Fidesz's impact on health policy since 2010. The major policy changes attempted and implemented by the party occurred during its three terms starting in 2010. The subsequent section analyses its response to the COVID-19 pandemic (from January to November 2020) to see how the party reacted differently from other PRR parties and practitioners. The final section concludes.

Fidesz's Turn to PRR

Fidesz (officially Fidesz–Hungarian Civic Union, in Hungarian: *Fidesz – Magyar Polgári Szövetség*) is the most electorally successful post-1989 Hungarian party. Founded by a group of anti-communist student activists led by Viktor Orbán, in 1988, Fidesz underwent a profound ideological transformation in the late 1990s and early 2000s and is now one of the most influential populist radical right (PRR) parties in Europe. Unlike many PRR parties, which emerged directly in their current PRR form (such as the German AfD) or transitioned from extreme right to PRR (such as the French National Front – since 2018 known as the National Rally), Fidesz began as a centrist liberal party in 1988 (Enyedi 2005). Until 2000, it was a member of the Liberal International, after which it joined the European People's Party, of which it is still an uneasy member (Fidesz was suspended in 2019, but not expelled).

Today, Fidesz can be considered a textbook example of PRR ideology. From its inception until its first electoral victory (and the first Orbán cabinet) in 1998, the party went from liberal anti-authoritarian to conservative authoritarian (Enyedi 2005). The party's ideological shift to PRR has only continued across its three consecutive terms holding a supermajority in parliament since 2010. These electoral victories – enabled by growing social tensions before 2010, popular disillusionment with cosmopolitan-neoliberal elites, a fragmented and weakened opposition, changes to the electoral system that favoured Fidesz, and voter apathy – allowed the

party to systematically undermine democratic checks and balances (Krekó and Enyedi 2018; Scheiring and Szombati 2020). In recent years, the party has cracked down on independent journalists, opposition groups, universities and NGOs. Orbán used the COVID-19 pandemic to further entrench his power and marginalise the political opposition by halving state funding for political parties and reducing opposition-led local governments' financial autonomy. According to Freedom House's democratic rating, as of 2020, Hungary is no longer a democracy (Freedom House 2020).

Attempts by the European Union to constrain Fidesz's authoritarian changes have been weak and have played directly into Orbán's populist rhetoric. Since Fidesz is the 'elite' of Hungarian politics, the party positions itself as the defender of the people against European elites, who it argues want to undermine Hungarian autonomy by their economic policies and by allowing migrants to overrun the country and reshape its values and ethnic composition (Foy and Buckley 2016).

Fidesz continues to benefit from its supermajority in parliament and a continuously fragmented opposition. While the opposition recently made gains in local elections, including winning the mayoralty of Budapest and other large cities (Scheiring 2019a; Novak 2019), electoral laws and an almost complete control over the media will continue to give it an important advantage in parliamentary elections.

While health policy features less prominently on the party's agenda than migration, economic nationalism (Scheiring 2020a; Bohle and Greskovits 2019), or other welfare policies such as unemployment, pensions and family policy (Szikra 2014), health care has nonetheless gone through notable transformations. The initial wave of healthcare reforms came in direct opposition to failed marketisation reforms during 2007–2009. After the transition from a centralised Semashko health system to a decentralised Bismarckian social insurance system in the early 1990s, Fidesz reforms recentralised health care by transferring the management of hospitals from the local level to the state and merging the social insurance funds into the national budget (Mihályi 2012).

Welfare Reforms Impacting Health

Fidesz won the 2010 elections with the largest vote share of any party post-1989, 52.7% of the popular vote which gave it an even more impressive 68% of seats in parliament, thus giving it a supermajority. Fidesz fundamentally restructured the welfare state and modified its economic strategy by reducing the reliance on foreign investment and boosting precarious employment (Scheiring 2019b). The total number of employees increased by 720,000 from 3.72 million in the fourth quarter of 2009 to 4.44 million in the fourth quarter of 2019 (HCSO 2020). The public works programme (*közmunka*), which makes unemployment and healthcare benefits conditional on participating in communal public work, played a significant role in this expansion in the first few years. In 2010, the number of people employed in the

public works scheme was 70,000, which increased to over 200,000 by 2016. The public works programme has been shrinking since 2017, although growing significantly again in response to the coronavirus crisis.

Aggressive reforms to the system of social protection also contributed to growth in employment, in line with the ideology of the workfare state, which penalises 'idleness' to an unprecedented degree. The retirement age gradually increased while the government eliminated early retirement and significantly cut back on disability benefits. The government also cut the duration of unemployment to 3 months, reduced the value of social benefits, cut paid sick leave by half and decreased the public works salary. Once the job-seeker benefit expires after 90 days, citizens are entitled to employment substituting benefits of about 22,800 forints a month (€65; the average net monthly salary in Hungary was €789 in 2019 (Hungarian Central Statistical Office 2020)). These reforms of the supply side of the labour market are not only unjust, but they also increase precarious employment and might depress productivity growth in the long run.

Income inequality skyrocketed in Hungary after 2010. Hungary was the only country in East-Central Europe to experience an increase in inequality. The Gini coefficient of income inequality jumped from 24.1 in 2010 to 28.7 in 2018, while neighbouring Slovakia, Poland and Czechia all saw a decline (Eurostat 2020a). As a consequence, Hungary is now the most unequal country by this measure in East-Central Europe. The number of people in severe poverty earning less than 40% of the median wage also grew dramatically, from 197,000 persons (2% of the population) in 2010 to 478,000 persons (5%), which is one of the highest increases in the whole EU (Eurostat 2020b). Spending on social protection was slashed from 18.1% of the GDP in 2009 to 13.3% in 2018 (Eurostat 2020d). Following this logic of social divestment, public healthcare spending also declined from 5.2% of GDP in 2009, a level already low in international comparison, to 4.7% in 2018, one of the lowest in East-Central Europe. At the same time, public expenditure has maintained a stable share of overall health expenditure (Eurostat 2020b).

These reforms indirectly impact people's health by increasing labour market insecurity, income and wealth inequality. The political sustainability of these potentially unpopular measures in part depends on the government's authoritarian solutions (Scheiring 2020a). These are designed to pre-empt the politicisation of popular dissent with the government's socioeconomic policies. This political closure significantly reduces people's capacity to influence policy-making, including feedback in the field of health. As Amartya Sen argued, political democracy is a crucial requirement for human development. Withdrawing resources from health care and education freezes social mobility in the long run and decreases the chance of building a capacity-enhancing developmental state, which is needed for long-term improvements in the quality of life and people's health.

Health Policies

Health care was prominently featured in Fidesz's 2010 manifesto. The party criticised the neoliberal reform attempts of the socialist-liberal (MSZP-SZDSZ) coalition and reaffirmed their commitment that access to care should not be limited by co-payments (Fidesz 2010). The manifesto's mentions of health care read as if they were written by a social-democratic party rather than a right-wing one. After running through several problems of the health system, including waiting times and geographic inequities, the manifesto espouses the party's commitment to maintaining a 'solidarity-based system' which pools individual risks nationally (Fidesz 2010). Fidesz's salient political opposition to neoliberal reforms before 2010 limited their policy space after 2010. After 2010, Fidesz created a health policy environment that combines statism, public healthcare budget cuts and buttressing by increasing out-of-pocket private health spending – without openly embracing neoliberalisation in the healthcare sector. Events leading up to the 2010 Hungarian elections destabilised the political system and gave Fidesz the upper hand. The socialist-liberal coalition (composed of MSZP – the Hungarian Socialist Party, and SZDSZ – Alliance of Free Democrats) was the first to win two consecutive terms following the 1989 regime change. After winning re-election in 2006, a private speech of the MSZP Prime Minister was leaked where he admitted to lying to the public. Trust in the government plummeted and protests erupted nationwide. Financial difficulties even before the 2008 crisis, as well as in its aftermath, prompted the government to attempt austerity measures which proved to be unpopular. During the same period, the government attempted to pass a package of laws to privatise the Hungarian health system. Controversy over the health reforms ultimately led to fracturing the government coalition and a caretaker government was instated in 2009 (Chevreul et al. 2011). Fidesz capitalised on the unpopular health reforms, among others, initiating a referendum against the introduction of co-payments. The party won the referendum, and the threat of a second referendum was partly responsible for the government withdrawing other parts of the legislative plan (Edelényi 2008).

During its second term (2010–2014), as well as later, Fidesz was successful in implementing a wide range of policies, including health policy (see Table 1). Its supermajority in parliament effectively shut down direct opposition to legislation. More importantly, the party used its supermajority and ensuing ability to alter the constitution in order to remove barriers to passing and enacting policy. The Constitutional Court, previously an important veto point, was systematically weakened and filled with party loyalists. Bureaucrats were also weakened by new regulations lowering their retirement age and allowing the government to dismiss them in case of 'low trust' (Szikra 2014). More specifically to health care, the Ministry of Health was dissolved, and its functions given to the Ministry of National Resources. This move can be seen in the context of trying to remove veto points from policy-making when it comes to health care. The dissolution of the Ministry of Health at once removed the power of bureaucrats within the ministry to resist changes and

Table 1 Hungarian health policies

PRR policy proposal	Implementation	Clientelistic nature	Comments/outcomes	Characterisation
National budget acts	Implemented	No	Significant reduction of public healthcare spending. This resulted in continued underfunding of public healthcare facilities, growing infrastructure problems, shortages of basic equipment like soap or toilet paper and the stagnation of health sector workers' wages	Liberal chauvinism
Act XLII of 2010	Implemented	No	Dissolves Ministry of Health, and creates a State Secretariat for Health within the Ministry of National Resources	Statism
Act LXXXIX of 2010	Implemented	Unclear/further investigation required	Suspends establishing new pharmacies and mergers	Statism
Act CLIV of 2010	Implemented	No direct evidence. However, centralisation implies control over budgets and clientelistic parties are known to prefer this in order to have resources to reward loyalists	Renationalised hospitals in Budapest	Statism
Act CXCV of 2011	Implemented	See comment above (CLIV/2010)	Merged Social Insurance fund into state budget	Statism
Act XXXVIII of 2012	Implemented	See comment above (CLIV/2010)	Renationalised municipal and county level hospitals	Statism
Act CXXXIV of 2012	Implemented	Fidesz was accused of handing out licenses for tobacco shops to party loyalists	Nationalised tobacco sale	Statism and clientelism

(continued)

Table 1 (continued)

PRR policy proposal	Implementation	Clientelistic nature	Comments/outcomes	Characterisation
Act XLI of 2011	Implemented	No	A comprehensive nationwide smoke-free law covering all indoors public spaces	Statism
Act CXXII of 2019	Implemented (in effect since 1 July 2020)	No	Those who do not pay health insurance contribution cannot receive even basic treatment without paying their debt first. This could result in the exclusion of around 100,000 citizens from the healthcare system (Danó 2019)	Liberal chauvinism
Further restrictions in smoking 2019	Only planned	No	Lázár's suggestion would contain points for stricter rules regarding smoking areas, financial penalties if someone smokes where it is forbidden and to close retail outlets that serve cigarettes to those below the age of 18. Lázár told Parliament that in the next 20 years, all traditional cigarette products should be banned in the country in order to help people quit smoking (About Hungary 2019)	Statism
Act CIII of 2011	Entered into force on 1 September 2011	No	Public product fee for unhealthy food and beverage products (chips tax). The fee targets food and beverage products which are considered unhealthy. The subject matter of the act is domestic sale of products with a certain content of sugar, salt and caffeine	Statism

(continued)

Table 1 (continued)

PRR policy proposal	Implementation	Clientelistic nature	Comments/outcomes	Characterisation
Decree No. 71 of 2013 (XI. 20)	18 February 2014	No	The decree set the highest permitted amount of trans-fats in food products, the conditions of inspection and distribution of trans fat containing foodstuffs as well as rules for tracking the population's trans-fat consumption (USDA 2020)	Statism
Decree No. 37/2014. (IV. 30.)	Implemented; slightly modified in 2016 due to public dissatisfaction with the regulations concerning salt and dairy products (Kiss et al. 2019)	No	Public Catering Act. New, stricter rules. The aim of the school meal provision was to reduce the prevalence of obesity and noncommunicable diseases (NCDs) among Hungarian children and adolescents, as well as promote healthier environments, especially in schools	Statism

centralised power more clearly in the hands of the Prime Minister. This was part of a broader effort by the party to (re)centralise health governance in the general framework of statism.

Given the high salience of health care before 2010, the government moved quickly to capitalise on popular disgruntlement with previous reforms. The Fidesz government renationalised hospitals by transferring management to the central government from the local level and also moved the statutory insurance fund under state control. This effectively transformed the system back to its Semashko roots, undoing reforms towards decentralisation and the purchaser-provider split in the 1990s (Mihályi 2012). However, the daily experience of patients was not severely affected by these reforms since access continued to be free at the point of delivery, and contributions remained stable. What did change was control over hospital administration, as well as capital investment into facilities, which had been previously controlled by local governments. These measures are not easily understood when placed on a left-right policy dimension since they did not directly influence distribution of resources and access to services. Rather, they can be placed on an axis of statism and decentralisation. Notably, the Polish PRR party PiS attempted similar reforms towards centralisation (Zabdyr-Jamróz et al., this volume).

Another set of noteworthy policy changes concerns smoking laws. A sweeping ban on smoking in public (including workplaces, clubs, pubs, restaurants) was

passed in 2011 and came into force in the beginning of 2012. The ban significantly improved the birthweight of children of mothers working in hospitality venues affected by the ban (Hajdu & Hajdu, 2018). This was followed in 2012 by the nationalisation of the sale of tobacco products. Entrepreneurs were required to obtain special licenses from the state in order to sell tobacco, and the number of points of distribution was reduced. While the World Health Organization (WHO) praised the measure as an effective means of tobacco control, the implementation of the law was widely seen to have been mired in corruption and clientelism. Fidesz was accused of preferentially giving licenses to party loyalists. The biggest winners of new concessions were connected to national capitalists close to Fidesz, such as the owners of the tobacco manufacturer Continental Tobacco and the retail chain CBA (Scheiring 2018). This policy thus combines statism with clientelism.

Overall access to health care, therefore, seems to be neither positively nor negatively impacted by these initial policies. However, some of the most recent reforms could lead to the exclusion individuals who do not have a job or significant financial resources to pay healthcare contributions. However, the Fidesz government also did little to overcome existing challenges of the Hungarian health system. The system continues to suffer from chronic underfunding: as Hungary's public (4.65% of GDP in 2018) as well as overall health expenditure as share of GDP (6.7% in 2018) are well below the EU average of 9.9% (Eurostat 2020c). Based on the Euro Health Consumer Index, the quality of the Hungarian health system is the third lowest in Europe (after Romania and Albania), sliding seven ranks since 2014 (Euro Health Consumer Index, 2015), primarily as a consequence of the underfunding of the public health system. In other words, Fidesz's refusal to address problems since the beginning of its second mandate constitutes a particularly costly case of policy inaction (McConnell and 't Hart 2019). As a consequence of chronic underfunding, the quality of healthcare infrastructure has declined after 2010, with an increasing number of the wealthy opting for private health care instead. Private out-of-pocket payments accounted for more than one quarter (26.89%) of health spending in Hungary in 2018, which is one of the highest proportions in the EU and nearly twice the EU average (Eurostat 2020c).[1] The high share of private out-of-pocket payments on health represents a major problem for citizens in lower income brackets.

COVID-19 Response

Like most East-Central European countries (Shotter and Jones 2020), Hungary managed to avoid a mass outbreak of COVID-19 during the pandemic's first wave. There were fewer than 3000 registered coronavirus cases and fewer than 2000 active infections at the end of April 2020 (the peak of the first wave in Europe). Per reports

[1] While Eurostat data shows out-of-pocket payments to be stable between 2009 and 2019, OECD data shows an increase of 4% in the same period, from 26% in 2009 to 30% in 2019 (OECD 2020).

from July 2020, half of all deaths from COVID-19 could be traced back to hospital-acquired infection (Index 2020; Kaszás 2020a, b). East-Central Europe is less connected to global movements (tourism, migration, businesses), and, thus, the first cases of COVID-19 appeared later, thereby giving countries in this region more time to prepare. After the first weeks of hesitation and confusion, the government's epidemic responses to the first wave were overall adequate – though there were critical problems with regards to infections in hospitals and care homes. Beginning in May 2020, the economy gradually reopened, and students returned to schools. However, the government did not use the months after the first wave to prepare for the second wave, which hit Hungary severely.

Hungary started to introduce significant restrictions on the 16th of March 2020, with a full shelter-in-place order effective starting on March 27. Shops, bars and restaurants were ordered to close after 3 pm, public gatherings were banned (with the exception of religious gatherings), and remote learning was introduced in schools. Epidemic measures also included other, less conventional, steps such as the admission suspension of migrants from transit zones on the southern border and the expulsion of some foreign students. Centralised military leadership was introduced in hospitals, care homes and companies in the food, health and pharmaceutical sectors that produce basic necessities. Furthermore, testing and the flow of epidemiological information were completely centralised.

Measures targeting the restructuring of hospitals were particularly controversial. On March 11, the government decided to freeze all non-coronavirus-related admissions with the exception of life-saving ones (75% of hospital treatments were postponed in the only hospital that provided detailed data about the effect of this measure) (Diószegi-Horváth 2020). On April 9, the Minister of Human Resources, i.e. the minister responsible for health, ordered publicly funded hospitals to free up 60% of hospital beds by April 19 for the treatment of new coronavirus patients.[2] Hospital directors who refused to fully comply were threatened, and two renowned hospital directors were dismissed.[3]

Freeing up 60% of the beds would only be required if there were 180–230 thousand *actively* infected people in Hungary, which was a hundred times higher than the actual number at the end of April, and exceeded the number of infected people even in Italy, a country with six times Hungary's population. Experts estimate that the reduction of hospital beds might have affected around 15,000 people who were previously being treated in hospitals and were sent home overnight without adequate home care services (Balázs 2020).

At a press conference, the head of the Prime Minister's Office stated that the coronavirus crisis highlighted the need to rethink the financing of health care, adding that the state should not maintain superfluous hospital capacities unjustified by

[2] This was reduced to 50% a few days later, with plans to free up additional beds at a later date.

[3] There was a solidarity demonstration in one the cases where a widely respected director was fired, but it proved unsuccessful.

the number of patients (István 2020).[4] The ministry responsible for health prepared a reform proposal at the beginning of 2020 that also referred to the need to reduce the number of hospital beds (Weborvos 2020). This reform process was temporarily put on hold by the coronavirus. The pandemic represented a unique opportunity to 'free up' further beds that would not be utilised even as the country slowly returns to normal functioning. Based on this statement, it is likely that hospitals will not return to the same number of beds as before. In short, it seems likely that the government will use the crisis to implement another, potentially unpopular, reform that would otherwise be very difficult to push through under normal democratic circumstances.

The response to the second wave of the pandemic (beginning roughly in September 2020) has so far concentrated on epidemiological measures, without any new or significant social or economic policy interventions (aside from those already announced during the first wave). Hungary has emerged as one of the most severely hit countries in Europe based on the number of deaths per population during the second wave of the pandemic. As of November 21, there were 170,298 cases registered in total, with 125,789 active infections and 3,689 deaths. The number of infections and deaths has been rapidly increasing since September 2020.

In late August, Viktor Orbán announced a renewed travel ban: no foreigners were to enter Hungary and Hungarians returning from abroad were subject to quarantine, though football fans from abroad would be exempt from the ban. After much hesitation and incremental steps, a new lockdown was introduced, though still less strict than in many other severely affected countries. The government imposed a 12 am–5 am curfew on November 4, and on November 10, the government expanded this curfew to 8 pm–5 am. Beyond the curfew the government also introduced restrictions limiting public gatherings and closing schools, restaurants and universities. Universities and schools above eighth grade went back to digital education.

On November 11, parliament passed a law extending the state of emergency, declared due to the pandemic, for 90 days. In addition to the Western pharmaceutical manufacturers (AstraZeneca, Pfizer, Johnson & Johnson), the government also entered into talks with Israeli, Russian and Chinese parties to get access to vaccines that cannot be obtained through EU channels. On November 16, Péter Szijjártó, Minister of Foreign Affairs and Trade, announced that Hungary would be the first European country to receive a sample of Russia's COVID-19 vaccine.

On the economic policy front, the most aggressive responses came from the central bank, the Hungarian National Bank. The central bank increased the amount allocated to the new round of the Funding for Growth Scheme (FGS) and introduced an unlimited collateralised lending facility. It also announced a quantitative easing programme, meaning that it would buy government bonds on the secondary market in order to ease the pressure on the central budget. The budgetary responses have thus far been much more limited and skewed heavily towards helping businesses.

[4] The overwhelming majority of hospitals in Hungary does not have enough resources to cover basic operational costs like buying syringes or masks; hospitals are constantly operating on the verge of insolvency (István 2020).

The government aimed to keep the budget deficit for 2020 below 2.7% – amounting to severe austerity – but was forced to accept a higher deficit later in the year. The European Commission currently predicts the deficit to reach 8.4% in 2020. A large part of the government's measures are financed from the reshuffling of existing budgetary chapters and reserves.

The pandemic has had a disastrous effect on society, with unemployment climbing steeply and large income losses even for many of those still employed. The government's ideological priorities – helping those who can help themselves, aiding the upper-middle class's embourgeoisement, supporting transnational corporations – are reflected in the social and economic policy measures adopted in response to the pandemic. The measures include a debt moratorium for all borrowers until the end of 2020 – later extended during the second wave – a projected increase in the number of public workers and military intake, a one-off bonus for health workers, an extra week of pension to be paid out every February between 2021 and 2024 and a limited wage guarantee scheme modelled along Germany's *Kurzarbeit*, albeit with a more limited scope. This scheme covers part of the wages lost for 3 months under certain restrictive conditions.

On August 25, the government announced that it would not be expanding the wage subsidy scheme. Until the end of August 2020, the government spent HUF 50 billion (approximately € 140 million) on the wage guarantee scheme (assisting 16,574 companies, with further 972 companies receiving R&D wage subsidies), which is one of the lowest amounts amongst all OECD countries (Bucsky 2020). At the end of November, after much hesitation, the government agreed to extend the wage guarantee scheme, but no further details were available at the time of writing. The government still refuses to extend the severely limited 3-month unemployment benefits. No new social policy tools were introduced to ease the burden of those living in poverty. Half of the 323,000 unemployed Hungarians in September 2020 did not receive any help from the government (Varga 2020). According to data from the Hungarian Central Statistical Office, government consumption, driven by the increased spending on economic functions, grew by 5.8% from the first to the second quarter of 2020, while spending on social policy declined by 11.1% (Kasnyik 2020).

The pandemic, especially during the initial phase in the spring of 2020, was used by Fidesz as a means of further consolidating power and undermining democratic norms. Parliament, where the government enjoys a supermajority, passed an act that allowed Orbán to rule by decree (Novak 2020). Public scrutiny has been curtailed by making the spreading of 'misleading information' about the government's pandemic response punishable by up to five years in prison. Dozens of people have been investigated already, and several were taken into custody for criticising the government on social media.

Although this emergency phase ended in June 2020, other measures will have lasting effects on Hungary's democracy. A few days after the introduction of rule by decree, the government cut the funding of political parties by half, under the pretext of reallocating money to the coronavirus response. The 1.2 billion forints (€3.42 million) reallocated is little compared to the budget of the crisis funds, but it

effectively hinders the operation of opposition parties that overwhelmingly rely on state funding as a source of revenue. Bolstered by their oligarchs and the political use of governmental resources, this cut does not affect Fidesz. The central government also reduced the budget of local governments by centralising road tax revenues, with further selective punitive financial measurers targeting communities controlled by the opposition (e.g. Göd, Budapest District IX). The government also refused to engage in any meaningful dialogue with opposition parties and with social stakeholders such as trade unions, although it communicates with business advocacy organisations.

The policy logic behind the government's responses to COVID-19 corresponds to the logic of Orbánomics (Scheiring 2020b): workfare, social divestment, labour flexibilisation and redistribution towards the upper-middle class and the national bourgeoisie. This has meant capitalism for the poor and socialism for the rich. Democracy and political competition must then be restricted to prevent a backlash from the victims of Viktor Orbán's illiberal populism (Scheiring 2020a). The most controversial responses of the Hungarian government prove to be effective but unpopular policies that require solutions to curtail democratic feedback mechanisms. The introduction of 'military leadership' in hospitals helped to quell the dissent of hospital directors against the drastic cuts to hospital beds. The curtailment of media freedom and party competition during the health crisis served to pre-empt the politicisation of diffused anger with the government's unpopular measures.

Fidesz's response to the COVID-19 pandemic sheds further light on its complicated relationship with health. On the one hand, the party restricted access to hospitals in order to save beds for coronavirus patients beyond what experts deemed necessary. The party also used the crisis as a means of further eroding democratic checks and balances and undermining the opposition by cutting funding to political parties. On the other hand, the Hungarian populists did not seem to share the scepticism towards medical experts shown by their American, Brazilian or British counterparts. Hungary is one of the few countries led by the PRR that did not have an uncontrollable COVID outbreak in the first wave. Similar to other Central and Eastern European countries, Hungary took early measures and treated the pandemic seriously. However, again similar to other countries in the region, Hungary is being hit harder by the second wave of the pandemic, after failing to adequately prepare in the summer.

Conclusion

Fidesz's welfare policies have been described as a 'mixture of neo-liberal, statist, and neo-conservative elements' (Szikra 2014, 488). And indeed, when it comes to most welfare policies, it seems that the party followed a strategy of liberal chauvinism: social disinvestment, lowering protections for vulnerable individuals and increasing economic inequality in the population. Given that economic insecurity and the lack of a proper safety net create negative health outcomes (Barnish et al.

2018), there is reason to believe that Fidesz indirectly negatively impacted population health by eroding the welfare state.

However, the party's direct impact on health policy shows a more complicated picture. The party's stance on health care seems to differ from other welfare policies. Fidesz's health policies seem to defy a single ideological orientation. They show elements of statism, as the party has systematically recentralised and renationalised health spending and facilities. These reforms were made explicitly in contrast to privatisation efforts during the previous government and will likely make further direct privatisation efforts more difficult. However, the more recent reform excluding those who are late to pay health contributions from basic services more closely fits the liberal welfare chauvinistic typology, as it aims at reducing the number of people who can access health care and penalise 'undeserving' population groups – a logic similar to Fidesz's 'workfare' social protection reforms. The rise of private out-of-pocket health spending shows a trend of creeping healthcare privatisation without directly embracing neoliberalisation in the healthcare sector. Moves to reduce the number of hospital beds fall into the same category, especially during a pandemic as health policy observers reconceptualised 'excess' hospital beds as a marker of a resilient health system rather than inefficiency (Greer and Lynch 2020) as per neoliberal orthodoxy. Fidesz's anti-smoking policies seem to have benefitted public health but have also been marred by controversy regarding the clientelistic nature of their implementation.

The party's track record on impacting population health is therefore mixed. It does not neatly fit into any current single concept of welfare state change. This sets Fidesz apart from its Western European PRR counterparts who engage more systematically in welfare chauvinism or liberal chauvinism (Falkenbach and Greer 2018; Rinaldi and Bekker 2020). The reasons for this difference remain to be explored. One possibility is that the size of the electorate plays an important role. Smaller West-European PRR parties have a narrow electorate to which the parties need to cater with more extreme policies (Moise 2020). In contrast, the wide electorate that Fidesz relies on is likely to also constrain it when it comes to health policy. Another explanation can be the distinct political circumstances that brought Fidesz its initial supermajority in 2010. Fidesz built its momentum in opposition to the previous socialist-liberal administration which aimed at privatising and further decentralising the health system. Fidesz health policy, therefore, initially focused on reversing previous policy and taking the opposing direction of renationalisation, constraining its policy options later.

Fidesz, therefore, only partly confirms the hypotheses laid out in the introduction to this volume. Hypotheses 2 and 3, according to which PRR parties engage in liberal chauvinism and conservative policy-making, hold true for Hungarian welfare policies more broadly, but less so for health policy. Importantly, Fidesz's conservative policy-making stems from its own ideology rather than from more centre-right coalition partners or competitors, as is the case with smaller Western PRR parties. Hypothesis 5, on clientelism, also shows some support, as Fidesz has used health-related policies to reward party loyalists by favouring them by, for example, giving them licenses to sell tobacco. On the other hand, Fidesz has not shown scepticism

towards science and experts in dealing with the COVID-19 pandemic (Hypothesis 6), nor has it had anti-welfare state attitudes (Hypothesis 4) or increased welfare generosity while restricting access. As one of the few examples where a PRR party goes mainstream and has sole control of the government, Fidesz is illustrative of how PRR parties' incentives and behaviour change once they have broader voter support.

Fidesz will continue to hold a supermajority in the Hungarian Parliament until the next elections in 2022. After 10 years of government control, the party has tilted the political balance in its favour by modifying electoral laws, the constitution, curtailing the free press and undermining opposition parties. The Hungarian centrist opposition continues to be divided and weak. In the 2018 elections, it was in fact the far-right party Jobbik that emerged as the second strongest party. Fidesz continues to hold the strongest position in Hungarian politics, moving forward. The party will, therefore, continue to be the main shaper of health policy and population health in the short-term, and possibly the long-term future.

Summary Box

1. Fidesz has been running a one-party government for 10 years, using its Parliamentary strength to undermine democracy in Hungary and consolidate its power.
2. The party has had a negative indirect impact on population health by undermining the welfare state.
3. In health policy the government has recentralised financing and facilities and opposed privatisation.
4. Fidesz stands in contrast to smaller West-European PRR parties when it comes to health reforms, by making less use of welfare chauvinistic reforms and embracing seamless privatisation as opposed to direct neoliberalisation of health care.

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Is the Polish 'Law and Justice' (PiS) a Typical Populist Radical Right Party? A Health Policy Perspective

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Introduction

This chapter examines the evolution of health policy in Poland during the governments led by the *Prawo i Sprawiedliwość* (Law and Justice – PiS) party since 2015. Unlike some of the smaller populist radical right (PRR) parties in coalition governments led by senior partners (e.g. in Austria), PiS has had a wide-ranging and detailed health policy programme, significant parts of which it managed to implement. We find that health policy under PiS does not necessarily confirm any of the established hypotheses on populist health policy. Instead, it should be seen as a socially conservative welfare state expansionist approach (Andersen and Bjørklund 1990; Keskinen et al. 2016; Koster et al. 2012; Waal et al. 2013).

The PiS governments since 2015 (spanning two parliamentary terms) have increased the generosity of health care for the vast majority of the population (in contrast to the liberal welfare chauvinist hypothesis) while publicly emphasising a small number of high-profile exclusions within reproductive health. Contrary to the welfare chauvinist and welfare populist hypotheses, however, these exclusions were, at least formally, less concerned with excluding populations such as

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immigrants or the unemployed. In fact, coverage by universal health insurance for the general population (including the unemployed) has been made easier during PiS's reign (Sowada et al. 2019). Poland hosts a large number of immigrants, mostly workers and students, from Ukraine, but exclusion of non-EU/EEA migrants from access to health care was never an issue during election campaigns or in the party manifesto (Zabdyr-Jamróz et al. 2020). Instead, the exclusions focused on categories of services that were defunded for religious reasons, such as in vitro fertilisation[1] (although territorial self-governments can still fund such treatments for their residents) and abortion (PAP/Rynek Zdrowia 2016). Due to constant pressures from PiS's conservative factions and conservative social movements and the appointments of judges by the latest Parliamentary majority, greater restrictions of access to abortion have been imposed by the mostly PiS-appointed Constitutional Tribunal on 22 October 2020 (TK 2020).

The government's pandemic response does not change our evaluation of PiS's health policy as expansionist, although it has exposed potential mismanagement due to poor governance and reaffirmed PiS's anti-elitist discursive strategies (medical populism). Generally, however, exclusions of services have been based on cultural or religious, rather than simply ethno-nationalist, grounds.

While PiS's focus on welfare state expansion in health care makes it different from many Western European PRR parties, clear elements of cultural chauvinism are still present across its other policies. In particular, although the PiS government welcomed Ukrainian migrants, it famously specifically rejected Muslim migrants and refugees from the Middle East. Most notably in 2016, the Polish government (together with other Visegrád Group countries) opposed the EU's refugee relocation system. In 2015, 160 migrants from Syria were let into the country, but these were only Christians invited by the 'Estera' foundation (Tutak 2018). This approach has been somewhat explained by the future president Andrzej Duda in 2015 in one of the presidential campaign debates, when he noted that Christian refugees will be 'culturally closer to us' (TVP 2015). The 'Other' undeserving populations in PiS's discourse are either absent or externalised and do not appear as salient categories in health policy (though women seeking reproductive care could be implicitly categorised as such, due to their non-conformity with conservative Christian values). By excluding what it perceived to be culturally alien groups through migration policy, PiS did not need to articulate welfare chauvinistic policies in health care, making it look almost social-democratic in comparison to the chauvinism of Western European PRR parties in countries with more permissive immigration policies.

This chapter begins with an overview of how PiS fits into the broader family of PRR parties and where its ideology converges and diverges from PRR. The chapter then catalogues the most important changes affecting health care – directly through health policy changes, and more indirectly through changes to the wider welfare state. The discussion then places the various policies within the wider Polish

[1] While, akin to other conservative parties, PiS is pro-natalist and otherwise supports pro-natalist policies, they do not support IVF on religious grounds due to their strong alliance with the church.

political context and considers how they differ from policies adopted by other PRR parties. The final section draws conclusions from these considerations.

PiS and PRR Ideology

The current Polish governing party *Prawo i Sprawiedliwość* (Law and Justice – PiS) has been described as a 'textbook example' of a populist radical right (PRR) party (Grzymala-Busse 2018). In 2008 (following its short-lived government in coalition with a smaller, now defunct radical right party, *Liga Polskich Rodzin* in 2006–2007), PiS was described as stressing 'the need to nourish a national community, based on shared values and traditions, with the principles of social solidarity as the basis for public policy', using 'expressions of economic nationalism, often with a euro-skeptic bent' and campaigning 'against the political and business elites' (Jasiewicz 2008). Twelve years later, PiS was re-elected to government first in 2015, when the party won a majority in parliament, and later again in October 2019 (though it lost majority in the Senate). Throughout this time, PiS has consistently checked all three boxes identified by Mudde (2013) to qualify as a PRR party. First, PiS prominently demonstrated its nativist preference for authentically Polish population by refusing to accept resettlement of refugees in 2015–2016 (Krzyżanowski 2018). Second, the party showed its authoritarian tendencies by imposing heavy control on public media, as well as on the justice system, soon after the 2015 elections (Kelemen and Orenstein 2016). Finally, it has been employing the populist logic in waging a 'culture war' against what it portrays as elites (national and international, ex-communist and liberal), including on issues such as the 'gender/LGBT ideology' (Kozłowska and Zabdyr-Jamróz 2020).

After the 2015 election, PiS became the first party to win majority in Poland's parliament since 1991, allowing it to rule without a coalition. The party rode a wave of dissatisfaction with the previous Civic Platform (*Platforma Obywatelska* – PO) administration, notably its austerity policies, neglect of peripheral regions and lack of policies addressing the precarious situation of low-wage workers. While Poland experienced the 2008 financial crisis without suffering a decrease in most significant economic indicators, the inequity of later development led to growing dissatisfaction. PO policies at the time were described as 'pendolinisation' – in reference to the government's railroad development programmes. The term refers to high-speed trains, called Pendolino, purchased in widely publicised contract to connect major cities considered as economy hubs. At the same time peripheral public transport connections were neglected or even entirely eliminated – decreasing social mobility opportunities for people living in smaller towns and villages. 'Pendolinisation' was thus defined as an 'island [selective] modernisation at the cost of the entirety of the system' (Templewicz 2015), becoming a metonymic description of Polish neoliberal developmental policies in general. This was combined with the persistent downplaying of anxieties of young adults entering labour market. During the presidential campaign of 2015, a young man asked Bronisław Komorowski (PO-associated

president at the time) about 'how to live' when one cannot find job with wages sufficient to take a mortgage to buy an apartment. The president's reply – 'change a job, take a loan' – was widely condemned as lacking in empathy and completely detached from reality (SE 2015; WP 2015).

PiS also entered the 2015 election opposing previous attempts by the PO to commercialise and decentralize the Polish health system. It obtained slightly more than 37% of the popular vote and ended up controlling 235 out of the 460 seats in the lower house, and 61 out of the 100 seats in the Senate. The party also won the presidency that year for a 5-year term and therefore had a free hand to dramatically change public policy, with minimal possibility for the opposition to block reforms. The party further strengthened its position with several measures meant to weaken checks and balances in the Polish political system, including attacks on the high court and civil servants (Fomina and Kucharczyk 2016).

The party's dominance over Polish politics continued after its first term. Following the 2019 parliamentary elections, PiS holds a majority in the lower house of parliament, necessary to form the government. The party is in a minority in the Senate. The Senate mainly serves as a veto point, since legislation needs to pass both houses. However, the lower house can override a Senate veto with an absolute majority. In July 2020, PiS also secured another presidency term, thus avoiding another possible veto point. The PiS parliamentary group, technically speaking, includes two other parties in addition to PiS (*Porozumienie Jarosława Gowina* and *Solidarna Polska*), which are essentially satellite parties of PiS with minimal own party structures (for instance, even their websites are out-of-date). They do not have their own political programmes when it comes to health policy and do not have manifestos separate from PiS. For these reasons, in this chapter, we refer to this coalition simply as PiS.

Shortly before the Polish parliamentary elections in October 2019, PiS published its political manifesto entitled *The Polish Model of the Welfare State* (*Polski Model Państwa Dobrobytu*) (PiS 2019), which clearly summarised the party's thinking on social policy, including health care. In it, the party declared its ideological foundations as 'respect for the dignity of every person' with a duty to guarantee it via 'proper existential conditions' relying on the state and listed three 'basic principles of the good society': 'protection of life, guarantee of freedom and solidarity'. The manifesto considers the entirety of the welfare system and is a unifying staple for policies that had been put in place since 2015, including the so-called Kaczyński's Five – a catalogue of flagship policies for the election campaign, announced in February 2019 (Kozłowska 2019):

- Expansion of the so-called 500+ programme, i.e. child benefits of 500 PLN (~118 EUR) also for the first child
- 'The thirteenth' – additional retiree pension bonus in 2020 (1100 PLN before tax, ~250 PLN), and two more in 2021
- Reduction of personal income tax for people under 26
- Decrease of personal income tax rate from 18% to 17% and raising the ceiling on deductible expenses
- Restoration of public transport networks for peripheral (rural) areas

The 2019 manifesto contains a clear declaration of a 'change of the economic model':

> We are convinced that escaping the middle-income trap and breaking away from the 'dependent market economy' is possible only through an active economic policy of the state. We do not believe that 'the capital has no nationality'. We reject principles of neoliberalism (PiS 2019, p. 17).

This is associated with international departure from neoliberal policies, as well as competition with the economic left party *Lewica* (*the Left*), or SLD (Democratic Left Alliance), who returned to the Parliament's lower house after one-term absence with new, even more economically left-oriented members (Kozłowska 2019), leading to the so-called positive radical flank effect (Haines 1984). With the unambiguously popular success of the PiS's social policies (CBOS 2017) (including the initially controversial benefits for children called the *500+ Programme*), this marks a clear displacement of mainstream Polish political discourse to the economic left ('shifting the Overton window').

In this declaration, PiS not only confirmed its political line since 2015 but doubled down on it. It replaced slogans of 'solidarity' and non-profit approach to health (that could have been aligned with the emphasis on subsidiarity and decentralisation of many socially conservative, Christian-democratic doctrines) with clearly centralist, statist (*etatystyczne*), neo-Weberian and (quasi)social-democratic approach (i.e. with greater emphasis on direct governing within a deconcentrated centralised system). In parallel, it retained elements of the traditional third sector partnership model (e.g. support for NGOs providing health promotion counselling) (Archambault et al. 2013). The left-wing economic approach is marked, among others, by a clear strive towards expansion of access to health – in terms of population insurance coverage and guaranteed services. In the case of migrants, a typical population excluded by many PRR parties, access to health care is not a partisan issue and remains linked to standard international regulations (Ministry of Health 2020).

When it comes to PiS's brand of nationalism, interestingly, the manifesto elaborates that the 'nation' is defined as 'a community of culture, language, historical experience, political tradition and civilization values, as a community of fate'. The document explicitly states that 'Although nations have their ethnic core, they are primarily a political and cultural community. The Polish nation was shaped and matured by uniting ethnically diverse people into a community'. It also states that the Polish nation 'is connected in a special way with Christianity' (PiS 2019, p. 12). This explains why the PiS government prominently resisted the relocation of Muslim (mostly Syrian) refugees from other European Union member states to Poland while at the same time publicly declaring their willingness to accept Christian refugees from the Middle East (Bartyzel 2017; Santora 2019). In parallel, the facilitated migration of Ukrainian workers and their right to health care (and other social benefits) were never questioned. This is particularly notable in light of observed discrimination and existing anti-Ukrainian sentiments within Polish society (Tyma et al. 2019). So far – aside from certain policies concerning historical remembrance – the governing party has not taken advantage of those sentiments in their electoral rhetoric nor in actual social or health policies. PiS's resistance to migrants should,

therefore, be understood in cultural, as opposed to, ethnic terms. The party does not espouse a narrative against migrants abusing the welfare system, rather as a potential danger to the traditional Polish culture (as well as to the national historic narrative) – thereby pursuing a cultural rather than a welfare chauvinistic approach.

In the following section, we analyse PiS's health reforms since 2015 and, where possible, assess to what extent the concrete policy proposals and their implementation reflected this discursive shift. However, given the recent nature of many of the proposals, combined with a lack of up-to-date publicly available data and policy evaluations as well as complications due to the COVID-19 pandemic, estimating the degree of implementation of PiS's proposals, let alone their outcomes, is difficult. For this reason, not all proposals are systematically assessed as to their implementation and outcomes in the following text.

Health Policy Reforms Under PiS Since 2015

Aside from common European health challenges (including ageing society and burden of disease), the Polish health system faces a variety of problems, including very low health expenses (4.6% of GDP in consecutive years until 2017) and growing shortages of medical professionals, especially nurses (5.1 per 1000 inhabitants, the lowest level in EU) (OECD/EOHSP 2019). Among specifically Polish problems is the issue of pharmaceutical shortages due to illegal or parallel trade drugs exports (by a so-called pharmaceutical mafia, consisting of wholesalers and pharmacies operating in legal grey areas) resulting from lower drug prices in Poland when compared to neighbouring countries (NIK 2019). In response, the 2019 manifesto declares the introduction of a Pharmaceutical Supervision Office (*Urząd Nadzoru Farmaceutycznego*) and a so-called intervention purchase to prevent shortages.

In 2015, when PiS took power from the liberal coalition of PO (Civic Platform Party) and PSL (Polish People's Party), its early health policies prioritised reversing several pro-market reforms, such as the commercialisation of public healthcare providers (Kowalska-Bobko and Mokrzycka 2016) (see Table 1). PiS's reforms stem from a variety of factors and incentives – from the original socioeconomic doctrine of PiS ('solidarity versus liberalism') but also from political pressures exerted by medical professionals engaging in strike actions such as those initiated by nurses (Zabdyr-Jamróz 2019) and medical residents (Bogucka-Czapska 2019). In both cases, the larger premises of reforms are poor working conditions and chronic deficit of healthcare professionals (Malinowska-Lipień and Kowalska-Bobko 2018). The protest of residents (trainee doctors) was also initiated to force the government to increase health spending as a percentage of GDP (MZ-PROZZL 2018). In response, the government increased residents' salaries of resident (trainee) doctors in September 2018 (Badora-Musiał and Kowalska-Bobko 2018), and the 2019 manifesto declared a continuation of the increase of country-wide limits on medical studies programmes from 6.8 thousand students in the academic year 2014/2015 up to 9.5 thousand in 2019/2020 (PiS 2019, p. 70).

Table 1 Governmental policies present in and absent from Polish Model of Welfare State

Health policy/reform	Implementation	Comments/outcomes		
		Idea:	'PMWS' manifesto Sep 2019	Legislation and outcomes
National Health Service (as replacement for the National Health Fund) planned for Jan 2018	Abandoned	Dec 2015	National Health Service (as replacement for the National Health Fund) planned for Jan 2018	Abandoned
Increase of expenses for health care to 6% of GDP by 2024 (via greater state subsidy)	In progress	Dec 2017 Agreement with striking residents	Increase of expenses for health care to 6% of GDP by 2024 (via greater state subsidy)	In progress
Increase of country-wide limits on medical studies programmes	June 2018 Special scholarship scheme for nursing students and graduates	2016	Increase of country-wide limits on medical studies programmes	June 2018 Special scholarship scheme for nursing students and graduates
Rebuilding of medical staff	In progress	Jun 2016 Agreement after nurses strike of 2016	Rebuilding of medical staff	In progress
'Pharmaceuticals 75+' – free pharmaceuticals for the elderly above 75 y/o	Sep 2017	Dec 2015	'Pharmaceuticals 75+' – free pharmaceuticals for the elderly above 75 y/o	Sep 2017
'Care 75+' – access improvement for care for the elderly	Jan 2018	2017	'Care 75+' – access improvement for care for the elderly	Jan 2018
'500 plus for the disabled' – monthly benefit of 500 PLN (110 EUR) for adults with disabilities	Oct 2019	Mar 2019	'500 plus for the disabled' – Monthly benefit of 500 PLN (110 EUR) for adults with disabilities	Oct 2019
KOS programme – cardiology care and rehabilitation	Oct 2017	2017	KOS programme – cardiology care and rehabilitation	Oct 2017
Oncological patient service centres	In progress	Manifesto pre-2015	Oncological patient service centres	In progress

(continued)

Table 1 (continued)

Health policy/reform	Implementation	Comments/outcomes		
		Idea:	'PMWS' manifesto Sep 2019	Legislation and outcomes
National Oncological Network	Since Oct 2017 Dec 2018−May 2020 Pilot programme	Manifesto pre-2015	National Oncological Network	Since Oct 2017 Dec 2018−May 2020 Pilot programme
National Oncological Institute	Oct 2019 Council of Ministers executive regulation: Maria Skłodowska-Curie Institute of Oncology in Warsaw renamed into National Oncological Institute		National Oncological Institute	Oct 2019 Council of Ministers executive regulation: Maria Skłodowska-Curie Institute of Oncology in Warsaw renamed into National Oncological Institute
National Oncological Strategy	Nov−Dec 2019 Strategy consultation	Jan 2019 Bill signed by the President	National Oncological Strategy	Nov-Dec 2019 Strategy consultation
e-health – e-sick leave and e-prescription	Oct 2018 Pilot programme	2018	e-health – e-sick leave and e-prescription	Oct 2018 Pilot programme
Expansion of the digital platform for patients	Online patient account, integrated patient guide	2018	Expansion of the digital platform for patients	Online patient account, integrated patient guide
Medical Research Agency	Mar 2019 Established	Sep 2018 Bill consult-ations	Medical Research Agency	Mar 2019 Established
Introduction of special phone line			Introduction of special phone line	
'Clean air till the year 2020' and 'clean air' programmes	Since Sep 2018	2017	'Clean air till the year 2020' and 'clean air' programmes	Since Sep 2018
Orientation of agricultural and food industry on environmental friendliness and population health			Orientation of agricultural and food industry on environmental friendliness and population health	

(continued)

Table 1 (continued)

Health policy/reform	Implementation	Comments/outcomes		
		Idea:	'PMWS' manifesto Sep 2019	Legislation and outcomes
Value-based health care			Value-based health care	
Increased role of the primary health care (PHC) developed within the model of coordinated health care		Manifesto pre-2015	Increased role of the primary health care (PHC) developed within the model of coordinated health care	
Greater emphasis on prevention and health promotion (within PHC)		Manifesto pre-2015	Greater emphasis on prevention and health promotion (within PHC)	
Improvement and expansion of outpatient specialist care		Manifesto pre-2015	Improvement and expansion of outpatient specialist care	
Elderly day care and home care			Elderly day care and home care	
Expansion of the rehabilitation system			Expansion of the rehabilitation system	
Improvement of waiting times at all medical rescue wards			Improvement of waiting times at all medical rescue wards	
Pain treatment teams in paediatric hospitals			Pain treatment teams in paediatric hospitals	
Free pharmaceuticals for pregnant women and hospital incentives for availability of birth anaesthesia			Free pharmaceuticals for pregnant women and hospital incentives for availability of birth anaesthesia	
Combating the 'drug mafia'		Various measures since 2014	Combating the 'drug mafia'	
Pharmaceutical supervision office			Pharmaceutical supervision office	
Development of Polish factory of blood products			Development of Polish factory of blood products	

(continued)

Table 1 (continued)

Health policy/reform	Implementation	Comments/outcomes		
		Idea:	'PMWS' manifesto Sep 2019	Legislation and outcomes
Reform of psychiatric care			Reform of psychiatric care	
Programmes for the support of 'citizen counselling'			Programmes for the support of 'citizen counselling'	
Expansion of early life health education			Expansion of early life health education	
Ensuring full healthcare insurance coverage		Pre-2015	Ensuring full healthcare insurance coverage	
Ensuring full healthcare insurance coverage for persons outside the system (proposed Polish Artist Guild)			Ensuring full healthcare insurance coverage for persons outside the system (proposed Polish Artist Guild)	

(Sources: HSPM Poland n.d.; PiS 2019)

A key reform proposed by the PiS government in 2016 concerned healthcare system organisation. The single-payer social health insurance system, with the National Health Fund as a semi-independent agency, was to be abolished and replaced with government-led, tax-financed National Health Service, ensuring universal access to statutory benefits to all residents, decoupling coverage from employment (Zabdyr-Jamróz and Kowalska-Bobko 2017). In parallel, some powers of the regional, or *voivodship* payer structures, would be transferred to the Ministry of Health, which would also administer a new 'Targeted State Health Fund'. These proposals, however, were 'abandoned upon the realization of their potentially destabilizing effects and high administrative costs' (Sowada et al. 2019, p. 172) and are absent from the 2019 manifesto.

Importantly, the abandonment of the National Health Service plans did not affect another key promise of the government from 2016: the increase of expenses for health care. Public funding for health was to gradually increase to 6% of GDP (to 160 billion PLN or 36,5 billion EUR) by 2024, which corresponds to an increase of about 0.2% of GDP annually (Sowada et al. 2019, p. 173). The finances are to come from personal income tax revenues and a state subsidy (Sowada et al. 2019, p. 172). The commitment to the increase was further reaffirmed in the 2019 manifesto. The effects of this commitment so far are disputed (NIK 2020), and while the COVID-19 pandemic made evaluation even more problematic, the declarations should not be taken at face value.

In 2018, the Minister of Health organised a 'national debate on health' entitled 'Together for Health' – aimed at developing a consensual strategy for health system reform. A series of conferences with the participation of experts and key

stakeholders were organised, and a summary report was edited by Polish health systems' scholars in August 2019 (Ministry of Health 2019) – just before the September publication of the Polish Model of Welfare State manifesto. It is unclear to what extent this particular series of debates directly impacted the health aspects of the 2019 manifesto. Nevertheless, some of its provisions are clearly present within both documents. For instance, the English term 'value-based health care' introduced in the conferences' report (Ministry of Health 2019, p. 12) is also introduced in the manifesto (PiS 2019, p. 69).

The PiS's commitment to expanding health insurance coverage is reiterated in the 2019 manifesto, which promises full healthcare insurance coverage for persons outside the system, including those unable to pay for healthcare contributions and artists. An element of the plans to achieve this goal is the proposed Polish Artist Guild (PiS 2019, p. 199).

The government also announced the intention to reform primary care (an evergreen in health reform). Specifically, it proposed in 2016 to introduce primary care teams, composed of doctors, nurses, school nurses and midwives (optionally also physical therapists) covering a single patient list. The team should provide primary care services, including health promotion and prophylaxis, in cooperation with hospitals, ambulatory specialist care, schools and kindergartens, and would have the authority to coordinate care for their patients. Notably, the primary care team should have a new budget model consisting of a capitation fee and budgets for diagnostic care and specialist ambulatory care (Sowada et al. 2019, p. 173). Pilots of three alternative models of primary and coordinated care started in March 2018, financed from EU funds and developed with the help of the World Bank (Sowada et al. 2019, p. 178). The 2019 manifesto continues the emphasis on an increased role of the primary health care developed within the model of coordinated care and with emphasis on health promotion (PiS 2019, p. 70), though Poland reports shortages of family medicine practitioners (Sowada et al. 2019, p. 178). Although coordinated care models and the strengthening of primary care are often associated with cost containment (McWilliams 2016), this does not seem to be the immediate goal of the Polish government, especially in priority disease areas such as oncology and cardiology. In 2015, the PO government abolished financing limits on cancer treatment financing and introduced an 'Oncology Pathway' – a best practice guidance aimed at increasing quality of cancer care and shortening waiting times for cancer patients (which has led to an increase in waiting times for other patients) (Sowada et al. 2019, p. 190). In the same way, the 2019 manifesto includes a promise of expansion of outpatient specialist care (PiS 2019, p. 71) by unlimited financing to services such as computer tomography, magnetic resonance imaging and cataract treatment.

Just like other governments before it, PiS has since 2015 declared the adoption of 'e-health' solutions, especially electronic health records, a priority, though adoption has historically been slow (Sowada et al. 2019). The government has been piloting e-prescriptions and e-referrals since 2018, aiming at full national implementation by 2020 and 2021, respectively (Sowada et al. 2019, p. 111). The 2019 manifesto stresses the need for a continued digitalisation of health care as follow-up to e-sick leave and e-prescription (PiS 2019, p. 77). Implementation of these measures in late

2019 and early months of 2020 preceded the COVID-19 pandemic, to the benefit of the healthcare system during lockdown.

In addition to these developments, several discrete new policy initiatives were announced in the 2019 manifesto, including:

- New measures of health system performance (including medical errors) within the notion of 'value-based health care'
- Efforts at reducing waiting times, such as a special information hotline, inclusion of telemedicine (advice and consultations) into guaranteed benefits baskets on equal basis with stationary services (PiS 2019, p. 71) and improvement of triage system and decrease of waiting times at all medical rescue wards (pp. 72–73). These initiatives are to be supported by the expansion of the digital platform for patients (*portal pacjenta*) – following the UK experiences – and the introduction of e-registration for visits and digital transfer of patients test results (pp. 77–78)
- Expansion of day care and home care; expansion of the system of medical, social and professional rehabilitation; introduction of pain treatment teams in paediatric hospitals
- Free pharmaceuticals for pregnant women and hospital incentives for availability of birth anaesthesia
- A shift from an institutional setting model of psychiatry to comprehensive ambulatory, environmental and home care
- Greater emphasis on prevention

Interestingly, reproductive health was not a major concern for the leadership of the governing party. While ministerial IVF reimbursement programmes were discontinued in 2016, territorial self-governments are allowed to conduct their own programmes (and indeed some of them do) and no real efforts from the government are being made to ban this practice. This decentralisation makes access to IVF highly territorially unequal (RPO 2019). Likewise, despite repeated attempts by other political parties, more conservative PiS backbenchers as well as conservative-religious organisations and lobbying groups (e.g. Ordo Iuris, *Pro-Prawo do Życia* Foundation, etc.), the leadership of PiS parliamentary majority initially appeared to be reluctant to introduce greater restrictions in the (already strict) abortions laws. For instance, one of the citizens' legislative initiative to ban 'eugenic abortions' was already rejected by parliament in 2016 in light of the mass protests known as 'General Women's Strike' (WP 2016). Other anti-abortion initiatives in parliament were processed slowly and were kept in legislative limbo for years.

This changed suddenly when on 22 October 2020 the Constitutional Tribunal ruled that abortion in the case of a severe and irreversible handicap of the foetus or its life-threatening incurable disease would be considered unconstitutional in Poland (TK 2020). Despite the COVID-19 pandemic, the ruling immediately sparked massive protests under the umbrella of a 'General Women's Strike' and was met with an aggressive police response (Gera 2020). The decision was the result of a request – by a group of parliamentarians (including some members of PiS) from late 2019 – for the Tribunal to review the constitutionality of the pre-existing 1993 law on family planning, protection of the human foetus and conditions for permissibility of

pregnancy termination. The decision (announced amidst the second COVID-19 wave) was widely considered as very poorly timed and was a surprise to commentators and politicians alike. Similar previous requests were ignored by the Tribunal, despite the fact that PiS-appointed judges had a majority in the Tribunal (PAP 2020). The Tribunal ruling still requires legislation to specify the permissibility of abortion; however, the urgency of the pandemic situation led to the postponement of the issue. As of November 2020, the government has not yet promulgated the ruling as procedurally required (in the *Journal of Laws of the Republic of Poland*), thus effectively postponing its implementation into the Polish legal system (Walker 2020).

Government's Response to COVID-19

The first measures to combat the spread of COVID-19 were introduced on 11 March 2020. On March 12 the 'state of epidemic threat' was declared by the Health Minister, legally enabling him to mobilise medical personnel and to issue further restrictions a day later. The state of epidemic was declared on March 20 with full lockdown measures implemented on April 1. None of these measures were characteristic of PRR parties. Border closures (March 15) were universal and not exemplifying any particular type of chauvinism. In terms of economic policy, a series of stimulus bills titled 'Anti-crisis shield' were introduced in March (Zabdyr-Jamróz and Kowalska-Bobko 2020; Iwona Kowalska-Bobko et al. 2020; Golinowska and Zabdyr-Jamróz 2020).

Poland suffered from serious shortages of resources in combating the disease – above all medical personnel. Testing capacity was a constant issue. Similar to Hungary, the Polish PRR government did not express anti-scientific stances and generally followed experts' recommendation. Łukasz Szumowski, the Minister of Health, himself even co-authored a scientific paper describing conclusions from initial COVID-19 cases in Poland (Raciborski et al. 2020). The government financially supported research dedicated to developing a locally produced COVID-19 test as well as research designed to increase ventilator capacity.

Polish leadership, however – especially during the second wave (September 2020) – was characterised by serious deficits in governance, most notably transparency, coordination and responsiveness. Government-sponsored research and development – while very successful – was not taken advantage of in a satisfactory manner with regards to the governments purchasing of tests and other home-made equipment (Klinger et al. 2020). Due to the pandemic, the presidential elections (won by the incumbent, PiS-associated Andrzej Duda) were eventually postponed; however, the government initially pushed for them to be held on May 10 (Zabdyr-Jamróz and Kowalska-Bobko 2020). This led to the waste of financial resources devoted to mail-in ballots. For the duration of the elections, held on June 28 and July 12 (the second turn), governmental politicians downplayed the pandemic threat, as PiS expected to benefit from high turnout. In July, the Prime Minister even declared

that the virus was 'in retreat' and that the populous would do well to fear it less (Morawiecki 2020).

At the start of the second wave (September 2020), the country was facing serious medical personnel shortages wherein one of the vice-PMs blamed physicians for not being 'sufficiently devoted' to helping coronavirus patients (Dziennik 2020). This showed certain discursive tendencies within PiS for 'medical populism', i.e. pitting people against the medical establishment (Lasco 2020). Overall, though, this tendency has not been very prevalent so far.

The PiS-led handling of the pandemic also lacked quality monitoring and evaluation and thus – as a result – led to a lack of evidence-based policymaking. All tiers of the deconcentrated State Sanitary Inspection (public health offices) have been underfunded and have faced significant challenges in collecting data. Large discrepancies in the numbers of COVID-19 cases were reported between county-level sanitary stations in the region and the regional stations' data. This resulted in the government informing the public of only data collected by the central level (Jędrysiak 2020).

When it comes to transparency, the media reported serious irregularities regarding the Ministry of Health's hasty purchasing of ventilators and personal protective equipment (PPE). Amidst personal allegations, the Minister of Health resigned by the end of August (wMeritum 2020) and the Director of the Supreme Audit Office scheduled an investigation of these issues – starting in November (Pieniążek-Osińska 2020).

The governance issues in Poland can be best explained through the problems with the urgent pandemic legislation. In October and November 2020, there was an urgent need for new regulations and funding for medical personnel. These were supposed to be ensured in the so-called Covid Act, enacted by parliament on the 28th of October 2020 and signed into law by the President on November 3. However, during the legislative process, the Senate added certain provisions that would expand the eligibility of medical personnel for epidemic wage increase (not only for those in contact with COVID-19 patients but also for those at risk of having contact with such patients, thus effectively for all). This had the potential of leading to unanticipated and exorbitant costs, which were overlooked by all legislative institutions and had not been vetoed or overruled. When this issue was finally noticed, the government simply decided not to promulgate the law in order to prevent it from entering into force (Mikulski 2020). This is a highly unconventional veto point in the legislative process, not foreseen in the Constitution. On November 28 the Covid Act was finally promulgated and on November 29 it entered into force.

Discussion

PiS came to power in 2015 on a general 'solidarity' platform – as opposed to the economically liberal policies of the previous government. PiS started increasing health funding, attempted to decrease waiting times and increase the number of

trained health professionals. It continued the process of expanding health coverage within the public health insurance scheme. While the outcomes of these reforms are contested and their full results remain to be seen (especially in the context of COVID-19 pandemic that complicated many policies), the proposed and ongoing reforms themselves stand in stark contrast to PRR proposals in other countries.

Despite its prominent place among the growing club of European populists, when it comes to health (and other social policies), PiS is different from many populist radical right parties in Western Europe. It has had a broad and comprehensive health policy agenda, and many of the reforms it initiated in its 2015–2019 term are currently in implementation. Unlike some PRR practitioners, for instance, Donald Trump, PiS does not use its pro-social agenda as an instrumental tool only to be forgotten after the elections. Given its size and its capacity to conceptualise and implement reforms, PiS is more similar to a traditional catch-all party than a fringe PRR party that needs a senior partner to enter into government (similar to, for instance, Austria). In health policy, the government has proposed and begun implementing numerous reforms that are not primarily driven by ideology and are arguably adequate responses (not prone to partisan critique) responses to urgent problems of Polish health care, such as increasing funding for health care, retaining and training new health professionals and decreasing waiting times. It also initiated or continued several non-partisan technological access improvements such as e-health expansion.

PiS does not conform to contemporary Western European left-right cleavages: PiS is highly sceptical of neoliberal globalist policies, in line with the perspective of the economic left. PiS has a strong social-democratic economic programme and in their manifesto stands clearly against austerity, privatisation or commercialisation of public services. At one point, the leader of PiS, Jarosław Kaczyński, has even (on record) praised and recommended the book *Capital in the Twenty-First Century* by Thomas Piketty – a bestselling economic analysis arguing for social-democratic reforms in light of growing economic inequalities (Archiwum 2015). The party started and later abandoned a proposal to replace National Heath Fund with a National Health Service. The details of the reversal are unclear – most probably this flagship reform was not followed through for any doctrinal reasons or doctrine, but rather due to technical and legal difficulties of such a significant reform in a highly complex system.

The earlier slogan of the party was 'solidarity' against 'heartless liberalism' of the Civic Platform (PO) government. In health care, PiS has focused on an overall expansion of benefits and access for all categories of beneficiaries (including welfare recipients, and migrant workers). The only reduction of access to health care concerned issues of reproductive health due to cultural conservatism (defunding of IVF). However, it appears that initiatives concerning further restrictions of access to abortions did not originate in the leadership of the party. It remains a matter of speculation whether the recent embryopathological abortion ban by the Constitutional Tribunal was a result of an explicit signal from PiS leadership (e.g. to avoid direct political responsibility). While the decision was clearly made by PiS-appointed judges, the Polish Constitutional Tribunal has a long history of systematically

restricting reproductive rights in Poland (e.g. in 2015 it expanded the conscience clause for physicians willing to refuse legal abortion for religious reasons).

PiS is vocal in its social conservativism, which emphasises traditional values such as family and religion – specifically Catholicism. Although PiS was strongly against accepting Muslim refugees from the Middle East, the party has not taken any negative stance, even rhetorical, towards the significant numbers of incoming migrants from Ukraine (unofficially estimated at 1.5 million) of incoming migrants from Ukraine (PNP24 2019), including circa half a million registered workers with health insurance (Kalwasiński 2019). Access to health care and other social benefits for migrant workers has not been an issue in PiS discursive strategies. This makes PiS different from other PRR parties that clearly delineate access to benefits between who they consider members of an ethnic nation and outsiders. However, the nuances are important here. PiS seems to include Christian Ukrainian migrants in its construction of 'us', while excluding and othering Muslim migrants, for reasons similar to other PRR parties. The absence of welfare chauvinism in PiS healthcare policy may therefore be due to pre-existing 'reactionary' and security-oriented migration policy (Tutak 2018). The party does not need to exclude certain population subgroups (Muslims) from benefits if they are not accepted into the country in the first place and, in a context of economic growth, does not even need to exclude groups previously accepted (Ukrainians).

The differences between PiS and numerous other PRR parties also come to light when we look at their response to the COVID-19 pandemic. As of July 2020, commentators note that populist leaders are presiding over the worst COVID-19 outbreaks in the United States, the United Kingdom, Brazil and Russia, among others (Leonhardt and Leatherby 2020). Part of the explanation is that populists distrust scientific expertise and therefore delayed their response to the pandemic, with disastrous consequences.

Poland, together with Hungary and the Philippines, appears to be an exception to this trend (Löblová et al. 2021). Along with most Central and Eastern European countries, Poland fared considerably better in their initial pandemic response compared to their Western European counterparts (Shotter and Jones 2020). The reasons for this still need to be carefully unpacked (one possibility is that the virus simply arrived much sooner in Western Europe, as early as December (BBC 2020)). This being said, it is clear that at least in the early response to the pandemic, the PiS government took the situation more seriously and acted faster than many other PRR governments, avoiding reflexive anti-scientific policies similar to, e.g. the United States or Brazil.

However, the second wave exposed many governance failures, including deficiencies in evidence-based policy-making. Further studies are required to establish whether this governance deficit is a result of endemic problems of the Polish public administration or if it is a result of the spoils system in the civil service implemented by PiS since late 2015. The latter might fit the clientelist hypothesis presented in chapter "Introduction" with regard to PRR parties.

Conclusion

The Polish Model of Welfare State – PiS's political manifesto – marks a significant point in Polish political history after the fall of the Soviet Block. It explicitly declares a departure from neoliberalism that had made a clear impact on Polish policy-making in the quarter of the century after the fall of the Berlin Wall. Since 2015, the PiS government initiated a significant departure from the austerity and market-oriented policies in health care. PiS introduced a unique flavour to its right-wing populist policies with a combination of Christian conservatism in cultural policies and social-democratic (not Christian-democratic – sic!) welfare policies. PiS therefore stands in contrast to small Western European PRR parties when it comes to health policy.

PiS policies do not easily conform to existing typologies for PRR parties such as welfare populism, welfare chauvinism or liberal chauvinism. While the latter category can be excluded, given the expansionary nature of PiS reforms, the first two cannot be completely dismissed. PiS's discourse against medical elites (see Table 2) early in its first term brings it closer to welfare populism (the discourse has somewhat re-emerged during the pandemic). The issue of welfare chauvinism is also unclear. While migrants are not technically excluded from the health system, PiS rhetoric particularly against Muslim refugees and migrants, and their policy restrictions on immigration, conform to similar stances by other PRR parties. It is unclear whether the lack of welfare chauvinist measures in health care is due to not wanting to restrict access to health care, or whether this is achieved indirectly through migration policy. Still, PiS differs from other PRR parties in that it has a more expansive non-ethnic (although religious) definition of 'the people', which apparently does not exclude Ukrainian migrants. Its exclusions of certain categories of services, and by extension of people who seek them (e.g. women who seek reproductive care beyond PiS's conservative Christian values), suggest a kind of cultural exclusionary approach is at play (within cultural conservatism).

The short- and long-term impact of PiS's reforms is debated and will require further studies. Despite – or perhaps due to – ad hoc reforms, the Polish health system continues to show important weaknesses that have not been addressed by existing policies. Underfunding continues to be a systemic problem, and PiS's attempts to increase funding still leave Poland far below the EU average of 9.9% of GDP spent on health care (Eurostat 2020). More importantly, Poles still pay a large share of costs out-of-pocket (23% in 2017), which is the most regressive form of health financing. Pharmaceutical shortages and the pharmaceutical black market continue to be a problem. Also, while further restrictions of access to abortion do not seem to be a direct result of PiS's agenda, the governing party is supportive of the decision despite postponing its implementation.

Although harsher anti-abortion proposals have been dropped, reproductive rights continue to be an issue. Nevertheless, PiS is unique in the fact that it represents a more welfare inclusionary approach that is combined with social policies that would normally be closer to social-democratic than even a Christian-democratic party. So far, PiS's stance can be defined as culturally conservative welfare state populism in

Table 2 Law and Justice (PiS) and the three faces of the welfare state under the PRR

Concept	Features	Is it present?	Comment
Welfare populism (de Koster et al. 2012)	Egalitarianism…	Yes	Appreciation of working class and peripheries (countryside and towns)
	…with critical views of the welfare state	No	Very positive view of welfare state (in contrast to the dominant opposition discourse). Strong inspirations derived from traditionally social-democratic traditions. Interestingly, PiS was sceptical towards traditionally Christian-democratic welfare solutions such as partnership model with the third sector (PiS was originally suspicious towards NGOs) and decentralisation. PiS represented 'etatist' (*statist*) administrative traditions, believing in greater centralisation of the state. However, currently the government is not critical towards decentralisation by delegation and accepted this model in its manifesto
	Increase welfare generosity…	Yes	Expansion of inclusive benefits
	…but only for the 'common man' in need of social assistance	No	Welfare and healthcare benefits are not means-tested, being available to all (insistence on supporting the middle class as well as the working class)
	Welfare state should not be seen as an instrument for catering to self-serving bureaucrats and those undeserving of assistance	No	The concept of 'the undeserving' is notably absent in the narrative (in contrast to the dominant opposition discourse oriented on the criticism of benefits to 'the unproductives' and criticism of wealth redistribution). Also, anti-elitist discourse is not directed against civil service

(continued)

Table 2 (continued)

Concept	Features	Is it present?	Comment
Welfare chauvinism (Andersen and Bjørklund 1990, p. 212)	'Welfare services should be restricted to our own' (welfare generosity but restricted to native population)	No (generally)	In general, PiS does not represent a discourse of restricting access to benefits for migrants (currently primarily Ukrainian). Despite earlier discourse against Muslim Middle Eastern refugees, presence of other migrant populations (e.g. Ukrainians) is not politicised (notably, at the time the government was willing to take Christian Middle-Eastern refugees)
Liberal welfare chauvinism (Falkenbach and Greer 2018)	Combining racial and ethnic animosity with a class conflict	No	There are only elements of class antagonism – Primarily, antagonism towards higher classes, and higher middle classes (lawyers, pundit class, etc.) – all in support of general middle class and working class, especially in smaller cities and in countryside
	Conservative preference for a small state	No	PiS doctrinal origins are notably anti-neoliberal, anti-minimal state and anti-austerity
	Decreasing welfare generosity with restricting it to the native population	No	Increase of welfare generosity without limiting it to native population (expansion of access to health care)

(continued)

Table 2 (continued)

Concept	Features	Is it present?	Comment
Cultural conservatism	Anti-LGBT narratives	Yes (somewhat instrumental approach)	Mild or passive support to religious right lobby groups (most notably Ordo Iuris) in their initiatives such as: 'LGBT-free zones'; ban on 'eugenic abortions'; declarations of conscience by physicians and pharmacists (allowing refusal for some services for religious reasons); etc. This radical flank effect appears to be strategically beneficial to PiS as it galvanises strongly religious constituencies. However, PiS does not seem to be proactive on those matters (e.g. not directly enacting various legislative proposals). The Constitutional Tribunal's ruling on embryopathological abortion ban exemplifies this strive to avoid political responsibility
	Anti-abortion		
	Anti-IVF		
	Strong alliance with the Catholic Church		
	Against 'western cultural degeneration'		
'Antemurale Christianitatis'	Cultural doctrine of being 'on the defensive walls of Christianity' and of western civilisation	Yes	Doctrine of being in a unique geopolitical situation as the first line of defence against Russia and other non-Western civilisations, as well as being better at representing western values that the core of the West, that has rotten over recent decades due to sexual promiscuity and laicisation
Anti-elitism (including 'medical populism')		Yes	Persistent, complex narrative against corrupt elites (lawyers, mainstream media). Few years back, it was also addressed against physicians (it was toned down afterwards)
Anti-globalism	Strong criticism towards 'global elites' and global free markets	Yes	PiS explicitly declares that they do not believe that 'capital has no nationality'

(continued)

Table 2 (continued)

Concept	Features	Is it present?	Comment
'Euroscepticism'		Yes	'Europe of homelands' – scepticism towards stronger integration within the European Union, primarily framed as opposition to German hegemony. However, with declarative support to the expansion of the EU and a looser integration
Etatism	Appreciation of the central government	Yes	Idea of the central government (the state) as a unifying power that ensures solidarity and
	Scepticism towards decentralisation	Yes	Opposition to Christian-democratic notion of subsidiarity, mistrust to territorial-self-governments (strong opposition to autonomy of regions such as Silesia) and scepticism towards partnership model of the third sector (delegation of public function to NGOs – weakened in the latest manifesto)
	Scepticism towards the third sector	Partial	
	Nation as a political community	Yes	Orientation on political and cultural community as opposed to nativism oriented on ethnicity

that it is not only 'welfare expansionist' (which can include delivery of benefits by the third sector) but also specifically welfare *state* expansionist – as a very unique flavour of right-wing populism.

Summary Box

1. PiS is different from small Western European PRR parties. It needs to appease a much wider electorate that is in favour of public health care.
2. PiS reforms are a combination of left-wing social policy and conservative cultural values.
3. PiS attempted to recentralise the health system, following failed liberal reforms towards marketisation similar to the Hungarian case.
4. PiS health reforms cannot easily fit current typologies of welfare populism/chauvinism/liberal chauvinism.
5. PiS stance can be summed up as conservative welfare state populism (culturally conservative welfare state expansionist populism).

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The Case of the United Kingdom Independence Party (UKIP)

Ian McManus

Introduction

The populist radical right (PRR) United Kingdom Independence Party (UKIP), despite never holding formal power in a ruling government, has nevertheless had a profound impact on political discourse and policy-making in the United Kingdom (UK). UKIP has influenced the British political agenda and public sentiment culminating in the country's decision to leave the European Union (EU) in the Brexit referendum. While initially formed as an anti-EU party, UKIP has embraced anti-immigration and welfare chauvinist policies that have affected mainstream politics. Far-right populist ideas and policies, for example, healthcare benefit restrictions for migrants, have made it into the centre-right Conservative Party's platform. The prevalence of far-right populism in UK politics has also been made apparent with the 2019 election of the populist Conservative Party leader and noted pro-Brexit advocate Boris Johnson as Prime Minister.

This chapter analyses the influence of far-right populist politics on health policy in the United Kingdom. It will begin by chronicling the rise of the PRR UKIP in national politics and their influence on centrist political parties. This section will also discuss how the distinct UK electoral system shapes the degree of PRR party influence in the political process. Next, literature on the PRR will be analysed to understand how actors such as UKIP fit within the far-right populist party family. Finally, specific health policies will be identified to evaluate the extent to which PRR ideas and proposals have been incorporated into the British policy agenda.

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The Rise of UKIP

Although established in the early 1990s, UKIP did not gain significant public support until the late 2000s. Euroscepticism was a major factor in UKIP's growing support as British trust in the EU, which had always been limited, dropped significantly beginning in 2007 and reaching an all-time low in 2012 (see Fig. 1). Growing anti-immigration sentiment and public dissatisfaction with the Conservative-Liberal Democratic coalition government also enabled UKIP's rise as an opposition party and helps to explain the party's surprising gains in the 2015 general election (Clarke et al. 2016). Figure 2, for instance, shows that as the urgency of the 2008 global economic crisis subsided, immigration grew as a public concern becoming the most important issue from 2014 to 2016[1] (see Fig. 2). Under the leadership of Nigel Farage, UKIP embraced an anti-immigration platform to capitalise on growing concerns over immigration and claim control of this issue, one that historically the

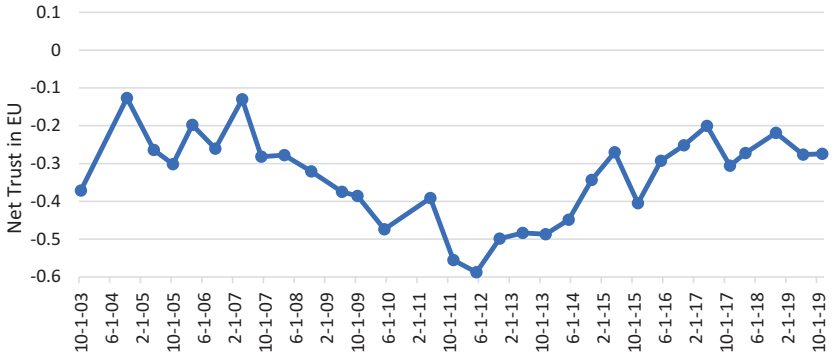

Fig. 1 Net trust in the EU (2003–2019). (Source: European Commission 2021a)

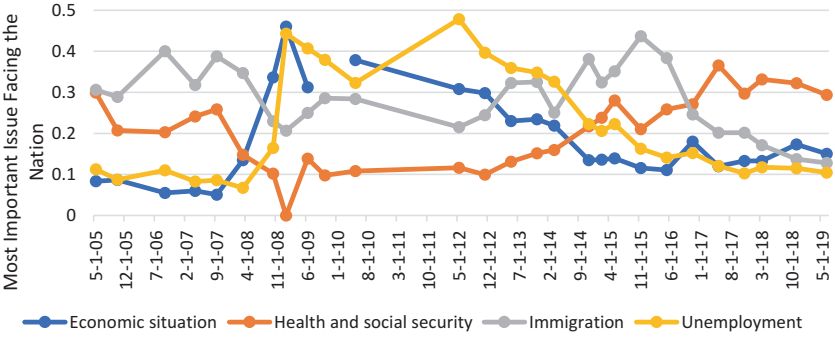

Fig. 2 Most important issue facing the UK (2005–2019). (Source: European Commission 2021b)

[1] Immigration peaked as an issue at the height of the European Migrant Crisis with 43.7% of respondents saying this was the most important national issue in November 2015.

Conservative Party had owned (Goodwin and Milazzo 2015). A poll of British voters revealed that, going into the 2015 general election, the Conservative Party had lost ownership of immigration as an issue to 'Other' parties.[2] The embrace of anti-immigration policies helped UKIP move from the political margins to achieve the party's best results in the 2015 election (Dennison and Goodwin 2015).

While public support and policy positions are important for PRR party success, structural constraints, such as electoral systems, also play an important role (Denemark and Bowler 2002; Jungerstam-Mulders 2003; Mudde 2007). Unlike the majority of European democracies which have proportional representation (PR) electoral systems, the United Kingdom is the only country that has a first-past-the-post electoral system in which two parties dominate national politics (Duverger 1959). This single-member plurality (SMP) voting system in the United Kingdom helps to limit the influence of PRR parties compared to the PR systems found in much of the rest of Europe (Copsey 1996; Eatwell 2000; Van Kessel 2015). For example, despite UKIP's record electoral performance in 2015, receiving nearly 4 million votes, it only gained one seat in Parliament (its first and only to date). Even after UKIP's relative success in the 2015 election, traditional parties refused to enter into a coalition with the far-right party. This further limited UKIP's ability to directly influence the legislative agenda.

By embracing extreme positions on key issues, niche parties such as UKIP attempt to distinguish themselves from centrist parties to gain support and influence legislative outcomes (Wagner 2012). As a result of this strategy, UKIP's ability to promote its political agenda far exceeds its representation in Parliament (Evans and Mellon 2019). The Conservative Party, for example, has been responsive to UKIP's key demands adopting a more Eurosceptic attitude and restrictive stance on immigration (Van Kessel 2015). This should come as no surprise as the risk of voter defection to UKIP was much higher for the Conservative Party's base than for either the Labour Party or Liberal Democrats (Lynch and Whitaker 2014).

As a party seeking representation UKIP, has met with limited success, but as an PRR actor trying to push its agenda, it has been able to move the political dial. Perhaps this is most evident in the decision made by David Cameron's Conservative-led government to hold a referendum on the UK's continued membership in the EU. This decision was influenced by UKIP who capitalised on the Eurozone and migrant crises to put pressure on the Conservative Party to hold a public vote on the UK's continued membership in the EU (Bale 2018; Pirro et al. 2018; Usherwood 2016). This is telling as Cameron himself was opposed to Brexit and campaigned before the referendum for the United Kingdom to remain in the EU. Not only did UKIP as a PRR party influence the Conservative Party's decision to hold the Brexit referendum, but PRR ideas and actors gained more prominence within the Conservative Party itself. This is exemplified by Conservative Party member Boris

[2] It is likely that the majority of respondents who chose 'Other' had UKIP in mind as the party had made immigration a central component of their platform (Yougov 2015).

Johnson's decision to defect from the Cameron administration and back the leave campaign.

In addition to elevating Euroscepticism on the political agenda, UKIP was successful in fusing anti-EU sentiment with other PRR issues including immigration and welfare chauvinism. UKIP painted mainstream parties on the centre left and centre right as ineffective on immigration. For example, UKIP denounced the incumbent Conservative-Lib Dem government for failing to fulfil its 2010 campaign promise to curb the number of migrants entering the country (Dennison and Goodwin 2015). Although David Cameron had committed in 2010 to reduce net migration into the UK to less than 100,000 a year going into the 2015 election net migration was nearly 300,000 per year (Grice 2015). UKIP was not only able to gain ground on the issue of immigration but was able to tie this to their broader anti-EU message. As UKIP's spokesman, Nigel Farage argued that unless Britain left the EU, the country would not be able to reclaim control over its borders resulting in a rise in migrant-related crime and 'benefit tourism' (Dennison and Goodwin 2015).

In response to UKIP's politicisation of immigration and welfare, during the 2015 election, the Conservative Party repeatedly described immigrants as a 'drain on the British social welfare system' (McKeever 2020: 59). Conservative-led governments since 2015 also adopted a number of policies favoured by UKIP such as fulfilling the promise that Britain would leave the EU and limiting welfare eligibility for immigrants (Chakelian 2017). In fulfilling its *raison d'être* with the successful Brexit campaign and the Conservatives co-opting some of its positions on Brexit, immigration and welfare, UKIP has seen a steep decline in support in recent years.[3] Despite UKIP's waning influence, PRR ideas and policies have remained salient in British politics. Not only have the Tories adopted some of UKIP's policy positions, but the ascent of Boris Johnson as Conservative Party leader signals the continued sway of the PRR within British politics.

UKIP and Radical Right Populism

Although UKIP is sometimes seen as an ambiguous case within the populist radical right party family (Mudde 2007, 2017), it exhibits a number of characteristics that warrant its classification as a PRR actor. UKIP's rhetoric and policies follow a common far-right populist framing, what John Judis refers to as 'triadic antagonism', in which the 'people' of a country are presented as being at odds with both corrupt elite actors and 'outsider' groups which seek to take advantage of them (2016). Since its founding, UKIP has been strongly opposed to the UK's membership in the EU, often criticising Brussels for being undemocratic, ineffective, corrupt and harmful to national sovereignty (Van Kessel 2015). Similarly, as an opposition

[3] In the 2017 general election, UKIP received 1.8% of the vote share and only 0.1% in the 2019 election (House of Commons 2020).

group, UKIP has blamed the elite Westminster political establishment for ignoring the interests and needs of British citizens (Geddes 2014). UKIP's anti-establishment position reflects PRR claims that mainstream political representatives and EU officials are unresponsive to the demands of the average citizen and that only UKIP can offer policy alternatives to address these needs (Mudde and Kaltwasser 2012).

In addition to railing against political elites, UKIP has established itself as an anti-immigration party blaming immigrants and multiculturalism for undermining British society (Dennison and Goodwin 2015; Ennser-Jedenastik 2018). This sentiment is reflected, for example, in the 2017 UKIP manifesto, which states: 'Nobody voted for multiculturalism, yet all of us are living with the results of it. It is generally those who have little interest in preserving British identity, or who are indeed hostile to the very idea of it, who champion multiculturalism most fiercely' (UKIP 2017: 35). This emphasis on preserving British culture from multiculturalism and 'outsider' migrant groups is informed by populist notions that politics should reflect the common will of 'the people' defined as a homogenous national group not a pluralistic and diverse one (Mudde 2004). This populist message is apparent, for example, in comments made by UKIP's leader Nigel Farage in the build-up to the Brexit referendum when he suggested that the campaign to leave the EU would not be one fought behind closed walls, but rather be decided by the British people (BBC 2015). This view is evident in UKIP's discursive strategy throughout the Brexit campaign which defined the 'real people' of Britain who were in opposition with two antagonistic groups elite mainstream political actors and immigrants (Bennett 2019). UKIP's presentation of the British people reflects populist and nativist perspectives associated with the PRR family.

Along with the rise of UKIP, the UK has also seen PRR ideas, policies and actors infiltrate the centre-right Conservative Party. While exhibiting some key differences, the influence of Boris Johnson, first during the Brexit referendum, and later as British Prime Minister and leader of the Conservative Party, parallels the rise of Donald Trump as a populist leader within the Republican Party in the United States. Both leaders have used nationalist appeals to 'the people' as a means to secure their own power and press forward on PRR issues and policies. Johnson's commitment to 'Get Brexit Done' and 'Unleash Britain's Potential' as Conservative leader reflect the kind of nationalism that underpins Trump's 'Make America Great Again' slogan (Conservative Party 2019). Johnson frames his commitment to 'Brexit at all costs' in populist terms as fulfilling 'the popular will' of the British people (Mudde 2004). Like Trump, Johnson uses charismatic appeals and a simplification of complex issues to communicate with his supporters. While charisma may not be an intrinsic quality of populist leaders, it is effective in demagogic communication (Barr 2009: 32; Nai and Martínez i Coma 2019). Johnson's discourse often strikes a populist tone that embraces an 'anti-elite, nationalist rhetoric that valorises ordinary people' (Jansen 2011, 82). The completion of Brexit was a key component of Johnson's success in the 2019 general election. His strategy bore many of the hallmarks of populism by radically simplifying a complex issue and promoting the political message that there was a 'common sense' approach to honouring the public desire to leave the EU one that could only be accomplished through his leadership and not by other

party and technocratic elites (Tormey 2020). So, while PRR parties like UKIP are not in the ruling government, Britain has seen the ascent of PRR ideas and actors, most notably Boris Johnson, within established mainstream parties and politics.

Beyond Euroscepticism: The Influence of PRR Politics on UK Health Policy

The Brexit campaign highlighted the growing influence of the PRR in British politics. Advocates of the United Kingdom's departure from the EU, such as UKIP, not only railed against EU elites but also were able to tie the referendum to a number of PRR issues; among these, immigration and health care were a major focus. One of the most infamous examples of this was the false claim made by the official Vote Leave campaign that the United Kingdom sent roughly £350 million per week to the EU, funds which could be reallocated to the National Health Service (NHS). This false statement appeared on the side of the Vote Leave campaign bus which toured the country; it ran in targeted ads on the internet and was repeatedly made by Conservative Member of Parliament and then Mayor of London Boris Johnson (Stone 2018). This claim reflected UKIP's position that funds should be redirected from the EU budget towards domestic social programmes (Ennser-Jedenastik 2018). Effectively, this turned the Brexit vote into a referendum not only about the EU but also about the preservation of national health care. Despite being a misleading statement, the argument that EU membership undermined the NHS was vital to the success of the pro-Brexit movement. Dominic Cummings, a former leader of the Vote Leave campaign, mentioned that research and the fact that the result was so close implies that the Remain Vote would have won (Stone 2018). In fact, while the claim has been thoroughly debunked, a King's College London study found that 42% of people who had heard the claim still believe it to be true (2018).

In addition to arguing that the EU posed a direct threat to NHS funding, UKIP also argued that EU membership encouraged higher levels of immigration into the United Kingdom which placed a greater burden on the healthcare system. This argument was effective in swaying voters even though there was evidence which challenged this claim. For instance, despite a report by the Migration Advisory Committee which concluded that EU migrants contribute £4.7 billion more in taxes than they use in welfare benefits and services, only 29% of the public correctly think that this is the case (King's College London 2018). Similarly, 53% of individuals who voted in favour of Brexit believed that European immigration decreased the quality of health care in the United Kingdom, despite official reports which showed that this was not the case and that a shortage of migrant healthcare workers from other EU countries would actually pose challenges for the NHS (King's College London 2018).

The narrative of 'benefit tourism', which was a prominent feature of the Brexit debate, is part of a larger framing that the PRR uses to portray immigration as a

threat to national welfare systems. A conspicuous example of this welfare chauvinist and nativist framing was the claim made by UKIP leader Nigel Farage that the majority of people in the United Kingdom diagnosed with HIV are foreign nationals who come to the country as health tourists seeking to take advantage of the NHS (Kmietowicz 2015). When challenged on this point, Farage added that '£2 billion a year is going on health tourism' in an effort to highlight the strain that migrants place on the NHS (Kmietowicz 2015). Frequent reference was made to the burden that 'health tourism' placed on the NHS in UKIP's 2015 platform. Rather than focusing on policies to improve healthcare services, this PRR welfare chauvinist strategy is often aimed at reducing benefits and excluding access to health care for migrants and others deemed as 'outsiders' (Falkenbach and Greer 2018; Greer 2017).

In addition to elevating welfare chauvinism on the political agenda, UKIP also began to advocate for more radical policies over time. Whereas UKIP opposed EU membership and sought to limit migration in its 2005 and 2010 manifestos, policies to address these issues were vaguely defined, and no mention was made of the perceived threat that either posed to the NHS. However, in its 2015 manifesto, UKIP made clear that limiting access to the NHS solely to British nationals was a top priority. To this end, the PRR party called for legislation that would require all new visitors and migrants have approved medical insurance (UKIP 2015). UKIP also promised that once in power, they would require that all new migrants to Britain make tax and national insurance contributions for five consecutive years before they would be eligible for NHS services (UKIP 2015). The party also called to limit healthcare access to foreign students requiring that all non-UK higher education students have private health insurance during their studies (UKIP 2015). UKIP has kept up its promise to "end 'health tourism' by foreign nationals" in its recent platform (UKIP 2017). The PRR party continues to advocate policies that limit access to the NHS for immigrants until they have made five years of tax contributions in its 2017 and 2019 manifestos (UKIP 2017, 2019). It also blames successive Labour, Coalition and Conservative governments for undermining the NHS and allowing it to be abused by 'outsiders' (UKIP 2017). Overall, UKIP's party platform reflects its populist roots emphasising anti-elitism, welfare chauvinism and nativism in its approach towards health policy.

Although more moderate than UKIP's platform, the Conservative Party has also focused on the perceived threat that immigration poses to health care. For example, the Conservative Party's 2005 manifesto emphasises that the NHS is 'a national health service not a world health service' and calls on immigrants to undergo medical tests to ensure that they will not 'impose significant costs to Britain's health system' although unlike UKIP's 2015 proposal it does not deny access outright (Conservative Party 2005). The Conservative Party's 2010 manifesto, however, makes no mention of the supposed healthcare burden imposed by immigrants. While the party committed to reducing net migration in its 2010 platform, it also acknowledged that 'immigration has enriched our nation over the years' (Conservative Party 2010). While not referenced at all in 2010, 'health tourism' was explicitly highlighted as a concern once again in the Conservative Party's 2015 manifesto. This reflects rising public concerns over immigration and pressure from

UKIP on this issue. While not going as far as UKIP to outright deny coverage to immigrants and visitors, the Tories promised that they would be 'taking unprecedented action to tackle health tourism and will recover up to £500 million from migrants who use the NHS' (Conservative Party 2015).

In keeping with this campaign promise, the Conservative government in 2015 introduced an Immigration Health Surcharge (IHS) of £200 per year for most non-European Economic Area (EEA) nationals which would impose upfront costs on foreign nationals before they could receive treatment from the NHS (Gower 2020). This surcharge is on top of tax and national insurance that migrants pay during their time living in the United Kingdom. Under this law, foreign nationals who received treatment but who did not pay the surcharge in advance would be charged 150% of the actual costs to the NHS (NHS England 2015). In 2019, the IHS fee was doubled to £400 per year, and it is scheduled to increase again in October 2020 to £624 per year (Gower 2020). In their 2019 manifesto, the Conservative Party committed to further increasing the IHS charge and extending it to EEA nationals after the Brexit transition period is completed (Gower 2020). Additionally, the 2019 Conservative manifesto included plans to double the budget for the health tourism enforcement unit an oversight group within the NHS (Conservative Party 2019). A critique of this policy is that the additional money for this unit would come directly from the existing NHS budget which would take funding away from other services (Valladares 2019). This critique reveals the welfare chauvinist logic underlying this proposal as it prioritises limiting immigrant healthcare access even at the cost of reduced funding for other health services and care. A Conservative Party leaflet distributed to voters in Northern England in 2019 claimed that the challenges facing the NHS are due to the medical demands of immigrants and health tourism (Molloy 2019). This leaflet was criticised for not only being inaccurate but intentionally fomenting racial, ethnic and religious divisions for political gain (Molloy 2019). Issues of welfare chauvinism, nativism and health care have not only made it into party platforms and election strategies in recent years but have also been implemented as policy in the United Kingdom (see Table 1).

In 2012, the Conservative-Liberal Democratic coalition government introduced the Home Office hostile environment policy, a set of administrative and legislative measures designed to reduce net migration by putting pressure on illegal immigrants to voluntarily leave by making life as difficult for them as possible (Hill 2017). The policy intended as part of a strategy to fulfil the Conservative Party's 2010 election promise to reduce net migration (Conservative Party 2010). The hostile environment policy has been criticised by some medical professionals who argue it has led to people being wrongfully denied health care (Usborne 2018). As immigration became a more pressing issue among the British public, the Conservative-led coalition government adopted the 2014 Immigration Act which among other things introduced a health surcharge for foreigners. While the centre-left Labour Party opposed this legislation and has proposed abolishing the Act, the Conservative government has renewed its commitment to the policy and increased the fee to impose a larger penalty on migrants creating a higher barrier for healthcare access. In 2017, stricter monitoring measures were put in place which require

Table 1 Overview of key healthcare and immigration policies

PRR policy proposal	Implementation	Comments/outcomes	Classification
Immigration Act 2014 (includes hostile environment policies)	Adopted April 2015	This Act includes the hostile environment series of administrative and legislative measures aimed at putting pressure on individuals without leave to remain visa status to leave the country voluntarily. This Act includes restrictions to welfare benefits	Welfare chauvinist
Immigrant Health Surcharge (IHS)	Adopted April 2015	Introduces a £200 per year fee for non-EEA nationals to access healthcare services. Migrants who receive treatment but who did not pay the surcharge in advance would be charged 150% of the actual costs to the NHS	Welfare chauvinist
Immigration Act 2016	Adopted May 2016	The Act includes amendments and expansions of hostile environment policies	Restrictions against immigrants
IHS increased to £400 per year	Adopted January 2019	The fee charged to non-EEA nationals to access healthcare services was increased from £200 to £400 per year	Welfare chauvinist
IHS increased to £624 per year	Adopted October 2020	The fee charged to non-EEA nationals to access healthcare services was increased from £400 to £624 per year	Welfare chauvinist
IHS extension to EEA nationals	Planned to go into effect January 2021	The IHS fee is planned to be extended to EEA nationals after Brexit is complete. This group of European migrants had formerly been exempted from this policy due to EU rules	Welfare chauvinist

NHS providers to make sure that patients were eligible for free health care and to charge them upfront if not as well as flag them in a database to ensure that their access remains restricted (Silver 2017). This change was implemented despite concerns voiced by the British Medical Association that it might prevent vulnerable individuals from getting the treatment and care that they need (Silver 2017).

Under the leadership of Prime Minister Boris Johnson, the Conservative Party has proposed further healthcare restrictions on immigrants be put in place post-Brexit. Once EU freedom of movement ends in January 2021, EU migrants will no longer be able to access welfare services after living in the United Kingdom for 3 months as the current rules allow (Conservatives 2019). Indicating the persistent influence of PRR ideas and policies, the current Conservative-led government has adopted the position that foreigners need to reside in the United Kingdom and pay taxes for five years before gaining access to health care and other welfare benefits (Conservatives 2019). This policy represents a clear take-up of UKIP's 2015 election manifesto proposal. The aim of this populist strategy is to incite fear of 'outsiders' to help justify discriminatory health policies particularly against marginalised

groups (Speed and Mannion 2017). As demonstrated by recent reforms, populist welfare chauvinism has been incorporated into UK health policy.

Despite claims by UKIP and other PRR actors that immigrants place a considerable burden on the British healthcare system, evidence suggests that 'health tourism' is not nearly the problem that it is made out to be. For example, although 'health tourism' was a major concern for UKIP during the 2015 general election, data from the International Passenger Survey conducted by the UK Office of National Statistics indicated that more people leave the United Kingdom than visit for medical treatment (Hanefeld et al. 2013). Critics of the policy also argue that restricting access to health services based on immigration status requires a complex bureaucratic structure which will impose a major financial burden on the NHS (Keith and Van Ginneken 2015). Rather than reducing the strain on the NHS these policies might end up costing it financially by limiting tax revenue due to a lower number of migrants contributing and imposing higher administrative costs to monitor who has access (Keith and Van Ginneken 2015). These discriminatory policies may also have negative consequences on public health, the medical profession, human rights and healthcare finances while also directly harming the health and well-being of vulnerable populations (Keith and Van Ginneken 2015). Ultimately, populist efforts to restrict healthcare access for certain groups run counter to the founding principles of the NHS which was established to be a universal and inclusive health system (Gough 2019). By enacting barriers to healthcare access, these policies can cause undue suffering, harm public health, undermine the NHS as a universal healthcare system and create an excluded and vulnerable population within British society (Gough 2019).

The COVID Crisis and Populism in the United Kingdom

The effects of the PRR on public health in Britain have been a recent concern in light of the COVID-19 pandemic. As with the rest of the world, the United Kingdom has been reeling from the spread of coronavirus which has presented an enormous threat to public health. The government's response to this crisis bears the mark of populism at the heart of Prime Minister Johnson's political approach (Tormey 2020). At the outset of the pandemic, Johnson tried to downplay the risks posed by the disease, radically simplify the problem and ignore the advice of health experts (Tormey 2020). As a result, the British government was slow to order a lockdown and even entertained the idea of allowing the virus to spread unchecked in order to achieve 'herd immunity' despite warnings by health officials that this approach could result in 250,000 deaths and the NHS being overwhelmed (Boot 2020). The government was also criticised for acting too late in providing protective equipment for medical staff and sufficient virus testing. While Johnson changed his position and began to take more seriously the advice of medical experts, particularly after being hospitalised himself for COVID, his early response to the crisis reflects aspects of medical populism.

Medical populism can be defined as the politicisation of public health issues that pit 'the people' against 'the establishment' (Lasco and Curato 2019). Medical populism politicises and simplifies complex health issues which can result in divisive and inadequate responses to pressing health crises. This approach is in sharp contrast to technocratic strategies which strive to reach a consensus based on diverse expert advice and the best available evidence (Tormey 2020). In the early stages of the COVID crisis, medical experts were treated with suspicion as elite technocratic actors by the British government. The decision, for example, not to require individuals to shelter in place, is indicative of this approach. In communication with the press and public, evidence was also rejected for political reasons. Despite having one of the highest COVID-death rates in Europe, Boris Johnson claimed success in his dealing with the pandemic, making the false claim that the United Kingdom was able to avoid the crisis that was affecting other countries (Boot 2020). Johnson even went so far as to joke about shaking hands with people in an attempt to minimise the risks of exposure to the virus (Knight 2020). There have also been concerns that although the government has agreed to hold more frequent press briefings, Johnson has been trying to frame the media as working against the public interest and paints its critiques of his pandemic response as politically motivated (Landler and Castle 2020). Efforts by Downing Street to control information and shape the narrative reflect populist appeals against the news media that were present throughout the Brexit campaign (Landler and Castle 2020). Such tactics not only hid the real dangers and human costs of the pandemic but also lead to more confusion, fear and uncertainty among the public.

Populist efforts to divide society between 'the people' and 'outsiders' realised in welfare chauvinist policies to limit access to health care, and other benefits are also troubling during a health crisis which affects the entire population. Concerns, for example, have been raised in the United Kingdom about the adequacy and equality of healthcare services for all people during the crisis. After accounting for age and geography, UK patients of Pakistani or African heritage who were treated for COVID had a mortality rate that was almost three times higher than that of white patients (Knight 2020). While the British government has taken a more reasoned approach to dealing with the COVID-19 crisis over time, for example, abandoning its herd immunity strategy, establishing a quarantine, providing more funding for NHS emergency response measures and relying more on medical expert advice, the initial response to the pandemic highlights the dangers that populism poses in the midst of a public health crisis.

PRR leaders have exploited the COVID-19 pandemic in an attempt to gain renewed significance in British politics. In response to the announcement of a second national lockdown by the government in November 2020, Nigel Farage has announced that he intends to recast UKIP as 'Reform UK', a party whose primary focus will be opposing coronavirus restrictions in Britain (Reuters 2020a). Since achieving Brexit, UKIP has waned in political influence, but this political rebranding by Farage and other party leaders reflects a populist strategy to capitalise on voter discontent in the midst of a crisis to put pressure on the government. Reform UK's anti-lockdown message has distinctly anti-elite populist undertones taking

aim at the response of government officials and medical experts. In a joint article announcing the formation of Reform UK, Farage and UKIP party chairman Richard Tice cited government cronyism, powerful vested interests and Ministers out of touch with the nation as key problems negatively affecting the country's coronavirus response (Farage and Tice 2020). They argue that the government's COVID-19 strategy has been to frighten the nation into accepting lockdowns and other public health rules and regulations (Farage and Tice 2020). Reform UK has also argued that government responses have relied on 'exaggerated or out-of-date figures' and 'dodgy data' provided by suspect public health experts to justify its 'draconian lockdown measures' (Brexit Party 2020). This message is in line with PRR positions in other countries such as Alexander Gauland, the co-leader of Germany's far-right Alternative für Deutschland, who argued that daily reports on infection and mortality rates were intended to scare the public (Reuters 2020b).

Farage and Tice have also adopted an antagonistic position against the prevailing public health consensus, writing that lockdowns and other quarantine measures don't work, and promoting a herd immunity strategy that medical experts warn would result in much higher infection and mortality rates (Farage and Tice 2020). While it is unclear whether Reform UK will be electorally successful, it may pose a threat to public health by creating a more polarised national debate around the coronavirus response that tries to paint PRR opponents of the lockdown as defenders and promoters of the people of Britain working against pro-lockdown political and scientific elites who are out of touch with the people (Guardian 2020).

Conclusion

The PRR has had an enormous and disruptive impact on politics and the policy agenda in the United Kingdom in recent years. While the SMP electoral system and the response of the British political establishment have limited the influence of populist parties in government, PRR discourse and positions have substantially shaped immigration and health policies. While unsuccessful in gaining significant political representation, UKIP had been able to put pressure on mainstream parties to adopt aspects of its platform (Greer 2017). For example, measures proposed by the Conservative government in 2019 which require immigrants to make five years of tax contributions before being able to access the NHS are based on UKIP's 2015 election manifesto proposal (Conservatives 2019; UKIP 2015). The Immigrant Health Surcharge also reflects the Conservative's policy take-up of the welfare chauvinist position that health tourism should be curbed and access to benefits limited to citizens.

Although established as a single-issue anti-EU party, over time UKIP has embraced a wider PRR platform which has allowed it to connect its Euroscepticism with other key socioeconomic issues such as welfare and immigration (Backlund and Jungar 2019). During the Brexit campaign, for example, UKIP argued that British and European elites as well as immigrants posed a serious threat to the

NHS. In recent years, the PRR has used welfare chauvinist narratives to elevate anxieties over 'health tourism' and the abuse of the national healthcare system by 'outsiders' making it a central discussion in British politics. This is reflected in the manifestos of UKIP and the Conservative Party as well as in legislation such as the 2014 Immigration Act which introduced immigrant health surcharges.

The influence of UKIP has waned after its record 2015 general election results and the successful Brexit campaign; however, the PRR continues to shape British politics particularly with the ascent of the Conservative populist leader Boris Johnson to Prime Minister. By taking up many of UKIP's positions, the Conservative-led government has enabled PRR ideas to influence health policy in the United Kingdom. PRR measures aimed at restricting healthcare access, for example, continue to feature prominently on the policy agenda. These discriminatory health policies may harm public health, create an excluded vulnerable population within British society and undermine the foundation of the NHS (Gough 2019; Keith and Van Ginneken 2015). The early response by Johnson's government to the COVID-19 crisis has raised concerns about the dangers that populism poses during a public health crisis. Ultimately, the PRR has reshaped British politics and has had a profound impact on UK health policy.

Summary Box

1. Despite achieving little representation in government, UKIP as a PRR party has been able to forward its agenda and get key policies implemented. Notably, this includes the decision by David Cameron's government to hold the Brexit referendum and the subsequent success of the Leave campaign.
2. Although established as an anti-EU party, UKIP has embraced anti-immigration and welfare chauvinist policies that have influenced mainstream politics. For example, UKIP proposals to restrict healthcare benefits for migrants have made it into the Conservative Party's platform and policies. This includes the implementation of the Immigrant Health Surcharge and Home Office Hostile Environment Policies.
3. While PRR parties like UKIP are not in the ruling government, Britain has seen the ascent of PRR ideas and actors within established mainstream parties and politics. Most notably Prime Minister Boris Johnson has adopted PRR strategies, discourse and policies which has had a profound effect on health policy in the United Kingdom.

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Rhetoric and Reality in the United States of America: Trump, Populism and Health Policy

Phillip M. Singer and Charley E. Willison

Introduction

The United States does not have a formal populist radical right (PRR) party with representatives in national government. American politics at the national level is dominated by two parties – the conservative Republican Party and liberal Democratic Party. And while political parties are an organising force (Aldrich 1995), influencing policy agenda setting and adoption (Bawn et al. 2012), PRR in the United States is driven by political actors standing at the head of their party, like President Donald Trump and the Republican Party.

PRR health policy in the United States under Donald Trump largely aligns with Mudde and Kaltwasser's framework. Trump's rise to the presidency was sustained by *negative* action, with rhetoric that was dismissive of institutions and norms, xenophobic and authoritarian. But, Trump's PRR policy output is indeed thin, delivering few concrete policies (Mudde and Kaltwasser 2017).

Despite the absence of a formal party, populism on both sides of the political spectrum has long existed in American politics (Bonikowski and Gidron 2016). Yet, there has been a spike in populism in the United States of America over the last decades. Since the early 2000s, and especially during the 2008 economic recession, racial resentment and animus rose amongst white Americans against racial and ethnic minorities (Jardina 2019) over economic concerns and threats to the status quo (Mutz 2018). Racial resentment was stoked after the election of the nation's first black president, Barack Obama. In response to Obama's election, Republican

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electoral losses, and passage of the 2010 health reform law Affordable Care Act (ACA), a PRR splinter group, the Tea Party, emerged. The Tea Party had a thin health policy platform, focused on repealing the ACA, but broadly advocated for a limited welfare state (Williamson et al. 2011). While their influence on American politics has waned, the Tea Party revitalised PRR politics and in combination with economic concerns and racial animus helped pave the way for Trump's election (Dyck et al. 2018; Gervais and Morris 2018).

The 2016 presidential election saw the emergence of two radical, for the United States, populist candidates from opposite sides of the political spectrums (Lacatus 2019). Senator Bernie Sanders campaigned on a populist radical left platform, focusing on economic populism, single-payer health care and opposition to institutions that catered to elites over the people. Donald Trump campaigned on a platform of PRR rhetoric, denouncing existing norms, institutions and political processes, extolling racial animus and prioritising white Americans as the 'people' that have been left behind. The success of both types of candidates highlights the increasing support for political leaders who de-legitimise existing political institutions, processes and norms.

In the remainder of this chapter, we place Trump and American PRR health policy into a broader context, highlighting how Trump fits with traditional frameworks of PRR. We then examine the health policies Trump has pursued in his presidency. We first consider health policies that fit within existing Republican Party policy preferences, before analysing the PRR health policies adopted under the Trump administration. Lastly, we explore how populism shaped Trump's response to COVID-19 and what his presidency means for health policy and PRR going forward.

PRR, Donald Trump and the United States

Defining and conceptualising PRR is highly contested (see Mudde 2016). Mudde (2007) defined three core characteristics which comprise PRR parties. First, they exhibit nativist tendencies, which combine nationalism and xenophobia (Lee 2019) to support policies that protect the interests of whites, while reproving 'others', often immigrants and minorities. Second, PRR parties pursue authoritarian policy, emphasising law and order and the criminalisation of social problems, as well as a stronger executive. Lastly, populists view society as divided between the people and elite. Leaders of PRR parties claim to represent the people in a fight against conspiring elites.

The health policies that have been pursued and/or adopted by Donald Trump fit within this framework of PRR. As discussed in the next section, the health policies Trump has advocated for, and far less frequently adopted, have been PRR in their approach. Trump has sought to focus benefits on his supporters and penalise his opponents. Trump has often demarked in- and out-groups through racialisation and nativist approaches. Trump has selectively applied authoritarian health policies, leveraging law and order approaches when applied to ethnic minorities, while

eschewing criminalisation of health policies largely targeting whites. Lastly, Trump has framed his policy preferences as beneficial for the people and protecting against business and medical elites.

To be clear, while there are instances of formal authoritarian regimes (see the chapters on Hungary, Poland and the Philippines for example), which outline a clear definition of authoritarian regimes and how these regimes have adopted PRR policies, we do not include the United States in this list. Rather, in the case of Trump and the United States, there is an authoritarian personality within the confines of a democratic country. Trump has governed on a platform of an authoritarian style of politics and personality, but the United States is not an authoritarian regime.

Importantly, the success of PRR health policies under Trump has largely occurred when it overlaps with the policy preferences of the Republican Party. Trump's policies do not always fit cleanly within traditional Republican health policy. When conflict between Trump's PRR and Republican policy preferences has occurred, Trump has largely abandoned his preferred PRR policy. This shift is due to the political institutions and party dynamics in the United States.

Trump and Traditional Conservative Health Policy

Trump's PRR health policy agenda is marked by the tension between his policy goals and the traditional conservative policies found within the Republican Party. Trump, as the leader of the Republican Party, has often been in tension with the more traditional segments of his party. During the presidential campaign, Trump highlighted this tension when he responded that his solution for health care was un-Republican (Anderson and Weisz 2015) because he was going to take care of everyone that had been ignored by political, business and medical elites, while vowing that the government was going to pay for all care (Team Fix 2016).

Yet, the central planks of Trump's health policy agenda in office have largely fit within Republican policy orthodoxy, for example, Trump's failed attempts to repeal the ACA and replace it with a 'conservative' plan (Trump 2018). Repealing the ACA and any replacement plan would have been harmful for the public (Ku et al. 2017) but had been a longstanding policy demand of Republicans (Oberlander 2017). Trump's campaign rhetoric of ensuring care for everyone did not match his administrative actions once elected.

Even after Republicans failed to repeal and replace health reform, Trump has continued to chip away at protections and financial support that the public gained through the ACA. Most significant was eliminating the individual mandate resulting in higher costs and weaker health insurance risk pools (Kamal et al. 2018) (Claxton et al. 2019), as well as supplying the latest constitutional challenge to the ACA. The Trump administration also hamstrung the effectiveness of the ACA by reducing enrolment outreach by 90% (Pradhan 2017), ending cost-sharing reduction subsidies programme (Levitt et al. 2017) and expanding access to short-term insurance plans, weakening coverage and financial protections (Keith 2018).

Other health policies that have been harmful for the public, but a long-term policy goal of the Republican Party, include making it more difficult to access family planning services. Title X of the Public Health Service Act provides funding for family planning services including contraception and counselling for low-income individuals while also explicitly excluding funding for abortion services. Republicans have long sought to undermine and limit access to family planning services, including contraception and abortion. Under the Trump administration, any provider that receives Title X funding cannot provide or refer an individual to an organisation that provides abortions, limiting access to family planning services (Bronstein 2018).

Trump's efforts to address healthcare costs has shifted away from rhetoric reprimanding actions by medical and business elites that are harmful to the people, towards adopting traditional Republican policy. Trump has repeatedly criticised the big business of American health care, equating drug pricing with robbery (Humer 2017) and health insurers getting wealthy off the backs of the people (Team Fix 2016). Trump was the only Republican presidential candidate that supported allowing Medicare, the social welfare insurance programme, to negotiate prescription drug prices to lower out-of-pocket spending for individuals (Associated Press 2016). These policy goals were all framed as protecting the people and standing up against business and medical elites.

Since his election, Trump has moved away from policy goals constraining business and medical elites and pursued piecemeal policies aligned with existing Republican tenets. Congressional Republicans were loath to adopt policies that would rein in costs by increasing government oversight of healthcare markets and harm business (Huetteman 2019). Pivoting from his PRR rhetoric, Trump instead proposed rules to increase market competition for generic drugs (Gottlieb 2018) or require hospitals and insurers to publicly disclose the negotiated rates for services and for insurers to provide personalised out-of-pocket spending for all services (US Department of Health and Human Services 2019).

Welfare Chauvinistic Policies

Trump's populist health policy has been most successful with welfare and liberal chauvinistic policies. In both cases, the goal for Trump has targeted supporters with policy spoils, while also restricting benefits for out-groups, such as racial or ethnic minorities. While race or ethnicity is a blunt mechanism to divide policy benefits, in the case of Trump and Republicans, it largely mirrors the voting patterns of the president and Republican core supporters. In 2016, Trump received a majority of votes by whites, but only 8% of African-American votes (The Roper Center for Public Opinion Research 2020), while in 2018, Congressional Republicans received just 9% of African-American votes (Tyson 2018). The overlap in voters along racial lines and policy preferences between Trump and Congressional Republicans has

meant that there has been more success in adopting these chauvinistic policies (see Table 1).

The racial divisions in policy benefits are evident in how the Trump administration has approached substance use policy. Deaths related to opioid overdoses in the United States have quadrupled since 1999 (O'Donnell et al. 2017) disproportionately harming whites (Case and Deaton 2015). During the first year of his administration, Trump designated the epidemic a national emergency and advocated for policies, like increased grants and funding for treatment, limiting prescriptions and increasing awareness, that were focused on prevention (McCance-Katz and Giroir 2019). Yet, Trump has revived failed 'law and order' policies to address other substance use problems which disproportionately affect minorities (Om 2018). This includes directing federal prosecutors to pursue convictions for marijuana, even in states that have legalised it (Gurman 2018) and calling for the death penalty for drug offenses (Korte 2018).

Similar divisions in policy benefits by race are evident in tobacco policy. Rates of Electronic Nicotine Delivery Systems, or ENDS – like Juul – increased by more

Table 1 Examples of proposed and enacted health policy under Donald Trump

PRR policy	Implemented	Outcome/comments	Classification
Repeal and replace ACA	No	Trump and Congressional Republicans had long sought repealing and replacing the ACA health reform law. In 2017, with control over the Legislature and Executive branches, they fell three votes short	Conservative
Weaken ACA	Yes, with important caveats	While Trump failed to repeal the ACA, he has successfully undermined health reform, largely through executive action. Congress did repeal the individual mandate, requiring all Americans to purchase insurance or pay a fine in 2017, thereby representing a legislative occurrence of weakening the ACA	Conservative
Public charge rule	Yes, with important caveats	Adopted through executive action, but in November 2020 was vacated by a federal judge as arbitrary and capricious. Since the rule was adopted by executive action, subsequent administrations will be able to modify the regulation	Liberal chauvinism
Medicaid work requirements	Yes	Work requirements have led to significant decrease in enrolment in the public insurance programme. Yet, political and legal challenges have limited the scope of programmatic change	Liberal chauvinism
Prevention and treatment of opioid use	Yes	Legislation was enacted in 2018 thereby improving access and funding for treatment	Welfare chauvinism
Tobacco regulations	Yes	Regulating ENDS products but did not account for flavours that are common amongst non-white populations	Welfare chauvinism

than 25% in 2019. ENDS use disproportionately affects white youth (Food and Drug Administration 2019). Rather than targeting policy at all tobacco products used by youth, the Trump administration acted in 2019 to ban certain flavours for ENDS products only. This action omitted regulating products used primarily by non-white youth, including cigarillos and menthol cigarettes that have historically been marketed to minorities (Lupkin 2020).

Limiting access to benefits and programmes for racial and ethnic minorities was also at the heart of changes made by Trump to the Public Charge rule. Immigrants seeking initial or permanent entry in the United States can be barred or expelled if they may need or receive public welfare benefits or enrol in other public programmes. The Trump administration expanded the types of public programmes that may be considered for limiting immigration, including health, nutrition and public housing programmes. Additionally, individuals with low incomes, low education, limited English proficiency, uninsured or previously applying for a public programme could be used against an application for citizenship or immigration (Perreira et al. 2018). Changes to the Public Charge rule serve the dual purpose of protecting whites by restricting immigration while also decreasing demand for public services.

Liberal Chauvinistic Policies

In addition to policies that divide policy benefits by race, Trump has also sought to adopt liberal welfare chauvinistic policies that combine racial animus with limiting the overall size of the welfare state and government in health care. In the case of these policies, everyone loses policy benefits, though it disproportionately impacts racial minorities.

Trump has attempted to rein in the welfare state through his Medicaid policies, a public welfare-entitlement programme. Over time, Medicaid has expanded its eligibility criteria and the costs of the programme, which the ACA Medicaid expansion accelerated. The Medicaid expansion has had important effects, leading to decreased rates of uninsurance (Frean et al. 2017) and has been a powerful policy for reducing coverage disparities for racial and ethnic minorities (Buchmueller et al. 2016). Yet, state decisions to adopt the Medicaid expansion have been racialised, and failure to adopt the programme disproportionately harms ethnic minorities (Grogan and Park 2017; Michener 2017).

The Trump administration has retrenched Medicaid benefits, and the social safety net, by giving states unprecedented flexibility to administer the programme. This is evident in the use of work requirements in Medicaid. Work requirements have never been used in Medicaid prior to 2018 but have been popular with conservative state policymakers, with 20 states, all led by Republicans, having sought to implement them (Singer and Willison 2019). Work requirements connect eligibility with a programme with enrollee behaviour, in this case, demonstrating that an individual receiving Medicaid benefits were engaged in employment, education or caretaking activities (Centers for Medicare and Medicaid Services 2020). Failure to

meet these requirements would be disenrolled in the programme. Adoption of work requirements, not surprisingly, led to a sizable disenrollment in Medicaid (Sommers et al. 2019), targeting ethnic and racial minorities (Bagley and Savit 2018). Ultimately, the impact of this change has been limited by political and legal challenges. Trump undertook this flexibility through regulatory action, not legislation, and can be modified by a subsequent administration. The Courts have also largely blocked states from adopting work requirements, raising concerns about whether the changes meet the legislative goals of the Medicaid programme.

COVID-19 and Trump

Prior to COVID-19, the United States had reason to be confident in their ability to respond to an infectious disease outbreak. The country has a well-funded health system, clinical and epidemiological expertise and sound infrastructure (Johns Hopkins University, & Medicine 2020) (The White House 2019). Yet, the country has had the highest COVID death rates and cases globally. Trump's policy approach to COVID-19 and the failures of the United States have been shaped by PRR policies.

Trump has consistently framed the disease through xenophobic and racist language. The use of racist language, like calling the disease the 'Chinese Virus' and 'Kung Flu' (Itkowitz 2020) has been done to focus on the origination of the disease in China, but it has also contributed to a spike in racial hate crimes anti-Asian sentiment (Chen et al. 2020). Under the guise of COVID-19 protections, Trump also banned immigration into the United States, including foreign workers and individuals with temporary work visas (Sands and Alvarez 2020).

The use of authoritarianism in Trump's response to COVID-19 is mixed. Trump largely devolved authority for policymaking and adoption to states, which resulted in a patchwork approach to the US response to COVID-19. Yet, Trump also used the executive branch as a mechanism to provide or deny benefits to states and governors that opposed his policies. This included withholding personal protective equipment, testing supplies and therapeutics (DePillis et al. 2020).

Additionally, Trump's response to COVID-19 has been marked by an anti-science and anti-authority approach. Trump has remarked that the United States had the pandemic under control and that it would just magically disappear one day, going against public health experts in his administration (Goldberg 2020) (Oprysko 2020). The anti-science approach to COVID-19 policy was on display in the use of the anti-malarial drug hydroxychloroquine. Trump announced that he was taking the drug, which clinical trials indicated was ineffective for treating or preventing COVID-19 and presented serious side effects. When touting the drug, Trump often remarked that the public had little to lose in trying the drug regime. Trump's quackery extended beyond hydroxychloroquine. The president also suggested that researchers should look into the efficacy of injecting bleach or using UV rays to treat COVID-19. Promoting anti-science rhetoric undermines and obscures the

reality of deep health disparities, exacerbated by COVID-19, between whites and racial minorities.

Conclusions

While there is no formal PRR political party in the United States, Donald Trump as president and leader of the Republican Party has pursued PRR policies. Prior to his election, Trump often supported populist health policies, criticising his fellow Republicans, as well as business, medical and government elites as ignoring the needs of the people. Trump's preferred policies have shifted during his presidency, and he has been constrained by the political institutions and policy tension within his own political party.

Once elected, Trump has largely pursued policies more in step with the Republican Party. The most policy success that Trump has had has been the adoption of welfare and liberal chauvinistic policies. Trump's inclination towards nativism, authoritarianism and populism overlaps with his Republican colleagues in providing policy benefits to whites, limiting benefits for immigrants and minorities, retrenching the social safety net and reintroducing law and order policies for social problems. Trump is less policy focused than many of his presidential peers. Rather, his focus is on policy 'wins'. During the debate over repealing and replacing the ACA, he cared less about what was included in a bill rather that he had something to sign into law. Trump's PRR policy goals are shaped by what he can get the Republican Party to support.

So, where does the PRR in the United States go from here? Even with few concrete health policies enacted under the Trump administration, there are consequences going forward (Kettl 2017). The United States has a weak social safety net and no universal health care, a fact which exacerbated the country's response to COVID-19. Historically, benefits and eligibility for social welfare and health programmes in the United States have followed an incremental expansion. The Trump administration has adopted liberal chauvinistic policies which seek to incrementally reduce the size, spending and eligibility of the existing safety net. At the same time the Trump administration has focused health policy benefits on their core supporters, further discriminating against out-groups, primarily minorities and/or immigrants. The continuation of these policies will have long-term consequences in the promotion of and extension of healthcare disparities in the United States. Trump's welfare and liberal chauvinistic policies will exacerbate rates of the uninsured, barriers to accessing care, quality of health care and other deleterious disparities for minorities and immigrants (Barr 2014).

The results of the 2020 election paint a mixed picture of the future of PRR in the United States. Donald Trump lost to Democrat Joe Biden in his re-election attempt. This loss means that the most visible and powerful PRR policymaker will no longer be in a position of power in January 2021. Because so much of the PRR policies that Trump adopted were done through regulations and executive orders, President

Biden will be able to revoke many of those health policies. Yet, even while Trump lost his election, the results were not a repudiation of the Republican Party – Republicans gained seats in the House of Representatives and retained many vulnerable seats in the Senate. This raises the question of what hold Donald Trump, and his policy preferences, will have over Republicans going forward. There is likely to be internal conflict within the Republican Party on future policy and leadership. Trump remains the most visible member of their party and could continue to direct policy amongst elected officials. Importantly, Trump has provided a template which future political actors may emulate for their electoral goals, which would include PRR policy objectives. If Trump and his policy worldview take hold within one of the two major parties, it will have consequences far into the future. While Trump has had few concrete policy wins, his PRR policy perspectives could bloom with future administrations.

Summary Box

1. The United States has no formal populist radical right-wing party, rather it is political actors at the head of the party that drives policy.
2. Trump administration has had limited concrete policies enacted, due to tension within Republican Party, political institutions and party polarisation.
3. Populist radical right success has largely followed welfare and liberal chauvinistic policies.

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Ruling Through Chaos in Brazil: Bolsonaro's Authoritarian Agenda for Public Health

Carolina Alves Vestena

Introduction

Brazil has been making headlines not only because of the deforestation and the wildfires in the Amazonian rainforest but especially because of the economic crisis and the catastrophic management of the public health response to the COVID-19 pandemic. After a period of democratic recovery post-dictatorship and 13 years of a social democratic government of the Workers' Party, Brazil faces once more a highly authoritarian ruling project under President Jair Bolsonaro.

Bolsonaro's way of ruling is characterized by a profound personalism and prioritization of his own interests. Although he was elected in 2018 as a member of the Social Liberal Party (Partido Social Liberal – PSL), he left this party by the end of the first year of government due to an internal leadership crisis and alleged corruption affairs (Mazui and Rodrigues 2019). Party changes are not, however, a novelty in his political pathway. Since the beginning of his political career as a regional deputy in the State of Rio de Janeiro in 1989, Bolsonaro has been in eight different parties.[1] He remained member of the Christian Social Party for a long period (between 2005 and 2016) and, then, in 2016 moved again to the PSL for the elections of 2018. Currently he is striving to create a new party named "Alliance for

[1] Jair Bolsonaro was a member of the following parties during the respective periods: 1989–1993, PDS (Partido Democrático Social); 1993–1995, PPR (Partido Progressista Reformador); 1995–2003, PPB (Partido Progressista Brasileiro); 2003–2005, PFL (Partido da Frente Liberal); 2005–2005, PP (Partido Progressista); 2005–2016, PSC (Partido Social Cristão); 2016–2018, PSL (Partido Social Liberal); and 2019, Aliança Brasil (Mazui and Rodrigues 2019).

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Brazil" (Aliança pelo Brasil) (Langevin 2020).[2] All parties of which he was a member share a conservative ideology and a liberal view on the economy. The latter parties (PSC and PSL), however, present a clear alignment with the conservative evangelical groups, the ideas of law and order, and are marked by nationalism. Unlike the bipartisan regimes still operating in Europe and the United States, most of Brazilian parties have highly fluid programmatic ideologies and therefore political coalitions are formed on the ground of regional and personal interests (Valle 2018). Historical parties, which played a fundamental role fighting dictatorship and consequently built the basis of the current Brazilian political system, such as the Workers' Party (Partido dos Trabalhadores – PT) and the Brazilian Social Democratic Party (Partido da Social Democracia Brasileira – PSDB), are nowadays generally compelled to forge coalitions with smaller parties drawing upon minimal programmatic consensus. In this sense, Bolsonaro's leadership is not more than an aspect, even if an important one, of this crisis of political representation in Brazil.

Even though some political scientists are already observing a tendency of growing right-wing radicalization in the conservative side of the Brazilian political spectrum (Alves Cepêda 2018; Codato et al. 2018), it is still more accurate to talk about populist radical right (PRR) leadership in the current Brazilian case. Departing from this interpretation, I begin this chapter by briefly summarizing the central features of Bolsonaro's ruling style, especially pointing out the personalist, nationalist and authoritarian-neoliberal character of his positions and policies. In the second and third parts, I analyse the concrete health policies of his government, also stressing his denialist responses to the COVID-19 pandemic. The conclusion points to some prospects of his authoritarian and liberal project.

Jair Bolsonaro's Populist Radical Right Leadership

Cas Mudde's concept of populist radical right has already travelled from the Global North to South and is deeply involved in trying to understand the conservative turn of Latin American governments (Mudde 2013; Mudde and Kaltwasser 2013). The term *populist* has long been, in Latin America, attached to general progressive governments which tried – even if not free of contradiction – to promote some level of inclusion and redistribution policies in one of the most uneven regions of the world (Chueri 2018). The so-called left cycle in South America was marked by the implementation of social policies in the region which achieved an important improvement on the social and economic status of the population due to the access to social safety nets, work opportunities and other public services (Brand 2016, 11). Brazil was part of a laboratory for political alternatives against neoliberalism. The former populist leaders in Brazil since the end of the dictatorship made efforts to promote the

[2] The legal procedures are still under review by the Brazilian Federal Electoral Court (Langevin 2020).

integration of social groups historically left aside. During the last years of government of the Worker's Party, from 2003 to 2016, Brazil experienced a stable period of economic growth and implementation of social policies, which pursued the elimination of poverty and hunger, the expansion of universal health policies and the inclusion of vulnerable parts of the population in the school and university systems (Vestena 2017). Bolsonaro, who gained ground because of some of the shortcomings of this period, followed a completely contrary direction as his politics is based on a very exclusionary pattern (Chueri 2018). He bets on social division and the construction of a government based on the ideal of "us" and "them", which only accentuates Brazilian social divisions and polarization. The most striking aspect, however, is that his supporters are not being addressed by comprehensive public policies. Due to permanent austerity cuts in public spending, the major part of the population only has access to a private health system that is expensive and of little quality.

Bolsonaro's political positions and ideas are, thus, close to the ones of current European and North American radical right leaders: he strengthens social divisions, draws upon anti-establishment and antiscience discourses and promotes even more social exclusion of his adversaries (Chueri 2018; Lasco 2020). Falkenbach and Greer (2018, 16) point out that populist radical right leaders share nativist, authoritarian and populist predispositions, which are reflected in the design of excluding social and health policies. This way of ruling combines features of nationalism and neoliberalism and can be best named as liberal welfare chauvinism when health policies are at stake (Falkenbach and Greer 2018, 15). Bolsonaro's political trajectory and his ruling practices are marked by these three pillars. An analysis of his campaign programme and some of the concrete measures and positions of his government confirm this interpretation.

The central primacy of the Bolsonaro electoral campaign was a strict defence of nationalism with an important touch of religious conservatism. The slogan "Brazil above everything, God above everyone" (Brasil acima de tudo, Deus acima de todos) summarized these ideals (Almeida 2019a). Strongly supported by a radical right basis, Bolsonaro promised to represent only the interests of the so-called good citizens, the ones who were neither leftists, communists nor activists for feminist or LGBTQ+ politics (Costa 2018; Vestena 2020). Other direct enemies of the nation according to Bolsonaro are supporters of the Workers' Party, the members of social movements or leftist social organizations and indigenous people. Bolsonaro sees these groups as being directly responsible for the economic crisis, despite the fact that the country was already engulfed in the crisis since 2015 because of the internal recessive context and declining export incomes caused by the international crisis of commodity prices (Barros and Silva 2020). For Bolsonaro these "enemies" also personify the problems of corruption and criminality (Chueri 2018). An industry of fake news and disinformation accentuated the polarization in the country. At least since June 2013, and again after the mass demonstrations against the 2016 Olympic Games and the PT government, right-wing groups started to resort back to national symbols and thus prepared the floor for the emergence and success of radical right politicians (Almeida 2019b; Codato et al. 2018). This culminated not only with the

election of Bolsonaro as President but also with major victories of conservative coalitions around the country for the senate and state regional governments.

During the campaign and after being elected, Bolsonaro resorted to typical right-wing communication strategies, especially drawing on simplification, preferring common sense and firsthand opinions instead of scientific or technocratic arguments and in addition dramatizing every public speech or gathering in which he took part (Anderson 2019; Lasco 2020). Looking in detail, he steadily mobilizes his supporters against different enemies. Besides the ones mentioned before, he directs special animosity against indigenous people which are protected under the Brazilian Federal Constitution of 1988. Instead of reinforcing the centrality of these peoples for the maintenance of the Brazilian indigenous cultural heritage, Bolsonaro call them lazy and privileged, since they receive financial help from the state and occupy territories which could be better directed to the agribusiness and the extraction of minerals (Watson 2019). This discourse fits perfectly in Bolsonaro's strategy to keep the support of big-farms owners and is only one example of how he mobilizes structural racist predispositions still present in the Brazilian society for his purposes (Quadros and Madeira 2018).

Bolsonaro also does not hide his authoritarian and militarist preferences. Before and after his election, he mentioned more than once that only a military intervention would solve the corruption problems in Brazilian politics. Most of the time, the response to the pandemic is being managed by members of the military since two former Ministers of Health have been replaced after confrontations with Bolsonaro (Domingues 2020). His government is also supported by conservative social groups in the population: the agribusiness sector, evangelical neo-Pentecostal church affiliates and the representatives of the weapons industry. These three groups are represented in the Brazilian parliament and have supported Bolsonaro over the past years. This pool of interests converges in a radical right-wing project in matters of security and order, in the visions about the role of the so-called traditional family in society as well as in the economic focus on agriculture and the primary sector, as Quadros and Madeira (2018, 494ff.) point out.

Finally, the populist radical right leadership of Bolsonaro is also marked by a neoliberal economic perspective. In addition to his proximity with the agribusiness, he has also been advocating for cuts in strategic sectors responsible for the promotion of social services in matters of health, education and social security. Bolsonaro's Minister of the Economy, Paulo Guedes, was trained in Chile during the Pinochet dictatorship, symbolizes this intrinsic fusion of authoritarianism and neoliberal economic policy (Domingues 2020). Some scholars therefore resort to the terms austerity populism and authoritarian neoliberalism to describe concrete policies implemented along the first year of Bolsonaro's government (Bravo and Pelaez 2020; Ortega and Orsini 2020). These definitions are also in line with the concept of liberal welfare chauvinism, in the sense that concrete policies are exclusively designed for certain parts of the population, who, in reality, also have difficulties benefiting from them, since the Bolsonaro's project aims at diminishing the state capacities in order to foster more privatization and commodification of social services.

Bolsonaro's Exclusionary Health Policy Before the Pandemic

Bolsonaro's government started in a context of fiscal adjustment and attempts to contain the effects of the economic crisis which fiercely impacted Brazil after 2015. Michel Temer, a traditional politician of political centre-right, who was Dilma Rousseff's Vice President and took office after her impeachment in 2016, proposed a constitutional amendment that froze spending on health, education and other essential sectors until the year 2035 (Castro et al. 2019). After taking office, Bolsonaro did not change the course of this ongoing policy. On the contrary, he instigated further public spending cuts and began enforcing an even intense opening of the health services market to private initiatives and large international health conglomerates as happened during the former governments (Bravo and Pelaez 2020, 203). The Brazilian population is entitled the fundamental right to health (Art. 196 of the Brazilian Constitution) and the federal government, states and municipalities share competences and responsibility for the administration and funding of public health policies. The Brazilian health system is universal and financed by public taxes, and the municipalities act in the bottom of the system, reaching the population with direct measures and providing health care free of cost through the Universal Health System (Sistema Único de Saúde – SUS). The federal and states administrations have subsidiary responsibility by funding and coordinating national and regional policies within municipalities. A survey carried out in 2019 showed that more than 70% of the Brazilian population has no access to a supplementary private health insurance, although this market has been growing in Brazil in the last years (IBGE 2020).

Since Bolsonaro's election, privatization has increased, and the already precarious infrastructure for Brazilian health policy has been undermined even further (see Table 1). During the elections of 2018, he already made it clear that in his government he would promote a strong privatization wave across the healthcare system. Bolsonaro's election platform did not foresee any increase in spending for the Universal Health System, which is the cornerstone of Brazilian public health policies and also well-known around the world due its universal and free-of-charge character and capillarity around the whole country (Castro et al. 2019). Instead of strengthening the capacities of the SUS, he reduced payments for staff costs in public hospitals and in the Ministry of Health itself as part of a state reform. The curtailments reached services for impoverished communities located in less urbanized regions of the country as well as the Brazilian leading programme to combat sexually transmitted diseases and HIV (Bravo and Pelaez 2020, 201). Since the 90s, Brazil was seen as a reference regarding their response to the spread of the HIV. They introduced a universal programme to combat the virus as well as other related diseases thereby providing free treatment for the concerned population. By means of a decree, Bolsonaro downgraded the department in charge of the programme on combating HIV within the Health Ministry. This change had an important impact on the strategical role of the programme since the most vulnerable population has lost access to resources to combating HIV and other sexual diseases (Hacker et al. 2007).

Table 1 Examples of proposed and implemented health policies under Jair Bolsonaro

	Implemented	Coalition partner	Clientelistic nature	Outcome/ comments	Classification
Cuts in personal and reforms within the Health Ministry	Gradual cuts have been implemented since the pandemic outbreak	Bolsonaro's initiatives and measures are supported by small as well as relevant right and conservative parties of the Brazilian system. However, such support does not occur in a structured manner, i.e. through a coalition	No	Spending on health, education and other essential sectors is frozen until the year 2035	Austerity/ liberal chauvinism
Programme to promote reforms in public hospitals and cuts in public spending in the health sector	Yes		Yes	Reduction of spending in staff in public hospitals	Liberal chauvinism
Downgrading of the programme of HIV combat under the Health Ministry	Yes		No	By reframing the structure of the programme, actions and campaigns related to combating HIV were restricted	Antiscience
Reduction of taxation of tobacco and cigarettes	Due to the resistance of the civil society, the government withdrew the project		No	Prioritizing law-and-order policies over healthy policies	Antiscience Authoritarian
Reform of the "Mais Médicos Programme"	Yes		No	Recalling more than 8500 doctors. Various cities were thus left without proper health support	Liberal chauvinism
COVID-19 policy response	No		–	Bolsonaro's main strategy was to restrain the attempts of governors in their responses to the pandemic	Authoritarian politics/liberal chauvinism

The government also called a group of experts and policymakers to analyse the prospects of reducing the taxation of tobacco and cigarettes produced in Brazil with the goal of combating illegal trade and contraband (Decree n. 263, 23th March of

2019 of the National Security and Justice Ministry). This project is still matter of discussion and has been criticized by the civil society as well as by officers within the Ministry of Health, which are trying to oppose this change (Silva et al. 2019). The National Cancer Institute, one of the most relevant institutions on this matter in Brazil, started a campaign to demonstrate how this initiative could mean a considerable step back in prevention policies against lung cancer (INCA – Instituto Nacional de Câncer 2020). This initiative shows that, in fact, national security is more central than health policy within Bolsonaro's authoritarian agenda (NAPP Saúde 2019, 10).

Another important measure of the Bolsonaro government was a reform in the "Mais Médicos Programme", which meant the concrete exclusion of certain groups from access to health services. Started during the former Workers' Party ruling period, the programme aimed at bringing doctors to regions of the country where working and social conditions were less attractive in order to offset the immense lack of qualified health services for vulnerable populations. In the context of this project, the Brazilian government made an agreement with the Cuban government to send doctors from Cuba to the countryside in the north and northeast of Brazil, the most deficient regions as far as healthcare services are concerned. Bolsonaro, on the other hand, carried out a structural reformulation of the programme with the purpose of diminishing its political while enhancing its technical character (Bravo and Pelaez 2020, 202). Diminishing the political character meant sending a clear sign to Bolsonaro's conservative voter base that the collaboration with the socialist Cuban government would no longer be tolerated (NAPP Saúde 2019, 4). Concretely, the recall of more than 8500 doctors implied that several cities in the deep interior of Brazil were left without proper health support again. This change affected areas with a high percentage of indigenous population in the north of the country the most. In its editorial of 10 August 2019, the journal *The Lancet* stated that "Bolsonaro's presidency represents the most serious threat to Brazil's indigenous populations since the 1988 Constitution granted Indigenous people the right to exclusive use of their land" (Lancet 2019, 444). The destruction of the rainforest along with the lack of access to health care, which is caused by the absence of resources and staff, have been increasing divisions between supporters and symbolic adversaries of the government. The combination of these factors presents a concrete danger especially to the Brazilian Indigenous population.

The analysis of the measures the Bolsonaro's government presented before the pandemic outbreak shows the exclusionary character of his populist radical right political project (Mudde and Kaltwasser 2013).

Denialist Populist Response to the Pandemic: Enhancing the Chaos

The COVID-19 pandemic brought a new destructive energy to the Brazilian context, which was already falling apart due to continuous curtailments in health spending. The number of infections is immense, more than 6,000,000 people, as well as the fatal cases, which surpassed 160,000 people, second to only the United States by November 2020. This distressing scenario could have been mitigated if a committed strategy to combat the virus, using the capillary structure of the SUS, had been put in place. Bolsonaro's reaction to the pandemic outbreak was instead marked by the denial of the risks and a strategical spectacularization of the crisis. He acted as a typical populist radical right politician simplifying, dramatizing and reinforcing social polarization (Lasco 2020, 1).

Since the first confirmed case of COVID-19 in Brazil (February 25, 2020), Bolsonaro has played down the risks of the pandemic affirming it is nothing more than a "mild or little cold" or that Brazilians could withstand the virus since they are used to much worse sanitary conditions (Lasco 2020, 4). He also criticized the municipalities and regional governors for taking measures to control the number of infections as well as the international commotion as being exaggerated, ironically repelling the fear of the population. Bolsonaro also bet on the fact that social isolation in Brazil would be virtually impossible in many social constellations, especially in favelas or poor neighbourhoods. He mentioned more than once that all Brazilians will have contracted the virus at some point in time, so it would not make any sense to take the risk of damaging the economy to protect the population. Thus, he downplayed his responsibility by saying "so what" when asked about the measures to be taken to control the pandemic, as reported by the journal *The Lancet* in one its most commented editorials published on 5 May 2020 (Lancet 2020).

He continuously tried to pass the blame to regional governors for implementing restrictive measures that were hurting the economy, thereby presenting himself as committed to its recovery. At the beginning of the pandemic, Bolsonaro refused to wear a protection mask and took part in spontaneous rallies to talk with the population in the streets of Brasília and surrounding cities (Domingues 2020) while governors were trying to enlighten the population about the need to respect isolation measures for their own protection. One clear step to the further spectacularization and simplification of the crisis can be seen in his appearances on social media where he claimed at one point that the best treatment against the virus would be the use of hydroxychloroquine. After being infected by the virus himself, he used his recovery as an example of the efficiency of this drug, ignoring the fact that there is still ongoing scientific controversy on this matter (Ricard and Medeiros 2020). He resorted to his firsthand experience and common sense to sustain his positions. He also launched an online campaign – #BrazilCannotStop – urging Brazilians to go back to work, thereby making the economic recovery a national priority before the health of the population (Lasco 2020, 4).

Like Donald Trump in the United States, Bolsonaro also reproduced conspiracy theories about the onset of the virus and questioned the role of the World Health Organization (WHO). He sustained his position drawing on divisions: the nation against the global opponents (especially China and the WHO), the government's common sense against the knowledge of global health experts and the federal government against the restrictive measures of the regional governors. The latter have been strongly discredited, whether concerning the policies of social isolation or their efforts to build facilities to improve the conditions of dealing with the pandemic or even simple measures such as recommendations to wear masks. At a controversial ministerial meeting leaked to the press, Bolsonaro openly intimidated regional governors by declaring that he would undertake all possible efforts to investigate how public resources have been spent to combat the pandemic (Murakawa and Bitencourt 2020). The conservative governors of São Paulo and Rio Grande do Sul and the right-wing governor of Rio de Janeiro who supported Bolsonaro during the election confronted him and introduced measures to control the evolution of the pandemic. While the governors and local governments acted under their regional powers, Bolsonaro's misleading communicative campaign produced more uncertainty among the population (Ventura and Martins 2020). Very often he propagated new facts and also fake news that made the apocalyptic scenario of the Brazilian health crisis even worse (Ricard and Medeiros 2020). Only 2020, Bolsonaro fired two Ministers of Health, both of them coming from conservative alliances and parties, only because they meant to follow the required protocols in order to control the pandemic and openly criticized the not scientifically proven use of hydroxychloroquine as a treatment against the COVID-19 (Domingues 2020).

Liberal Welfare Chauvinism, Authoritarianism and Chaos as a Strategy

Considering that the pandemic began in 2020, only 1 year after Bolsonaro took office, the concrete response to the pandemic plays a central role for the analysis of the health policies implemented under his government. The main characteristic of his political agenda in this area has been the denial of the harmful effects of the SARS-CoV-2, which fatally affected more than 160,000 Brazilians by November 2020. The strategy of engendering chaos by discrediting and intimidating regional and local governments seemed to work to keep the support of the radical base which led to Bolsonaro's victory in 2018. Given last opinion poll results of 2020, this support does not seem to have lost momentum as they confirm that Bolsonaro's radical right-wing government has been able to increase its backing (Campos and Siqueira 2020). On the one hand, Bolsonaro keeps enhancing his legitimacy with an anti-corruption discourse, and on the other, he places the regional governors at the centre of responsibility for managing the response to the pandemic. By doing this,

Bolsonaro removes any threat to his political personality, which is already looking ahead to the upcoming national elections in 2022.

Bolsonaro's self-centred populist agenda also relies on the expansion of military power. Given his detachment from a structured party with skilled political staff, he mantain ties with military personnel to take over the management of public policies during the pandemic (Domingues 2020). This strategy reinforces his promilitary and authoritarian ideological position, which is so valuable to his conservative electoral support base. This authoritarian project is also tinged with a neoliberal dimension. The policies for the health sector were specifically marked by disinvestment and structural cuts to the Universal Health System over the last years. When the pandemic first hit Brazil, several experts predicted that the managerial capabilities developed during the last 40 years of structuration of the Universal Health System could be mobilized for an exemplary management of the response to the pandemic. The scarcity of resources after years of austerity coupled with a governmental strategy which intentionally aims at fomenting chaos drastically reduced the chances of success in dealing with the pandemic and may have long-term effects on the infrastructure involved in Brazilian health policies (Ventura and Martins 2020). Brazilian scholars are still trying to grasp the extent of these effects (Ventura et al. 2020). A certain hope, however, still remains in light of the SUS's own sedimented capacities and in the judicial disputes, which aim at ensuring the effectiveness of the right to health, a fundamental right guaranteed by the Brazilian Constitution of 1988, that are still pending.

Summary Box

1. Brazil's President Jair Bolsonaro is a populist radical right leader who follows an exclusionary pattern of social and health policies.
2. Austerity is the signature of his economic agenda, and drastic cuts have affected the Brazilian Universal Health System since Bolsonaro became President.
3. Bolsonaro simplified the severity of the COVID-19 pandemic and mobilized his responses to it as a stage to increase social division and polarization. His purpose was to surpass the crisis politically unscathed, thereby maintaining the support of his electoral base.

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An Authoritarian Reaction to COVID-19 in the Philippines: A Strong Commitment to Universal Health Care Combined with Violent Securitization

Wolfram Schaffar

Introduction

The presidency of Rodrigo Duterte marks a rupture in the political development of the Philippines. Prior to the elections, polls did not see him as a candidate likely to win. As a long-term mayor of the provincial town of Davao, he was mainly known for his zero tolerance for crime and his support for paramilitary groups like the Davao Death Squads (DDS) in his war on drugs. He drew on a nationalistic, anti-Western and anti-establishment rhetoric which, due to his unexpectedly bold and often brutal choice of words, found a broad echo in the social media. But equally important for his success was his social agenda and health politics, through which he also reached out to older, working-class Filipinos, including overseas Filipino workers (OFW). On this basis, he rose to unprecedented popularity and until early 2020 enjoyed the stable support of over 80% of the population. In this chapter, I will begin by explaining Duterte's rise to power and how he established himself as a populist radical right (PRR) politician through his reliance on authoritarian populism and on a specific policy of exclusion, portraying similarities with nativist exclusion (Falkenbach and Greer 2018). I will then look at the health policies, which – against this backdrop – can be characterized as welfare chauvinistic. The next section is devoted to the COVID-19 pandemic. Duterte took a proactive stance and implemented one of the world's longest and most restrictive lockdowns. Contrary to other PRR politicians, Duterte expanded the healthcare system considerably. I will argue that this response can still be analysed as a radicalization of his PRR political strategy, in so far as he relied on active social policy and a discourse of internal security. The radicalization of the authoritarian element of his

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strategy – the excessive use of violence and intimidation – makes any political balancing impossible and seems to erode the hitherto successful political strategy.

Political History of the Philippines and the Rise of Duterte

The Philippines under Rodrigo Duterte is a clear example of the erosion of democracy. Between 2016 and 2020, around 30,000 people died in extrajudicial killings, and international observers documented a systematic and incremental infringement of the freedom of press and continuous assaults on independent institutions like the Human Rights Commission. All this happened in a country that used to be the spearhead of democracy in the region.

In 1986, the long-term dictator Ferdinand Marcos was ousted by a broad middle-class-based social movement, in what became known as the People Power Revolution. Since then, the Philippines were seen as a successful example of democratization in the developing world. However, the liberal democratic system of the post-Marcos era can best be described in the words of Fraser (2017) as "progressive neoliberalism". It was characterized by the elite compromise of subscribing to the rule of law and liberal human rights and to a parliamentary process of political and social reforms. For a long time, this post-Marcos elite compromise stood in stark contrast to the revolutionary approaches taken by the Communist Party of the Philippines (CPP) and the National People's Army (NPA), both of which operated underground.

The core characteristics of Duterte's election campaign, his success and his ability to consolidate power were due to his strong anti-establishment rhetoric against the so-called Yellow forces – specifically the liberal powers that dominated Philippine politics in the post-Marcos era. One of Duterte's entry points into the political arena was his criticism of the establishment for their failure to deliver substantial social redistribution, pass a land reform or promote inclusive economic growth. On the contrary, inequality was rising, and the politics, based on liberal democratic parliamentarianism, effectively fostered an oligarchic system. From one election to the next, the demands of the poor for a more just and inclusive political system and for redistribution of wealth and power were put off.

Duterte: A PRR Politician?

The case of Rodrigo Duterte and how he fits into the populist radical right (PRR) framework developed by Cas Mudde (Mudde 2007) is not as clear-cut as some of the other cases in this book. Duterte's success in the 2016 presidential elections was part of a global wave of new authoritarianism, and it came as much as a surprise as the Brexit vote in Britain and the election of Donald Trump in the United States in the same year. Moreover, Duterte shares many commonalities with other leaders in

Southeast Asia and globally, especially with Thaksin Shinawatra, who was Prime Minister of Thailand between 2001 and 2006, or leaders like Recep Tayyip Erdoğan in Turkey – all of whom can be characterized as authoritarian populists (Demirović 2018; Bruff and Tansel 2019; Schaffar 2019). The most obvious parallel with Thaksin and Erdoğan is that they were newcomers to the political arena, coming from the neglected hinterland of their countries and representing both the marginalized population of the provinces and new rising factions of provincial entrepreneurs and businessmen. This is the basis on which they challenged the established economic and political elites in the capitals. In their rhetoric, they criticize the globally oriented, neoliberal economic agenda of the capital and demand that the state become more active and supportive and that rural and provincial areas become more developed.

In his election campaign in 2016, Duterte's rhetoric was explicitly anti-neoliberal with a populist appeal. His success rested on the combination of several elements: social policy, special attention to the OFW as his constituency and his trademark of systematic intimidation through political violence.

With regard to social policy, he promised to implement the long overdue social reforms. In order to give this claim credibility, he appointed both a peasant leader as Secretary of the Department of Agrarian Reform and a social activist as Secretary of the Department of Social Welfare and Development. In 2017, when the peace talks with the CPP and the NPA failed (Batac 2020), Duterte's alliance with the revolutionary left broke altogether, but his image of favouring a bold approach to social problems beyond parliamentary procedures remained.

As part of his social policy, Duterte systematically addressed the large constituency of Filipinos abroad – 11–12 million people, of which many are overseas Filipino workers (OFW). In the past, the leading strategy of overcoming economic crises was the encouragement of outward migration – a neoliberal, globalist strategy, which made the Philippines one of the most important sending countries for migrant workers (Rodriguez 2010). Apart from concrete institutional support, this promotion of outward migration was underpinned by a rhetoric of migrant workers as national heroes. Duterte systematically addressed the migrant community by promising better and more comprehensive state and diplomatic support in legal and social issues in their host countries. But he also broke with the idea that outward migration is a desirable development strategy and suggested that a more comprehensive solution to migrant workers' multiple concerns would be to increase the economic development within the Philippines, so that people would not be forced to go and work abroad in the first place.

To dismiss this programme as populist or as an incoherent basket of promises that are presented to the people as quick solutions to "complicated" problems does not do justice to Duterte's proposed policies. Most of the reform steps have been discussed extensively and were subject to intense political struggle over many years (Borras 2008; Leones and Moreno 2012; Obermann et al. 2018).

These various aspects of his political programme are bound together by a strong security discourse and are highly authoritarian resulting in an excessive use of political violence. Political violence and intimidation are Duterte's trademarks. In almost

every public appearance, he shows off as a strongman who can lead a strong executive. As proof of his determination, he showcases his performance as long-term mayor of Davao and the number of people shot dead in an enduring campaign against alleged drug dealers and criminals. During this "War on Drugs", the so-called Davao Death Squads (DDS) – paramilitary forces indirectly supported by Duterte – were responsible for hundreds of extralegal killings. After his election as president, this programme was applied to the national level (Thompson 2016). Meanwhile, the number of extrajudicial killings has risen to 30,000 cases, and these have been condemned by the highest levels of international human rights institutions as state crimes – albeit without any effect within the Philippines or on Duterte.

This violence has a political character. It is directed against the weak and poor sectors of society such as street children in Davao and alleged drug users and dealers. Increasingly, it is also directed against political enemies, including Duterte's former allies from the radical left – CPP, NLA and basically every oppositional force – who are being branded as "terrorists".

Several aspects qualify Duterte as a PRR politician. His strategy of "othering" and dehumanizing vulnerable groups or political opponents as "enemies of the society" in order to construct an imagined social cohesion is clearly populist. Prosecuting these groups as targets for his ultraviolent crusade to intimidate and consolidate his power proves his authoritarian character.

It is worthwhile noting, however, that the violence is not directed against groups, which are usually singled out by PRR politicians. Duterte does not rely on anti-Chinese, anti-Muslim or other ethnic or religious rhetoric – different from the Hungarian PRR, which essentially rests on anti-gypsy or anti-migrant mobilization. There is also no anti-LGBTIQ discourse, which plays a central role in the rhetoric of Jair Bolsonaro in Brazil or within Poland's PiS government. In so far it is difficult to fit Duterte in the frame of nativism, as he does not support "a xenophobic form of nationalism in which a mono-cultural nation-state is the ideal and all non-natives (i.e., aliens) are perceived as a threat to the nation" (Mudde 2014). However, Duterte perceives certain parts of the population (drug dealers, etc.) as threats to the nation, so that his political violence is functionally equivalent to the nativist agenda.

Duterte's Health Policies

Healthcare politics played an important role within Duterte's political agenda, thereby following his rationale of anti-neoliberalism and populism (Table 1). In February 2019, he signed the Universal Health Care Bill (Republic Act No. 11223), which arguably put an end to 50 years of political struggle over health reform. Due to the existence of several parallel systems and a strong presence of the private sector, diverging interests effectively jeopardized any attempt of a comprehensive reform for a long time (Bredenkamp and Buisman 2015). The new bill was hailed by the WHO as a breakthrough and as the first of its kind in the Western Pacific

Table 1 Duterte's health policies

PRR health policy	Implemented	Outcome/comments	Classification
Universal Health Care Bill (Republic Act No. 11223 of 2019)	Yes	Introduction of a de-commodifying and universal healthcare system, based on state-regulated health insurance (PhilHealth) and a tax-funded, state-organized network of public clinics – so-called local government unit (LGU) hospitals	Social democratic universalism
Nationwide establishment of Malasakit Centers (Republic Act No. 11463 of 2019)	Yes	Malasakit Centers provide health assistance, including hospital financial assistance, funeral/burial assistance and pharmaceutical assistance	Welfare chauvinism
(On the local level: Lingap Center of Davao City and Executive Order No. 7, 2018)		The Lingap Center of Davao City officially excluded drug dealers, terrorists and members of the NLA from the services	
Deployment ban for health workers and medical staff	Yes	Stopped the deployment of 14 categories of healthcare professionals abroad	"Welfare nationalism"
Philippine Overseas Employment Administration (Governing Board Resolution No. 9, Series of 2020)	Enforced between April 2, 2020. The ban modified and partly lifted end of November 2020		

(WHO 2019). However, the reform really follows the trend of the health reforms in Thailand under Thaksin Shinawatra in 2003 and the debates in Indonesia since 2010.

The parallels to Thaksin are especially apparent. In 2000, Thaksin asked for advice from NGOs and social movement activists for his electoral campaign and took up the demand for a comprehensive health system. His plan to set up a tax-funded Universal Coverage Scheme was heavily criticized as financially unsustainable, and development agencies as well as neoliberal political elites labelled it an empty populist promise (Pye and Schaffar 2008). But during his first term in office, he not only managed to set up the scheme, but was even able to include the treatment of HIV/AIDS – one of the most serious health issues in Thailand (Schaffar 2015). The Universal Health Scheme resulted in his unprecedented popularity, which became the basis of all his and his allies' subsequent electoral successes (Schaffar 2015). After Thaksin had shown the feasibility and popularity of health reforms, the issue became a central topic throughout Southeast Asia and featured prominently in the electoral campaigns in Indonesia (Aspinall 2014).

As in the Thai example, the Philippine healthcare system can be characterized as de-commodifying and universal. In the categories of Esping-Andersen (1990), it can be seen as a social-democratic system in so far as it relies on a tax-funded

state-organized network of public clinics, so called local government unit (LGU) hospitals, which provide health services to every citizen irrespective of their income or health status. It is mixed with elements of the conservative, corporatist type in so far as costs are covered through membership in a state-regulated health insurance (PhilHealth), which partly rests on formal working contracts and tripartite contributions. The WHO compares the system to the United Kingdoms' National Health Service and China's model of developed health service provision (WHO 2019). From a budgetary perspective, the reform is ambitious: The Ministry of Health announced that it would need to spend 257 billion pesos (4.5 billion euro) to implement the Universal Health Care in its first year. The most important tax sources are sin taxes, tobacco and alcohol taxes, of which 85% are channelled into the health system; 80% of general taxes would be used for enhancing Universal Health Coverage and 20% for the maintenance and improvement of health facilities (Obermann et al. 2018; Mendoza 2020).

Although the UHC can be characterized as social-democratic and inclusive, Duterte's version bears traces of social exclusion. In addition to the UHC system, Duterte established social assistance centres (Malasakit Centers), which provide financial assistance for indigent patients. In March 2018, an amendment to the executive order on the centre in Davao city (Lingap Center) specified that drug users, members of the NLA and others who fall under the category of terrorists are not eligible for any assistance (Mellejor 2018). In 2019, the senator and special assistant to Duterte in charge of the healthcare system, Christopher Lawrence "Bong" Go, came out with a statement that drug convicts should rather be killed in the hospitals with poisonous injections (Agonoy 2019) – echoing Duterte's War on Drugs rhetoric. On the basis of this discourse, Duterte's health policies can also be categorized as a type of welfare chauvinism. Although it does not exclude people on the basis of nationality, it does so on political sympathies and on the idea of "harmful subjects" – such as alleged drug dealers and terrorists.

The dehumanizing rhetoric and actual political violence are beyond description. However, in their campaigns against Duterte, civil society groups do not only focus on his anti-human rights record but also criticize his politics generally as being neoliberal (Focus 2017, 2019). This coincides with the literature's criticism of authoritarian populism in general, which argues that leaders like Orbán and Erdoğan are really neoliberalists in disguise – and authoritarian populism constitutes a third wave of neoliberalism (Demirović 2018; Bruff and Tansel 2019). I argue that this is an inadequate description. It is true that there are serious flaws within the Universal Health Care programme. Apart from the exclusions discussed earlier, which carries Duterte's welfare chauvinist signature, there are serious cases of corruption (Reyes 2020; Focus on the Global South 2020), in which 15 billion pesos (266 million euro) of PhilHealth funds were pocketed by members of the government corporation's executive committee. To many of Duterte's supporters, these issues are negligible problems. They are organized in groups with names like Diehard Duterte Supporters, the abbreviation of which matches that of Davao Death Squads (DDS). This naming expresses the open support of Duterte's PRR agenda, including his excessive use of violence.

Against this backdrop, and the fact that the healthcare act is real, any attempt to unmask Duterte as neoliberal is therefore missing the point. This is why in the mid-term elections in May 2019 he won the vast majority of votes. Even in January 2020, he enjoyed more than 80% approval – the highest support of any president in the Philippines.

Duterte and the Coronavirus

The picture of COVID-19 in Southeast Asia is very fragmented. The numbers of recorded deaths, 1.625 in Myanmar, 138 in Malaysia, 60 in Thailand, 35 in Vietnam and 0 in Cambodia and Laos, first and foremost suggest that the statistics are not reliable. Compared with their neighbouring countries, though, 7.862 cases of COVID-19-related deaths in the Philippines appear to be relatively high. However, on a global scale, the Philippine mortality rate of 1.7% and 4.77 deaths per 100 K capita can count as very moderate and is considerably lower than in most European countries, let alone in the United States and Latin American countries.

At the beginning of the pandemic, Duterte joined the choir of PRR denialists – Bolsonaro in Brazil, Erdoğan in Turkey and Trump in the United States. Duterte downplayed the threat and subordinated his policy to his geopolitical strategy of re-approaching China. In late January, for example, Duterte's health secretary admitted that Chinese tourists could not be banned from entering the country, even after COVID-19 became a public health threat so as not to ruin diplomatic relations with China (Bello 2020).

In March of 2020, however, Duterte took a U-turn and started what can be described as a hyperactive approach, which – following his general political strategy – was designed and implemented in a highly authoritarian way and was accompanied by an excessive use of political violence.

The Lockdown and Its Implementation

By mid-March, Duterte implemented a comprehensive and strict lockdown. Within only 48 h, the entire island of Luzon, including Metro Manila, with more than 30 million people were sealed off. After 2 months of a strict enhanced community quarantine (ECQ), where leaving the house was forbidden for everyone, the lockdown was modified according to the infection numbers of the area. Highly affected zones stayed under modified ECQ, with only slightly relaxed rules compared to the initial ECQ. Zones with fewer COVID-19 cases came under a general community quarantine (GCQ) or under a modified GCQ, where mask-wearing and physical distancing were required but moving around was permitted.

The strict lockdown in March was accompanied by the Bayanihan to Heal as One Act granting financial assistance of 5000 to 8000 pesos (88–140 euro) for 2 months

for families in need as well as livelihood assistance grants to the low-income households affected by the enhanced community quarantine (ECQ). Allegedly 18 million families benefitted from the programme.

In line with Duterte's political rationale, the lockdown came with highly authoritarian measures. At the beginning of April, he publicly gave the police the order to kill people that were not obeying lockdown orders (Tomacruz 2020). The threat was directed at the general population, but – after some demonstrations against the poorly implemented lockdown and the resulting chaos – "leftists" were explicitly addressed and targeted by Duterte's threats (Tomacruz 2020).

On April 5, a few days after the order, a 63-year-old man who refused to wear a mask became the first victim after being shot dead by police. In addition to the new COVID-19-related order, a report by Human Rights Watch found that according to the government's own statistics, the police killed 50% more people between April and July 2020 than they did in the previous 4-month period in its ongoing war on drugs (Conde 2020).

The Impact of COVID-19 on the Medical System

Despite the recent expansion under the Universal Health Care Act, the Philippine medical system was not prepared for a crisis like the corona pandemic (Quintos 2020). There is 1 medical doctor for 40,000 people and 1500 intensive care units with ventilators for a population of 105 million inhabitants – compared to Germany, with 1 doctor per 300 people and 30,000 intensive care units with ventilators (Phua et al. 2020). Yet, this state of unpreparedness was not different from countries like Germany, where the healthcare system was subjected to continuous neoliberal restructuring, which led to bad working conditions, underpayment and consequently a constant lack of qualified personal – especially nurses. To solve this problem, in August 2019, the German minister of health had signed a special agreement with the Philippines, which facilitated the recruitment and migration of Philippine medical staff to Germany.

In the Philippines, the COVID-19 crisis revealed a severe shortage of personnel as well. Against this backdrop, on April 2, Duterte ordered the Philippine Overseas Employment Administration to temporarily suspend the deployment of healthcare workers, in order to prioritize human resource allocation in the Philippine's healthcare system (Tomacruz and Rey 2020). The resolution, which was partially lifted end of November 2020 (Aljazeera 2020b), emphasized that it was of utmost national interest to prepare health personnel to replace, substitute or reinforce healthcare workers currently working in the local healthcare facilities. In addition to the emergency hiring of health personnel on 3-month service contracts, the government offered an allowance of P500/day (9 euro) as compensation for medical staff volunteering (Tomacruz and Rey 2020). This deployment ban, in addition to the low salary and low daily allowance, led to an outcry and was harshly criticized as forced servitude and depriving overseas Filipino workers of their freedom of movement

and right to work. However, the deployment ban fit into Duterte's overall strategy of moving away from labour migration as a development strategy in favour of a more sustainable domestic economic development – again implemented in an authoritarian way. In so far as it supports the expansion of the Universal Health Care programme, this step can be categorized as social democratic universalism – yet with an isolationist, nationalist flavour.

During the lockdown, the Duterte administration also used the restriction on assembly to curb the freedom of expression. The biggest TV channel ABS-CBN had to shut down because its license was not extended. In June, a court found Maria Ressa, founder and head of the online news site *Rappler*, guilty of libel and sentenced to 6 years in jail (Gomez and Favila 2020). The most serious move, however, was the signing of a new antiterror bill in June of 2020, which gave the executive far-reaching competences (Bernardo 2020).

None of the authoritarian measures implemented by Duterte brought a long-term sustainable solution to the pandemic. When the quarantine was lifted in June, it had been the longest continuous lockdown in the world leaving the Philippine economy severely damaged with a drastic increase in unemployment from 45% compared to 5% in 2019. Unfortunately, soon after the lockdown was lifted, the number of new infections began increasing again. On August 4, 80 associations representing 80,000 doctors and a million nurses issued an open letter and called on Duterte to toughen restrictions again in order to curb the spread of the virus and prevent the medical system from collapsing (Westfall 2020). Duterte reacted promptly and, again, put the entire Metro Manila and the neighbouring provinces under general community quarantine and modified enhanced community quarantine. The new quarantine affected 25 million people and has been continuously extended until end of September. Moreover, Duterte ordered the police to go on a house-to-house search to apprehend "non-self-isolating" COVID-19-positive patients (Bello 2020).

Duterte also approved the hiring of 10,000 medical professionals to support the current workforce and granted additional benefits for healthcare workers treating COVID-19 patients. But as quickly as Duterte's reaction was, it – again – came with an authoritarian tirade against the medical staff, who had dared to issue the open letter in the first place. He accused them furiously of plotting a revolution and threatened that if they ruin the success of Duterte's COVID-19 measures, it will mean that all patients will be killed (Aljazeera 2020a).

Conclusion

Duterte can be described as an authoritarian populist who came to power with a specific mix: a strong and credible commitment to health and social policies coupled with an extreme level of political violence used to implement his policies. His greatest health reform came in the form of a Universal Health Care Bill, which considerably enhanced access to medical services. While this bill seemingly granted all Filipino's access to health care, drug dealers and persons labelled as terrorists

were excluded from services through informal regulations giving the Bill a welfare chauvinistic character. In some of the support centres complementing the Universal Health Bill, this chauvinistic exclusion was even formalized.

The measures taken by Duterte to combat the corona pandemic can be characterized as proactive, even hyperactive. They were very different from the continued denialism of Bolsonaro or Trump. He imposed the longest and strictest lockdown worldwide. At the same time, he abruptly banned migrant health workers and medical staff from leaving the country in order to prevent shortages in the domestic hospitals.

Duterte's politics to expand the health system were continued and even accelerated during the COVID-19 pandemic. This is the major difference between Duterte and other PRR leaders, who are closely associated with a reduction in welfare generosity – either through welfare chauvinism or liberal chauvinism. However, Duterte's obsession with authoritarianism and his belief that any expression of opposition is sabotage backfired and jeopardized the entire policy process. At the time of writing, Duterte's strategy to contain the pandemic seems to have failed completely. The infection numbers are rising, and the government was forced to impose another lockdown without having enough funds to help people in need of financial assistance. One of Duterte's major constituencies – the overseas Filipino workers – has been alienated as a result of the continued deployment ban of medical workers, and inside the country the soaring rates of unemployment are pushing more and more people into poverty.

Summary Box

1. Rodrigo Duterte is a PRR leader, whose rise to power in 2016 marks a steep decline of democracy in the Philippines. His electoral victory and sustained popularity rests on active social policies and the establishment of social assistance centres (Malasakit Centers).
2. Duterte's policies are combined with a strong internal security discourse and the excessive use of political violence. The major targets of Duterte's violence – alleged drug users and dealers and members of the radical left – are also increasingly excluded from health benefits, giving his policies a welfare chauvinistic flair.
3. Duterte first joined the group of PRR corona denialists. But in March 2020 he took a U-turn and implemented strict countermeasures, imposing the longest and strictest lockdown worldwide as well as a deployment ban for migrant health workers and medical staff.
4. Despite his welfare expansion, Duterte's obsession with authoritarianism backfired and led to a failure of his strategy. Within Southeast Asia, the Philippines is the country with the second highest infection numbers and COVID-19-related deaths.

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Conclusion

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In the Introduction, we marvelled at the fact that a topic at the nexus of two of the world's biggest scholarly literatures – health and the populist radical right (PRR) – could be discussed in a mere handful of publications. Contributors to this volume have examined the impact of the PRR on health, testing consistent hypotheses about the PRR's impact on the generosity and exclusivity of health systems as well as the propensity of the PRR to antiscientific behaviour or rhetoric and the propensity of the PRR to clientelism. We found consistencies that this chapter will discuss, but before we examine those, it might pay to ask why there seems to be so little original research on the intersection of a much-studied political force with a much-studied policy area.

The Viewpoint from an Island: The PRR, Health, and the Pandemic

As mentioned in the introduction, the floods of scholarly literature on populism, health, and the pandemic somehow left an island at the point where they should interconnect research on populism and health policy. Anybody travelling in health policy or public health circles since at least 2016 has seen that this is not for lack of interested people. It is easy and useful to look at the dynamics of scholarly research and publication in order to start to understand the problem. There is a longstanding

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lack of connection between political science research and health research (Greer 2017; Fafard and Cassola 2020; Gagnon et al. 2017; de Leeuw et al. 2014; Greer et al. 2017) despite the efforts of journals such as the *Journal of Health Politics, Policy and Law* and *Health Economics, Policy and Law* as well as various disciplinary publishers and journals that are open to such research.

Political Science, Public Health, and the PRR

On the political science side, in most western countries, political science as a discipline has an aversion to complex policy questions, except when they produce useful data for inferential strategies that purport to get at broader questions. For every article we found about the impact of parties of any kind on policy, we could find a hundred on electoral behaviour. This pattern, of focusing on parties, voters, and politicians and avoiding policy detail, is common to other topics (Greer and Löblovà 2016).

In a sense it is intrinsic to the definition of the field if political science is about the operation of political systems, for dividing the operation of the political system into policy fields would make it hard to claim that there is a science of politics rather than a science of the politics of health, of education, of arts, of tram stops, of fisheries management, or of any other of the many issues of public policy. Given that one government will deal with all of these, the burden of proof should indeed be on those who would divide the phenomenon of politics in any one country, or comparative politics theory, by policy area. The politics of, for example, health, the military, and transport in any given country might differ, but the characteristics of the political system are likely to be as or more important than any distinctiveness of policy fields. There is no separate head of government for any given area of specialist government, and ministers are in generalist political careers rather than specialist ones (Fox 2017). So political scientists have a point when they refrain from constricting their studies of a topic (populism, parties, voting behaviour) to a concrete field, an argument reinforced by the difficulties of understanding and having credibility in both political science and a policy field.

To avoid discussing the impact of politics on policies nonetheless undermines the quality of research on politics. There is a great deal of research, much of it disjointed, on various feedback loops between policy and politics, but a bias towards studying the political system means that the bulk of published literature in political science privileges politics over policy – with the result that we know much more about determinants of PRR voting than we do about the impact of PRR parties on those determinants. Those determinants include health policy, which is a way to win or lose votes.

That public policy frequently influences voters is unarguable even if there are many cases in which something else (race, ethnicity, religion, etc.) also matters – perhaps more so. Insofar as votes matter, public dissatisfaction with public services can matter. It follows that one key reason to be interested in health policy is that

insofar as PRR politicians are responsible for any policy area, including health, their performance in the field can strengthen or weaken their party – whether by delivery of good-quality and accessible services, or by turning the healthcare system to clientelistic ends that serve broader purposes (as in Hungary). Thus, for example, the PRR politician Boris Johnson ascended to lead the Conservative Party and the United Kingdom in large part on a promise that Brexit would strengthen the NHS; the manifest under-resourcing of the English NHS, made clear by COVID-19, might well turn out to undermine his party and government in polls.

Even in the case of democratic backsliding, which is strongly associated with PRR parties (Diamond 2020), policy performance can matter. Democratic backsliding in the modern era, and in middle- or higher-income countries, is relatively slow. The authoritarianism of Viktor Orbán's Hungary, with its legalism and veneer of democracy, is more the model than the older concept of a sudden coup. It seems to take at least two elections for a government to make democratic backsliding essentially unstoppable. In that time, there is an opportunity for better or worse policy performance to matter. Poor policy performance can accelerate antidemocratic moves as when COVID-19 was a pretext for democratic backsliding in many countries. It can also undermine the performance legitimacy of governments that cannot contain the pandemic, compensate with social policy measures that support public health and the economy (Greer et al. 2020), and make popular distributional decisions as they manage its effects. Populations that are accustomed to good health care do not respond well to healthcare system failures, as perhaps we see best in the difficulties faced by politicians who tried to dismantle, or manage, post-communist healthcare systems (Haggard and Kaufman 2008).

In other words, while political scientists might be reluctant to invest in research on specific, complex, policy fields that might not produce broadly generalizable findings, the payoffs might be dramatic if it allows political science research to address basic questions – such as whether parties matter (Rose 1984; Schmidt 2015) and whether and how public policies in areas such as health change electoral and political outcomes.

Public Health and PRR Politics

Public health and health policy literature, meanwhile, has extensive literature of a strangely apolitical tone, and extensive literature and commentary of a very political tone, and not much that manages to contribute theoretically productive mid-level theory (Merton 1968; Greer et al. 2018).

Thus, on one hand we have many articles about causes of avoidable morbidity and mortality whose policy and political implications must be inferred by the reader. In some cases, it is clear that the abstruseness or occlusion of political relevance is a disciplinary strategy to preserve autonomy and credibility of the sort that sociologists of knowledge understand well (Fourcade 2010; Bourdieu 1988, 1989). On the other hand, we have strong opinions in Commentary and Editorial sections of public

health and medical journals, some of which have long crusading histories, and entire subfields of public health literature on particular topics in politics (such as tobacco politics) that are substantial and highly normative research enterprises with substantial contributions that political scientists often ignore. They coexist with publications of often frustrating vagueness that, for example, underspecify "neoliberalism" and then use it to explain much more concrete, researchable, and contingent health outcomes. This is despite the fact that neoliberalism can be investigated in itself (Offer and Söderberg 2016; Ban 2016; Slobodian 2018) and as a component of health policy and politics (Lynch 2020; Greer 2020).

This is not a particularly new tension in the history of public health; while we cannot date the insight back with any reliability, we can invoke Rudolf Virchow's analysis of typhus in nineteenth-century Upper Silesia, which after exhaustive epidemiological analysis concluded that inequality was the problem (Taylor and Rieger 1985; Greer et al. 2021). Virchow quite reasonably drew the conclusion that "medicine is a social science, and politics nothing but medicine at a larger scale", a conclusion whose ambiguities and big implications have been woven throughout the history of western public health (Mackenbach 2009). The inequalities that are now captured by, for example, fundamental causes theory (Phelan and Link 2015), change slowly, and change still more slowly under the conditions of neoliberal political economies (Schrecker and Bambra 2015; Bambra 2019).

On the other hand, they seem amenable to interventions, such as Virchow's focus on education and empowerment, which means that a great deal of politically engaged public health literature focuses on very small-scale interventions and effects. Between large-scale political economy and small-scale interventions, the public health literature has often shown weaknesses. Those are exactly the areas – the analysis of how politics and policies work in particular places – that political science can best address, for it is a social science of the middle range.

The broader politics of public health, though, are not always aligned with democracy or empowerment; public health as a scholarly discipline and field of activity grew up in the service of states, which makes it no accident that in most countries it has a bureaucratic culture as well as a history of involvement in projects such as eugenics. Authoritarian regimes do sometimes produce good public health, for various reasons, and even in regimes that are basically hostile to public health, building public health policies might mean drawing on coercion (Greer and Mätzke 2012).

Between Political Science and Public Health

The somewhat amorphous field of public health produces an interesting if sometimes frustrating mixture of big theory, campaigning, science, and bureaucratic report and often is weak on middle-range theories. Political science has a huge fund of middle-range theories, from studies of voting behaviour to party manifestos, that could remedy the gap. In this book, we contributed to the reduction of the gap by focusing on one issue of great relevance to both fields: the impact of the PRR on

health. If you are interested in health, then the existence a party family with a consistent effect on health is important, whether to the exclusiveness of benefits, the role of science or the quality of public administration and its resistance to clientelism.

In other words, this book should show not just the interaction of politics and health, but also the advantages of bringing together different disciplinary outlooks. What did we learn?

Findings

The Introduction suggested a series of hypotheses drawn from the extensive literature on populism as well as the small literature on the PRR and health. Four of these hypotheses suggested a four-cell of results from PRR party influence in government (Table 1). Table 2 summarizes the findings with regard to hypotheses 1–6, originally presented in Table 2 in the Introduction.

When looking at the six hypotheses outlined in the Introduction (see Table 2), it has become clear that all except for welfare populism have some validity; however, some have proven to be more dominant and applicable to a diverse set of PRR politicians than others.

While welfare populism was a dominant theme during Jörg Haider's reign over the FPÖ in Austria, for example, it never produced any health policies. Similarly, welfare populism was dominant during PiS's first term in government but turned into cultural chauvinism shortly thereafter. The two additional hypotheses addressed the relationship between the PRR and *science* and the PRR and *clientelism*. In these cases, the story was less consistent, but we found a tendency by PRR leaders to be uninterested in science and sometimes overtly anti-scientific as well as prone to clientelism and corruption- not in any hazy group sense that might be confused with normal democratic politics, but specifically prone to corruption and clientelism. While we cannot, from the evidence in this book, conclude that PRR parties are more clientelistic or anti-scientific than other kinds of parties, the evidence is suggestive.

Table 1 Welfare politics

	Increase or maintain access to benefits	Reduce access to benefits
Increase or maintain generosity of benefits	Social democratic universalism	Welfare chauvinism
Decrease generosity of benefits	Liberal universalism	Liberal chauvinism

Source: authors

Table 2 Summary of findings

Hypotheses	Categorization	Country case
1. Increase welfare generosity and exclusivity	Welfare chauvinism	**Austria** (e-card with photo ID)
		The Netherlands (elder care reform)
		Italy (Salvini Decree)
		United Kingdom (immigrant health surcharge)
		The United States (tobacco regulations)
		The Philippines (increasing, but mostly informal, exclusion of drug users and "terrorists" from services)
		Germany (pharmaceutical notification mandate, export bans, revision of rebate contracts; pharmaceutical import quotas)
2. Decrease welfare generosity and increase exclusivity	Liberal chauvinism	**Austria** (health insurance merger)
		Hungary (National Budget Acts)
		The United States (Medicaid block grant)
		Brazil (downgrading of the programme for HIV combat)
3. Decrease welfare generosity	Conservative	**The United States** (repeal and replace ACA)
		Brazil (budget cuts of Health Ministry and the reform of the "Mais Médicos Programme")
		Germany (restricting EU online pharmacy access)
4. Increase welfare generosity for the common citizen; generally antiwelfare state	Welfare populism	**The Philippines** (Universal Health Bill, ban on deployment of health workers for the sake of national supply)
		Germany (pharmaceutical notification mandate, export bans, revision of rebate contracts; accreditation standards for foreign healthcare professionals)
5. Administration of welfare programmes become more clientelist under PRR	Clientelism	**Austria** (private hospital financing reform)
		Hungary (nationalized tobacco sales)
6a. PRR are more likely to act on arguments with less scientific validity	Anti-science	6a.
		Austria (COVID-19, anti-vaccination, renege on smoking ban)
		Italy (COVID-19, anti-vaccination)
		The United Kingdom (COVID-19)
		The United States (COVID-19)
		Brazil (COVID-19)
		Germany (COVID-19)
6b. PRR are more likely to undermine science by starving education and research		6b.
		The United States (defunding health research and public health institutions)
		Brazil (spending on health and education frozen until 2035)

Source: authors

Conclusions and Future Research

This book has sought to bring together political science and health research. Its focus is on what is already known – so that we do not reinvent the wheel or misdirect resources – and on what health researchers and their expertise in particular could contribute to a broader understanding across the social sciences of the phenomenon. We drew some additional conclusions about possible directions.

Don't Study Populism

The problem with populism as an object of study is its thin-centredness. *Grosso modo*, there is little we can say about Jobbik, Fidesz, Syriza, Evo Morales, Donald Trump, Hugo Chávez, Narendra Modi, Juan Perón, William Jennings Bryan, and Marine Le Pen and reasonable arguments that the inclusion of any given member on that list is itself misconceived. In terms of health policy, there is almost nothing at all. Existing analyses of populism have done us the service of essentially framing it as a thin-centred style of politics rooted in antielitism and anti-pluralism. We must go beyond that and break down the notion of populism rather than trying to generalize from the English Defence League to the Conservative Party, let alone Syriza or the Five Star Movement. This problem is especially challenging in a policy area such as health, since populist behaviour alone tells us little about policy. Populism is a pejorative term for most, a badge of honour for a few, and illuminating about policy for almost none, so it is especially helpful to add definitional characteristics.

Leave the Poor Voters Alone

There are limits to the usefulness of studies of voting behaviour, whether through electoral and survey analysis or psychological experiment. There is an abundant literature on the triggers of animosity against out-groups and on the structural characteristics of societies and places that produce in-groups and out-groups (Craig et al. 2018; Federico and Malka 2018; Mutz 2018). Some of the effort and expenditure on survey experiments and public opinion surveys might profitably be redirected towards more studies of elite behaviour and the impact of policies – on opinion but also on how policies and politics including the PRR structure future political competition and policy options. For example, what are the effects on population health and behaviour of life in a country that has just voted for the populist radical right?

Do Study Political Parties and Coalitions

Voters' authoritarianism, racial animosity, in-group pride, and out-group prejudice are all, as survey research has shown, susceptible to activation by political and media cues. Going deeper, political and media cues can help to produce powerful

framing effects that allow voters to make sense of the world in a particular way (Cramer 2016). Political parties, and to a variable and generally lesser extent interest groups, cue their followers and set agendas. Even if some combination of racial, xenophobic, or other animosity and economic anxiety creates tinder, the flame comes from somewhere. And even if we assume *somebody* would eventually set the fire, it matters considerably whether that somebody is a marginal political actor in an organizationally weak party such as UKIP or a leader of a powerful party in government such as Boris Johnson.

There are two factors shaping the partisan effect of populism that deserve more attention. All of the PRR parties that have entered government in post-war Europe were in coalition of some sort. This creates some methodological challenges but highlights the impact of voting rules and coalition politics on policy. We do not really know what would happen were the PRR to gain office in a more majoritarian system, though the strong PRR currents in the contemporary UK and US ruling parties, and the experiences of Brazil and the Philippines, offer some signs. Likewise, the impact of federalism on muting or encouraging PRR parties is unclear, and strong counterfactual analysis would probably be needed. The impact of subnational PRR party governance, remarkably, has not been the subject of research despite their presence in government in regions of Italy, Switzerland, and Austria.

Do Study Media

Recent elections have shown the extent to which political communications have changed in politically consequential ways. Issues as diverse as the importance of social media platforms, the development of new media sources, the apparent openness to manipulation of social media as well as the increasing flow and acceptance of fake news within the mainstream media, and the extent to which there are even shared understandings of the political agenda have increased the significance of the media (Benkler et al. 2018). This is an area where research into health communication (e.g. on anti-vaccine movements) could easily cross-fertilize and it already has successfully done so in the hands of some scholars (Nyhan et al. 2013, 2014; Fowler and Gollust 2015; Gollust et al. 2017). Given that cranks and charlatans in both health and politics work through many of the same mechanisms and are sometimes the same people, and that we understand those mechanisms even less well than we did in older technologies such as direct mail, this is an area of common research interest.

Look for PRR Practice, Not Just at PRR Parties

This point is obvious in the United States and Spain, for example, where PRR politics are within the Republican Party and the Popular Party whereas the formal PRR parties are historically marginal. It is less obvious in a place such as Austria where

the FPÖ has been and is again in national government. But even in Austria, Switzerland, or Italy where the PRR parties have been in power, their impact on mainstream parties has been profound and has shifted agendas and policy preferences towards the PRR (Albertazzi and McDonnell 2015). Such *droitisation* is well documented in cases such as the impact of the Rassemblement National in France, but it has also affected left parties which have become notably less enthusiastic about immigration and most forms of multiculturalism.

The research challenge of identifying the PRR within larger, older, and more diverse parties is hard. It is easy to identify the English Defence League as PRR, but it is harder to be precise a priori about PRR practice within the Conservative Party. The PRR, and indeed authoritarianism, is quite compatible with respect for the letter, if not spirit, constitutional law (as shown by Fidesz and many US Republicans). Considerable country expertise is likely to help as is an acceptance that many politicians whose instincts are otherwise will adopt PRR rhetoric and ideas if that keeps them in power. There is also a tendency for populists to start out sounding leftist and drift to the right, as we see with the Five Star Movement in Italy. The solution is not to probe the political ideology of an individual politician or party; the solution is to look at the rhetoric, choices of policy focus (e.g. migrant access to health care), and actual policy proposals, and gauge their nativism, authoritarianism, and populism in a way that identifies the PRR and tracks changes over time.

Focus on What the PRR Does in Office

The key result of our literature review was the finding that there is very little being written on health effects of PRR parties, probably because there is almost no empirical research literature on any policy effects of PRR parties. Political science researchers, especially ones in areas such as political parties, will often avoid engaging too closely with policy analysis and might not take a systematic approach to the policy effects of, for example, having a PRR health minister in charge of the bureaucracy. By contrast formal policies, including legislation and guidance, and less formal policies, such as decisions about the allocation of resources, are core areas of health politics and policy. They can also point to health effects of PRR policies, e.g. the impact on communicable disease prevalence of reducing healthcare access for the undocumented.

Of our four hypotheses, two, presented in Table 2, focus on health care policy. PRR parties almost always use welfare chauvinist language when campaigning, but coalition negotiations and office make such promises hard to fulfil. Whether and why PRR parties have a welfare chauvinist or liberal chauvinist impact in practice is crucial to understanding their effects on health and political longevity.

Do Study Public Administration

Two of the hypotheses we found in the literature about the effects of populists are substantially about their approach to public administration. The first is that populists are more clientelistic than other parties. In a functioning democracy, runs the argument, politicians' direct benefits to large groups. But they have other options. One is the purest form of clientelism, directing state resources to the profit of particular groups such as the local tobacco monopolists created by Hungary's government. In a field with the expenditures, corruption (European Commission 2013), and discretion of health, we should be able to advance understanding of the empirical question of whether populists are more, or distinctively, clientelistic politicians.

The second hypothesis is that science will be downgraded (e.g. in the budgets and influence of advisors) and ignored in decision-making by populists, more than other parties. Again, health policy is a useful site to study this question since there are endless questions which can be seen as primarily scientific as well as substantial research budgets. Finding indicators of science policy and attitudes to science is not so much the problem as finding ways to manage the counterfactuals.

Don't Normalize a Normal Pathology

Finally, the PRR is, as Mudde wrote, a normal pathology (Mudde 2010). It is an extreme version of ideas and forces found in every democracy. When it strengthens, or when the political system's antibodies weaken, it matters more. That means it is important not to underplay its pathologies but also not to denormalize it so thoroughly as to imply it is wholly alien. Established elites implying that a genuinely popular politician or party is alien and marginal certainly looks like it plays straight into populist antielitism. It also means that complex issues, such as the relationship between Trump and the Republicans, key to understanding what is and is not changing in US health care (Marmor and Gusmano 2017), or the adoption of PRR stances by left parties on certain issues, will be hard to understand if we do not keep both the normality and the pathology of the PRR in mind.

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