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Medical Populism and the Moral Right to Healthcare

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Abstract: Medical populism, as a political style of handling the challenges of a public health crisis, has primarily been analyzed in terms of its influence on the efficacy of governmental efforts to meet the challenges of the current pandemic (such as those related to testing, vaccination, and community restrictions). As these efforts have moral consequences (they, for instance, will affect people's wellbeing and may lead to suffering, loss of opportunities, and unfair distributions), an analysis of the ethics of medical populism is much needed. In this essay, we address the need to analyze the moral dimension of medical populism by relating it to issues in healthcare ethics. Specifically, we identify the moral significance of medical populism by demonstrating how it contributes to the failure of governments to discharge their moral duty to provide for the healthcare needs of their people, and, correlatively, to the violation of the people's moral right to healthcare. We argue that with medical populism, governments tend to mishandle the constraints that would morally justify their shortcomings in fulfilling such duty. We identify such constraints as mainly referring to the governments' given (economic and institutional) capacities and the relative degree of incumbency of their competing duties.

Keywords: medical populism, populism, right to healthcare, pandemic, healthcare

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Introduction

Populism is a concept that is frequently employed yet can be regarded as somewhat vague. Though relatively old,[1] the concept often figures in the way present-day scholars analyze various forms of political governance. As Mudde and Kaltwasser stated, "[p]opulism is one of the main political buzzwords of the 21st century."[2] It is, for instance, customary to read about some world leaders and their style of political governance

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[1] Müller (2016): 7.
[2] Mudde, Rovira Kaltwasser (2017): 1.

being branded as populist. The concept, however, is somewhat vague as those who use it often do not agree on what it specifically means, thereby casting doubt on whether the phenomenon it represents truly exists. In the words of Mudde and Kaltwasser, "[i]t truly is an essentially contested concept."[3] Some think of it as an ideology, while others think of it as a political style, among others. And while there may be some general points of agreement, like its preference for the common interests of the people (believed to be pure and authentic) to the personal interests of the elite (believed to be corrupt and inauthentic), the meaning of these further concepts, which will aid in cashing out the notion of populism, is not readily clear yet.[4]

One of the relevant applications of the concept of populism is in the area of public health. Recent studies, for instance, have used it to analyze how some governments handled or mishandled the challenges of the current public health crisis caused by COVID-19. This application has given birth to the term *medical populism*.[5] Perhaps due to its being a relatively new concept, studies on medical populism mostly focus on validating the reality of the phenomenon by showing its various instantiations in the hands of some contemporary world leaders[6] and its actual effects on the efficiency of governmental efforts in meeting the challenges of the current pandemic, such as those involving testing,[7] vaccination,[8] and lockdowns and other restrictions.[9]

There is, however, another important side to medical populism. While most studies on the phenomenon strive to be objective in their account of the relevant facts and scientific in their methodologies, quite often at the end of their analyses they also suggest, implicitly or not, some injunctions (i.e., what ought to be the case) without being clear about the normative framework that would justify such prescriptions. The move from "is" to "ought" requires grounding in some normative principles—for our purposes, moral principles. Furthermore, governmental efforts in meeting the challenges of a public health crisis obviously have moral consequences. They, for instance, will affect people's wellbeing and may lead to suffering, loss of opportunities, and unfair distributions.[10] The issue is thus not just about the reality and processes of medical populism, but likewise about its ethics.

In this essay, we address the need to analyze the moral dimension of medical populism by relating it to issues in healthcare ethics. As healthcare rights are at the heart of healthcare ethics for which (national) governments are practically the main duty bearers, we focus on how medical populism would influence governmental efforts in satisfying their people's moral right to healthcare. We argue that with medical populism, such a right would be violated as governments would tend to mishandle the constraints that would morally justify their shortcomings in fully satisfying the demands of this right. We identify such constraints as mainly referring to the governments' given (economic and institutional) capacities and the relative degree of incumbency of their competing duties.

[3] Ibidem: 2.
[4] Ibidem: 9–19.
[5] Lasco (2020); Hedges, Lasco (2021).
[6] Lasco (2020); Greer (2017).
[7] Hedges, Lasco (2021).
[8] Recio-Roman, Recio-Menéndez, Román-González (2022).
[9] Rogers, Cruickshank (2021).
[10] Mabaquiao (2020).

We divide the paper into three parts. In the first part, we provide an overview of the phenomenon of medical populism. We first look into the various approaches to understand the concept of *populism,* after which we examine how this concept has been applied to the area of public healthcare and policy. In the second part, we discuss and defend the universality of the moral right to healthcare and identify the morally relevant constraints to its correlative moral duty of healthcare provision. In the third part, we analyze how medical populism would influence the way a government would handle the morally relevant constraints to its moral duty of healthcare provision.

Medical Populism: An Overview

Lasco and Curato introduced the concept of *medical populism* to refer to a politicized response to health crises or medical emergencies. In their own words, it refers to "a political style that constructs antagonistic relations between 'the people' whose lives have been put at risk by 'the establishment.'"[11] Medical populism is populism as it is played out within the area of public healthcare and policy. To get a better handle of this concept, we thus need to be clear about what populism means and how Lasco and Curato understood it as they applied it to the medical field. While there seems to be some consensus on the actual instantiations of populism, what populism is or how to properly understand it is still a contested matter. As Moffit noted: "while authors may not agree on what populism 'is', they tend to agree more on who populists are...."[12] Accordingly, there are competing approaches to the study of populism, each advancing an account of what constitutes the defining feature of the phenomenon. For our purposes, let us briefly examine those deemed central by the *Oxford Handbook of Populism,*[13] namely, the *ideational, political-strategic,* and *socio-cultural* approaches.[14]

Mudde, representing the ideational approach (also called the *ideological approach*), defined populism as "an ideology that considers society to be ultimately separated into two homogenous and antagonistic groups, 'the pure people' versus 'the corrupt elite', and which argues that politics should be an expression of the volonté générale (general will) of the people."[15] Mudde made two critical qualifications regarding the basic elements of such a definition. First, the ideology is qualified as "thin" or "thin-centered," in contrast to the "thick" or "full ideologies" of the likes of socialism and liberalism. As a thin ideology, populism has a limited scope and, as such, it often works in partnership with a full-blown ideology. This explains why populism can be right-wing or left-wing, among others. Second, the opposition between the "pure people" and "corrupt elite" is understood as a moral one being based on the moral traits of *authenticity* (attributed to the people) and *inauthenticity* (attributed to the elite). This opposition contrasts with those based on non-moral traits such as social class, race, or ethnicity. Accordingly, pop-

[11] Lasco, Curato (2019): 1.
[12] Moffitt (2016): 39
[13] Rovira Kaltwasser, Taggart, Ochoa Espejo et al. (2017). See also Rueda (2020): 1; Mudde, Rovira Kaltwasser (2018): 1668–1669.
[14] Other approaches include the discursive and political logic approaches, see Moffitt (2016): 17.
[15] Mudde (2017): 16.

ulism works for the political elevation of the people whose general will is threatened or corrupted by the elite.

The political-strategic approach is represented by Weyland who defined populism as "a political strategy through which a personalistic leader seeks or exercises government power based on direct, unmediated, uninstitutionalized support from large numbers of mostly unorganized followers."[16] A leader, in Weyland's perspective, is seen by the people to be embodying their general will. Through his or her charisma, the leader is able to establish a personal relationship with the people in order to be seen as their representative and protector. With the popular support from the people, the leader, however, usually bypasses organizational structures which are seen simply as hurdles to the expression of the people's general will. The leader, consequently, often uses this authority granted by the supporters to strategize political moves primarily intended to promote his or her own personal agenda and to stay in power.

The socio-cultural approach is represented by Ostiguy who described populism as the "flaunting of the 'low'."[17] Ostiguy identified an important dichotomy or axis in politics, which he called "high-low axis" and which he regarded as more concrete than the traditional *right-left axis*. The high-low axis is cultural in nature for being about the different "ways of being and acting in politics."[18] It has two closely related components: the *socio-cultural,* which "encompasses manners, demeanors, ways of speaking and dressing, vocabulary, and tastes displayed in public",[19] and the *political-cultural,* encompassing "the way of making decisions in politics."[20] In both components, there is a *high kind* and a *low kind.* Accordingly:

> On the high, people publicly present themselves as well behaved, proper, composed, and perhaps even bookish. Moreover, politicians on the high are often "well-mannered," perhaps even polished, in public self-presentation, and tend to use either a rationalist (at times replete with jargon) or ethically oriented discourse. Negatively, they can appear as stiff, rigid, serious, colorless, somewhat distant, and boring. On the low, people frequently use a language that includes slang or folksy expressions as well as in their demeanor, and display more raw, culturally popular tastes. Politicians on the low are capable of being more uninhibited in public and are also more apt to use coarse or popular language. They appear--to the observer on the high--as more "colorful" and , in the more extreme cases, somewhat grotesque.[21]

The high and low in politics have nothing to do with economic status, since wealthy politicians can be low in their political ways and not so wealthy politicians can be high in their political ways. Consequently, it is when one of the two components of the high-low axis is publicly displayed by politicians as low that they can be said to be

[16] Weyland (2017): 62.
[17] Ostiguy (2017): 73.
[18] Ibidem: 78.
[19] Ibidem: 79.
[20] Ibidem: 79.
[21] Ibidem: 78.

populist. A perceived advantage of this approach is that it accommodates the possibility of politicians being populist in some areas but not in others. As this public display occurs in the course of the performance of political actions by the politicians, this approach is also called a *performative approach*.[22]

Needless to say, each of these three approaches claims a degree of superiority over its rivals. Interestingly, each charges the others with providing imprecise or extended boundaries to the concept of populism (among their other arguments), which Bonikowski and Gidron refer to as the issue of the "precise bounding of the concept."[23] That is to say, each regards the rival definitions of populism as either too narrow, thus excluding some apparently populist phenomena, or too broad, and thereby including non-populist phenomena. Be that as it may, some scholars (such as Bonikowski and Gidron) have identified some common elements among these approaches, most notably populism's *anti-elite orientation*. Accordingly, it is in the explication of the basis, manifestations, operations, and implications of this orientation where these approaches differ.[24]

One further approach which tries to incorporate the salient features of all the above is the performative approach of Moffitt. [25] Moffitt defined populism "as a *political style* that is performed, embodied and enacted across a variety of political and cultural contexts."[26] Moffitt characterized political style as consisting of three features, namely: (a) the appeal to "the people" versus "the Elite," (b) bad manners, and (c) response to a crisis, breakdown, or threat.[27] The first feature recognizes the importance of the moral distinction between the people and elite, which is one of the core elements of the ideational approach. The second feature basically corresponds to what Ostiguy called "flaunting of the low" in his socio-cultural approach, which, incidentally, is likewise described as a performative approach. The third feature incorporates the element of Weyland's political structural approach, which refers to the way a populist leader responds to a crisis, breakdown or threat. This response is decisive, short-term, and immediate, and often bypasses "the complex machinery of modern governance and the complicated nature of policy solutions, which in contemporary settings often require consultations, reviews, reports, lengthy iterative design and implementation."[28]

In explaining the concept of medical populism, Lasco and Curato drew on Moffit's approach to populism as a political style.[29] For their purposes of examining health issues and crises, they found Moffitt's definition to be the most meaningful and appropriate. According to them: "This definition is broad enough not to be tied to definitions of populism that connect it to substantive worldviews (e.g. nativism, tribalism, nationalism) but specific enough to characterize a political practice distinct from other responses to

[22] Ibidem: 74.
[23] Bonikowski, Gidron (2016): 7.
[24] Ibidem: 7.
[25] Moffitt (2016): 28.
[26] Ibidem: 3.
[27] Ibidem: 44.
[28] Moffitt (2016): 44.
[29] As this paper focuses its analysis on medical populism as conceptualized by Lasco and Curato, which follows Moffitt's performative approach to populism, the paper thus assumes the same approach to populism.

moral panics."[30] Corresponding to Moffitt's three features of populism, they consequently identified three characteristics of medical populism. First, medical populism projects an image of 'the people' as victims of neglect that led to threats against their health and safety.[31] Second, medical populism dramatizes health crises and justifies non-measured responses and immediate action.[32] And lastly, medical populism promotes and legitimizes simplistic and spectacular solutions to health crises.[33]

Lasco and Curato further elaborated on these features using a distinction made by Brubaker[34] between the vertical and horizonal dimensions of medical populism.[35] The vertical dimension, on the one hand, makes a distinction between "the people" and the "medical elite." The horizonal dimension, on the other hand, separates "the people" from the "dangerous outsiders." To illustrate these features, Lasco and Curato identified and examined four examples of medical populism which, according to them, were "drawn from scholarly research and journalistic reportage."[36]

The first example was Thabo Mbeki's HIV denialism which undermined the gravity of the AIDS epidemic and framed it as a form of imperial racism. The second was the Dengue Vaccine Scandal in the Philippines that resulted in a significant drop in vaccine confidence. The third was the Ebola Scare which spectacularized the crisis and proposed urgent and simplified responses that paved the way for harsh immigration policies. The fourth was Southeast Asia's Drug Wars that were motivated by a narrative that was sustained by rhetoric and merely exaggerated the problem. In all four cases, medical populists challenged the medical establishment by offering a counter-narrative that reframed or subverted the health crisis in a way that only worsens it. These examples also demonstrated, for Lasco and Curato, how medical populism could impact crisis governance, specifically, public health policies concerning vaccine availability and accessibility to healthcare.[37]

Lasco also demonstrated how medical populism was used by political leaders in construing and responding to the COVID-19 pandemic. He noted four relevant features in this regard.[38] The first was the *simplification of the pandemic*, which resulted in pandemic responses that downplayed the severity of the crisis and offered simplistic solutions and arguments. The second was the *dramatization of the crisis* by offering exaggerated and distorted narratives that led to disproportionate or inappropriate pandemic responses. The third was the *forging of divisions* that capitalized on economic and health insecurities, pitting one group against another. Finally, there was the *invocation of knowledge claims*, which were false and went against science.

[30] Lasco, Curato (2019): 2.
[31] Ibidem.
[32] Ibidem.
[33] Ibidem.
[34] Brubaker (2017).
[35] Lasco, Curato (2019): 3.
[36] Ibidem.
[37] The normative implications of Lasco and Curato's assessment of these cases are brought about by the populist anti-elite orientation (as one necessary feature of medical populism as they conceptualized it), referring to the divide between the "people" and the "medical elite." This divide, according to Mudde [(2017): 16], is moral one based on the moral concepts of *authenticity* and *inauthenticity.* Being moral in nature, the populist anti-elite orientation thus has normative implications.
[38] Lasco (2020): 1418–1419.

Lasco presented three cases to demonstrate the occurrence of medical populism at the time of COVID-19.[39] The first was the pandemic denialism of Brazilian president Jair Bolsonaro which downplayed the virus and its consequences by framing the narrative as one that pits the economy against public health, forging political divisions and invoking the language of conspiracy.[40] The second was the Philippines' president Rodrigo Duterte's simplified and reluctant initial pandemic response, which dismissed the seriousness of the virus by mocking measures backed by science as overreactions. Later on, he also dramatized the response to the crisis by using war language that threatened the use of force. The third was the United States' president Donald Trump's initial downplay of COVID-19 by making various knowledge claims about the virus that ignored science and appealed to commonsense, later on turning the phenomenon into a spectacle by using hyperbolic language and the rhetoric of blame.[41] Like Duterte's approach, Trump's handling of the crisis shifted from simplification to spectacularization. [42]

Other studies on medical populism further demonstrated its actual impact on governance during the pandemic. Hedges and Lasco claimed that coronavirus testing has been used as a populist trope.[43] For one, they observed that in both the Philippines and the United States, the demand for testing had been spectacularized with political actors invoking controversial knowledge claims and promoting testing as the singular solution to the pandemic.[44] These things caused divisions that negatively affected policies on public health, promoting a pandemic response based on an oversimplification of the crisis.[45]

Recio-Roman et al. argued that politicizing vaccine-related issues influenced vaccine uptake rates since distrust or discontent in political and economic institutions lower the odds of vaccine acceptance.[46] Brubaker maintained that politicized lockdown policies have fostered populist sentiments by heightening distrust, exacerbating antipathy, and amplifying skepticism.[47] He then concluded that medical populism is paradoxical, explaining that "by invoking, performing, intensifying, and dramatizing crisis, populists and other political actors contribute to *producing* the very crises to which they claim to *respond*."[48]

Other studies have focused on the impact of populism on various aspects of healthcare policy in specific contexts. In an editorial to a special issue in the journal *Critical Public Health* (2022, Vol. 32, No. 1, 44-47), Speed, Carter, and Green examined the different aspects and challenges of evaluating the success and failure of public health policies of national governments in handling the COVID-19 pandemic, specifically in controlling the spread of the infectious disease. Such polices included border controls,

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[39] Ibidem: 1419–1423.
[40] Ibidem: 1420.
[41] Ibidem: 1423.
[42] Ibidem: 1421–1422.
[43] Hedges, Lasco (2021).
[44] Ibidem: 82.
[45] Ibidem.
[46] Recio-Roman, Recio-Menéndez, Román-González (2022).
[47] Brubaker (2020): 82.
[48] Ibidem: 79–80.

masking mandates, contact tracing, economic support, and communication strategies. Among the examined challenges, they included the following:

1. how trust in the government shaped responses to contact tracing;
2. the unequal distribution of resources to cope with illness, economic disruption and stress;
3. the plight of migrants living in poverty who are often most at risk from both infectious disease and the consequences of pandemic control measures;
4. the rise of criminalization, discrimination, and ethnic inequalities;
5. how to make individual citizens be more responsible in reducing COVID-19 transmission;
6. global inequalities of vaccine access;
7. profiteering on COVID-19 vaccines; and
8. the burden of care on often already over-stretched providers.

Speed and Mannion[49] scrutinized the influence of the global rise of populism on health policy and health professionals with a special focus on a specific health policy in the UK called the "Seven-Day NHS" (NHS – National Health Service). Their analysis primarily considered the industrial action undertaken in 2015/2016 by junior doctors in the UK. They attributed the global rise of populism to both economic and cultural factors. In particular, they pointed to the increasing economic inequality and growing social exclusion associated with post-industrial societies, and to "the cultural backlash thesis, which views populism as a retro-backlash against successive waves of progressive cultural change which since the 1970s has sought to foster greater social tolerance of diverse lifestyles and cultures."[50] Using Laclau's conceptual apparatus for explaining the phenomenon of populism, namely the concepts of *logics of equivalence and difference,*[51] they explained how a certain political issue concerning the medical profession was dealt with in a particular performative setting. They demonstrated how some common populist practices resulted in the prioritization of specific approaches to health policy. Such practices usually involved openly undermining the role, authority, or expertise of certain actors or social groups.

In an earlier paper,[52] Speed and Mannion demonstrated the same kind of analysis on the effects of populism on public health. This time, however, they used three international cases as illustrations: "the election of President Trump in the United States (and subsequent healthcare reforms), the United Kingdom's vote to withdraw from the European Union (Brexit), and how this has played out in the context of the UK National Health Service, and the rise of a politically aligned anti-vaccination movement in Italy."[53] They showed, for instance, "how populist policies tend to create specific barriers and challenges for people accessing services, and for the types of services that are available."[54]

Finally, some other studies examined how the COVID-19 crisis provided an avenue to assess the plausibility of social theories in terms of how social justice can best be

[49] Speed, Mannion (2021).
[50] Ibidem.
[51] See Laclau (2005).
[52] Speed, Mannion (2020)
[53] Ibidem: 1967.
[54] Ibidem: 1977.

established given the dynamics created by the pandemic between individuals and society. The presupposition was the following: the kind of social theory one adopts in meeting the challenges of the pandemic will significantly affect the kind of interventions one will favor in addressing such challenges. Given this, Walby[55] took issue with the tendency of most discussions on this topic to focus on the opposition between the social theories of *libertarianism* and *authoritarianism.* Walby believed that this focus is insufficient for the contestation within social democracy and that a consideration of neoliberalism is equally important. In the analysis of Delanty,[56] for instance, which considered six competing moral and political philosophies as responses to the pandemic (namely: Utilitarianism, Kantianism, Libertarianism, Agamben's Foucauldian philosophical approach, Slavoj Žižek's Post-capitalism and Radical Politics, and Badieu's Nudge Theory), Walby noted that the social theories of social democracy and neoliberalism were significantly missing. Consequently, she made a case for the inclusion of these two other social theories in the debate on how social justice can best be established given the challenges of the current pandemic. It can be gleaned in her discussions that she was endorsing the theory of social democracy as the best alternative response to the pandemic. As she remarked: "The social democratic vision is fundamental to the public health response that is currently actively contesting the individualistic, neoliberal understanding of society found in UK (and US) policy and is actively rejecting the false polarity between individuals and society as a zero-sum game. Making visible the social democratic vision allows for a better understanding of the arguments ongoing within science over COVID and their interpretation within social theory."[57]

Moral Right to Healthcare

By "moral right to healthcare," we generally mean everyone's entitlement to a minimum set of healthcare resources necessary to guarantee a healthy life in one's society. We follow Daniels' distinction between two types of healthcare resources, namely, those intended for therapy and those intended for enhancement.[58] The minimum set of healthcare resources guaranteed by the moral right to healthcare only refers to those intended for therapy.[59] By "healthy life," we mean a kind of life that is able to prevent or manage sickness and disability and maintain normal functioning in one's society.[60] And by "healthcare resources," we follow Buchanan in understanding it in its most inclusive sense, in that they refer to "any goods or services that can reasonably be expected to have a positive effect on health. Thus, health-care resources include, but are not restricted to, medical resources."[61]

We likewise understand the moral right to healthcare as equivalent to the so-called *human right to healthcare.* We take the standard understanding of "human rights"

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[55] Walby (2021).
[56] Delanty (2020).
[57] Walby (2021): 24–25.
[58] Daniels (2009): 368.
[59] Fried (1976): 29; Daniels (1981): 175; (2001): 5.
[60] Daniels (2001); Daniels (2009).
[61] Buchanan (2009): 38.

as referring to the moral rights of humans, which all humans have by virtue of their common humanity.[62] Being such, these rights are necessarily universal and independent of the contingent realities of humans such as their race, nationality, gender, socio-economic status, religion, political affiliation, and so on.[63] Moral rights contrast with conventional rights which include contractual and legal rights. Conventional rights, being based on human agreements in consideration of the contingent realities of life, are not universal.

The human right to healthcare is one of the human rights identified in the United Nations' Universal Declaration of Human Rights (UDHR) in 1948.[64] Some consider it to be implied by the human rights "to food, clothing, housing, and medical care"[65]; while some contend that it is "affirmed in Article 25 that 'everyone has the right to a standard of living adequate for the health of himself and of his family'."[66] According to Corella, the "UDHR was a monumental event in international law," which subsequently "influenced the different regional systems and national legal systems."[67] Consequently, many countries have incorporated the right to healthcare in their constitutions as a basic human right.[68] In the Philippines, for instance, it has been incorporated in its constitution through the Universal Health Care Act (Republic Act No. 11233), signed into law by President Rodrigo Roa Duterte on February 20, 2019. The law intends, among others, to provide all Filipinos access to a comprehensive set of healthcare resources and services.

In virtue of the universality of human rights, it is quite clear to most scholars that what the UN means by human rights in its UDHR are the moral rights of humans.[69] Corella, for instance, explained this using a Kantian perspective: "Universality as a feature of the concept of human rights, along the lines proposed by the Declaration, … is a direct consequence of the Kantian requirement of the moral imperatives' universality, but one that transcends this scope with positivity, internationalization and specification of rights."[70] Be it as it may, there are, however, those who question the alleged universality of human rights, mainly by invoking the reality of cultural differences.[71] They allege, for instance, that the UDHR "suffers from a Westernist perspective, or worse imperialist."[72] Consequently, they claim that there really are no such things as human or moral rights since all rights are conventional.[73]

As in the case of human rights in general, the question on the moral status of the right to healthcare focuses on the claim to universality.[74] Simply, if the right cannot be universal, then it cannot be of the moral kind as moral rights are supposed to be universal. In recent literature, the claim that the right to healthcare cannot be universal is argued

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[62] Jones (2013): 267; Perry (2020): 437–438.
[63] Pavel (2019): 502.
[64] Wolff (2012): 85–86.
[65] Velasquez (2014): 103.
[66] Pillay (2008): 2005–2006.
[67] Corella (2018): 2.
[68] Pillay (2008): 2005.
[69] Perry (2020); Corella (2018): 20.
[70] Ibidem: 15.
[71] Ibidem: 7, 15.
[72] Ibidem: 2.
[73] Jones (2013); Wolff (2012): 85; Pavel (2019).
[74] Pavel (2019): 519.

based on the alleged impossibility of satisfying the demand of the right's correlative duty.[75] The right to healthcare, being a positive right, imposes the duty of healthcare provision. If the right is universal then everyone has the correlative duty to provide for the healthcare needs of everyone else, which some find absurd. As Sreenivasan explained: "It is highly implausible to contend that 'everyone' bears the duty correlative to a moral human claim-right to health. It seems clearly false, for instance, that individual inhabitants of Mozambique, to take Wolff's example, each have a moral duty to preserve the health of any given individual of Brazil."[76] Connected to this, it is further alleged that having a duty that cannot be satisfied leads to the absurdity of always violating a right even when nothing morally wrong is being done. In this regard, Pavel, for instance, concluded: "if duty-bearers can routinely violate a human right without doing anything wrong, the human right in question does not exist."[77]

Mabaquiao and Dacela, in a recent essay,[78] have shown why this particular argument against the existence of the moral right to healthcare does not work. They claimed that the argument fails to consider that there are morally justifiable constraints to the universality of the moral duty of healthcare provision.[79] The failure to satisfy the duty's demand for universality as a result of these constraints does not invalidate the universality of the duty and its correlative right. They identified such constraints as consisting of (1) the given capacity of the duty bearer to satisfy the demand of the duty, which we shall henceforth refer to as the "capability constraint," and (2) the degree of the duty's incumbency relative to its competing duties, which we shall henceforth refer to as the "incumbency constraint."[80]

The capability constraint is morally grounded in the ethical principle *ought implies can,* which generally states that we can only be obligated to perform actions that we can actually perform. We obviously cannot oblige a child, for instance, to perform actions that they cannot yet do, say, join a medical mission in a remote area, however morally desirable such actions may be. On the other hand, the incumbency constraint is morally grounded in the ethical theory advanced by W.D. Ross[81] which is often referred to in the literature as *deontological pluralism* or *pluralist deontology*.[82] This theory generally states that duties, as they initially appear to us, often compete with one another and, in the face of such competition, the one we are morally obligated to actually perform is the one with the strongest degree of incumbency in consideration of surrounding morally relevant factors.

The ethical principle *ought implies can* is actually also used to question the universality of the moral right to healthcare and, consequently, reject the existence of this right.[83] Accordingly, if the universal demand of the moral right of healthcare provision cannot

[75] Pavel (2019); Sreenivasan (2012).
[76] Sreenivasan (2012): 244.
[77] Pavel (2019): 501.
[78] Mabaquiao, Dacela (2022).
[79] Ibidem: 83–88.
[80] Ibidem.
[81] Ross (1930).
[82] Tohăneanu (2015).
[83] Pavel (2019): 519; O'Neill (2005): 431.

be satisfied, then there is no universal obligation to promote this right. And without such obligation, the right in question cannot be said to be of the moral kind, or the moral right to healthcare cannot be said to exist.[84] This reasoning, however, does not look into the kind of constraints that make it difficult, if not impossible, to satisfy the universal demand of the right's correlative duty in certain circumstances. We contend that if such constraints are morally justifiable, the conclusion that the moral right to healthcare does not exist would not follow from the failure to satisfy the right's correlative moral duty.

One such morally justifiable constraint, as earlier noted, is the capability constraint. If I do not have the required resources or abilities to save a person's life in a remote place from severe hunger or sickness, for instance, that does not mean that the duty to save that person does not exist. I may not have such duty due to my circumstances, but others in a favorable position may assume it. Consequently, my inability to save the person does not negate the fact that the needy person has the right to life or any assistance to save his or her life. What can be inferred from this is that while it is true that, in principle, everyone has the moral duty to provide for the healthcare needs of everyone else, in morally justifiable circumstances some do not assume such duty. Another way of interpreting this is that "everyone" here does not really refer to every human being regardless of their circumstances in life. For obvious reasons, it does not include, for instance, infants and mentally challenged individuals. The obvious reason why such individuals are excluded from "everyone" is the fact that they do not have the necessary capacity to perform what the duty requires. In this light, we can thus interpret the universality of the moral right to healthcare to mean the following: "everyone appropriately situated has the moral duty to provide for the healthcare needs of everyone else."

Another is the incumbency constraint. The point of this constraint can very well be explained using Ross's distinction between our *prima facie* and *actual* duties,[85] which Vranas, in contemporary philosophy, refers to, respectively, as our *pro tanto* and *all-things-considered* duties.[86] Our *prima facie* moral duties are our initial or immediate moral duties. They are the moral duties we immediately recognize given the circumstances we are in. For instance, when we make a promise, we immediately recognize our duty to fulfill this promise. On the other hand, our actual moral duties are the moral duties we should actually perform, for these are the ones we feel obliged most strongly to do after factoring in all morally relevant considerations. Suppose that on your way to meeting a friend whom you earlier promised to meet, you received a call from your mother requesting you to accompany her to a hospital as she suddenly felt so sick. You then have two *prima facie* duties in conflict. For Ross and Vranas, what you are morally obligated to actually perform in a conflict situation like this is the one that proves to be stronger in terms of its obligatoriness after careful consideration of the relevant factors surrounding both cases. Similarly, Elizabeth Harman argues that sometimes our failure to perform an action we are obliged to do is a morally permissible mistake.[87] For Harman, this applies to those instances in which we do not do anything morally bad, but we do

[84] Pavel (2019): 512.
[85] Ross (1930).
[86] Vranas (2018).
[87] Harman (2016).

fail to do something morally good.[88] And while we could be criticized for these mistakes, they are not blameworthy, and so are morally permissible.[89] In the example cited earlier, breaking your promise to your friend is a moral mistake because it constitutes a failure to do something morally good, which in this case is fulfilling your promise. However, given the circumstances with your mother, this mistake is morally permissible. Following Harman, we can say then that in some cases, our failure to perform our *prima facie* duties does not involve the same sort of moral failing that would be involved in performing a morally bad action.

It is important to note that both Ross and Vranas qualified that when our *prima facie* duty is overridden by a stronger one, it does not disappear as our duty. For Ross, this is because our non-performance of the overridden duty, which is an action in itself, may bring about another *prima facie* duty—usually the duty of reparation. For Vranas, this is because we often feel guilty for not being able to perform the overridden duty.[90] Given the framework of this ethical theory, when we say that the moral right to healthcare is universal, we can mean that it is everyone's *prima facie* duty to provide for the healthcare needs of everyone else. There is nothing strange in the fact that when we come to know of a person in great need (even if this person is in a very remote area, say in Mozambique), we immediately feel the obligation to help the person. But for this *prima facie* duty to be our actual duty, it must prove to be stronger in its incumbency relative to our other *prima facie* duties. While we all have the *prima facie* duty to provide for the healthcare needs of everyone else, it may not, therefore, be the *actual duty* of some of us. But since an overridden *prima facie* duty does not cease to be a duty, its universality is preserved.

Medical Populism, Governments, and Healthcare Rights

Given the universality of the moral right to healthcare and its correlative duty, a question arises concerning the right's main or primary duty bearer. For Wolff, it is either the international community or the national government—the government of the country in which the moral right holders reside.[91] If it is the national government, Wolff explained that the role of the international community is to "take steps to encourage and assist national governments in carrying out their duties, and perhaps to pick up the duty in extreme cases of failure ..."[92] On the other hand, if it is the international community, Wolff qualified that "for practical purposes it may be necessary to devolve responsibilities to national governments, but this is by way of delegated responsibility from the international community."[93] In either case, it seems that for Wolff, from a practical viewpoint, in terms of which is better suited to discharge the duty, it is the national government that is the main duty bearer. Pavel explained that this is because the provision of healthcare

88 Ibidem: 392.
89 Ibidem.
90 Ibidem: 488.
91 Wolff (2012): 86.
92 Ibidem.
93 Ibidem.

goods “requires specialized, professional knowledge, large resource investments and a well-developed infrastructure.”[94]

While (national) governments are practically the main duty bearers of the moral right to healthcare, they (especially those of developing countries), however, will most likely be unable to fully satisfy the demand of this right even under the reading that such demand only involves the provision of a decent minimum of healthcare resources for everyone.[95] Needless to say, this is because of certain constraints, most notably the ones discussed above, namely, the capacity and incumbency constraints. When morally justified, such constraints excuse agents from moral accountability for their failure to discharge certain moral duties. With governments, the capacity constraints primarily refer to their limited economic resources and institutional structures, while the incumbency constraints refer to their other important duties such as those related to national security, economy, peace and order, education, and others.

Accordingly, governments are not morally accountable for their inability to fully provide for the healthcare needs of their people under the following conditions. The first is when it is beyond their capacity (in terms of economic resources and institutional structures) to satisfy such needs. Consistent with the moral principle “ought implies can,” Pavel, in this connection, noted: “It cannot be the case that human beings have rights to very specific services that their governments are not in a position to provide due to decisions made in accordance with just procedures.”[96] The second is when their moral duty of healthcare provision, consistent with the Rossian ethical theory of deontological pluralism, is overridden by a stronger moral duty. Governments have to simultaneously deal with a lot of duties, both legal and moral, which include, in addition to public health, those related to national security, national economy, education, criminality, infrastructure, and so on. While, for instance, the duty of healthcare provision becomes the priority in a public health crisis, some other duties, due to some urgent and serious circumstances, may challenge its priority. This duty may conflict with the duty to maintain national security, which was the case recently in Afghanistan as it dealt with a war during the time of the pandemic,[97] or with the duty to protect the national economy, realized for example through government decisions to limit community lockdowns to mitigate the damages to the national economy and people’s livelihood, though such lockdowns are necessary to contain the pandemic.[98]

It follows that for a government to fulfill its moral duty to provide for the healthcare needs of its people, it must be able to handle or manage these constraints well. That is, it should be able to maximize the use of its limited economic resources and institutional structures and decide well which among its competing duties to prioritize to provide the greatest benefits to its people or to best promote its people’s interests. If this is ensured, the shortcomings of a government in discharging its moral duty of healthcare provision are morally justified: in the absence of the government’s moral

[94] Ibidem.
[95] Ibidem: 512.
[96] Ibidem: 511.
[97] Zucchino, Abed (2021).
[98] de Lara-Tuprio, Estuar, Sescon et al. (2022).

accountability for these shortcomings, the moral right to healthcare of its people is not violated. In contrast, if the government fails to maximize the use of its limited resources and institutional capacities and to handle its competing duties well to provide for the healthcare needs of its people, its shortcomings, in this regard, are not morally justified and, thus, its people's moral right to healthcare is violated.

How a government handles these constraints thus defines whether it violates its people's moral right to healthcare. Now, one critical contributing factor here is the political style of the government or the leadership style of its head of state. It is in this regard that medical populism, as a political style of governments in dealing with the challenges of public health crises or, in general, with the healthcare needs of their people, requires ethical examination. Based on the points made above, when a government's adoption of medical populism leads it to mishandle the relevant constraints to its moral duty of healthcare provision, then it, in effect, violates its people's moral right to healthcare.

The studies we cited earlier, which identified the impact of medical populism on governance during the COVID-19 pandemic, have already hinted at how medical populism can lead to the mishandling of these constraints. Specifically, the four features of medical populism, which Lasco[99] identified and illustrated in the cases involving populist leaders, demonstrate how medical populism shapes the way governments manage the constraints to their duty of healthcare provision in ways that are not morally justified.

The simplification of the pandemic indicates that economic resources and institutional capacities will not be utilized well to provide healthcare services that could significantly control the spread of the virus. Take, for instance, Bolsonaro's pandemic denialism. A recent study[100] suggests that if it were not for Bolsonaro's denialist rhetoric,[101] which weakened the country's social distancing policies, there would have been approximately 318, 850 fewer cases of COVID-19, and more than 10,000 lives would have been saved. Bolsonaro has refused to follow World Health Organization's recommendations related to the pandemic, has procured drugs that have no proven effect on COVID-19 instead of securing oxygen which COVID-19 patients need, and has refused to respond to vaccine offers.[102] Bolsonaro even appointed an Army General with no medical experience as interim Minister of Health after disagreements with former ministers with respect to the use of COVID-19 treatments that were not scientifically proven.[103]

Duterte's earlier dismissal of the virus has resulted in an inadequate initial response, characterized by the lack of available critical care beds and health human resources,[104] and insufficient COVID-19 testing (with only 200 to 250 people getting tested daily, and only 2,000 kits available for the entire population).[105] By August 2020, the Philippines had set the record for the worst outbreak in Southeast Asia.[106] Trump's

[99] Lasco (2020): 1418–1419.
[100] de Arruda, de Menezes, dos Santos et al. (2021).
[101] Lasco (2020).
[102] Canineu, Muñoz (2021).
[103] Barberia, Gómez (2020).
[104] UP COVID-19 Pandemic Response Team (2020).
[105] Batino, Jiao (2020).
[106] Calonzo, Jiao (2020).

downplaying of the threat[107] made him averse to consulting with relevant councils and experts to which he clearly had access.[108] Trump's simplified response to the pandemic focused on testing capacity, but even then, testing capacity was limited.[109] It also made him ignore crucial problems with early testing.[110] Before the pandemic, Trump already compromised the country's response capabilities by eliminating the White House global health security office, ending PREDICT, a global early warning programme, and cutting critical programmes at the Centers for Disease Control and Prevention.[111]

The dramatization of the crisis similarly leads to the misappropriation of economic and institutional capacities. Duterte's "optics of power," as coined by Filipino sociologist Randolf David[112] and as illustrated by Lasco,[113] dramatized the response to the crisis by framing it as a kind of "war." This served as the justification for the implementation of what is considered the world's most draconian COVID-19 measures, with entire provinces and cities placed on strict lockdowns that affected the mobility of people and lasted for several months.[114] However, that only worsened the health crisis and widened its economic, political, and social implications, with 7.6 million households experiencing involuntary hunger, 7.2 million people becoming jobless, and an economy that contracted at the rate of 9.5 percent.[115] The country's Commission on Audit also reported that the Department of Health mismanaged 67.3 billion pesos causing the delay of critical medical supplies.[116] Trump's "politics of blame,"[117] on the other hand, has turned the pandemic into a spectacle invoking the language of war.[118] His rhetoric of blame has alienated foreign nations and organizations,[119] cutting UN agency funding and threatening to withdraw from the global health organization.[120] Trump also spectacularized the urgency of having a COVID-19 testing program but failed to implement any efficient national strategy, relying instead on the uncoordinated initiatives of state and local government.[121]

During the pandemic, governments are confronted with the dilemma of public health versus the economy. Two competing duties then are at stake when governments construct their responses to the pandemic. These are the duty to ensure economic stability and the duty to provide healthcare and promote public health. The pandemic response of a government is usually framed as a decision to prioritize either one of the two. The impact of medical populism in this decision is quite evident. Invoking knowledge claims

[107] Lasco (2020).
[108] Rutledge (2020).
[109] Patel (2020).
[110] Lasco (2021); Hedges, Lasco (2021).
[111] Yamey, Gonsalves (2020).
[112] David (2020).
[113] Lasco (2020): 1422.
[114] Hapal (2021).
[115] Arguelles (2021).
[116] Teehankee (2022).
[117] Lasco (2020): 1422.
[118] Ibidem.
[119] Ibidem: 1423.
[120] Gostin, Koh, Williams et al. (2020).
[121] Hedges, Lasco (2021): 79.

that forge divisions greatly contribute to governments' mishandling of these competing duties. Bolsonaro's populist rhetoric that made appeals to commonsense has forged a divide that pits the economy against public health.[122] Faced with economic challenges when COVID-19 pandemic emerged, Bolsonaro minimized its relevance to lessen its economic impact.[123] He has insisted that normal economic activity resumes, and has criticized social-isolation measures, threatened researchers who call for the lockdown of states, and warned governors against implementing such measures.[124] After repeated claims that the pandemic will end soon and consistently recommending unproven treatments, Trump similarly pushed for a premature opening of states due to economic concerns,[125] going as far as encouraging protests in spite of repeated warnings from experts that such a move could actually set the country back economically.[126] Both decisions undermine the governments' capacities to sufficiently respond to the challenges of the pandemic, and thus fail to provide for the healthcare needs of their people.

Conclusion

The COVID-19 pandemic places a spotlight on governance as we collectively experience its impact on our lives amid this unprecedented public health crisis and its socio-economic implications. Governments around the world struggle to respond urgently and efficiently to novel challenges that go with planning and coordinating emergency responses to contain the spread of the virus, setting up a mass testing program, imposing lockdown protocols and other measures, procuring and rolling out vaccines, and managing the economic fallout. With various governance styles on display, we realize that pandemic governance lies on a spectrum. And on one end of it lies a political style that has been proven to be paradoxically detrimental to public health, "producing the very crisis to which they claim to respond."[127]

Recent studies on medical populism demonstrate how it is used as a style of governance that determines the way governments manage the pandemic and how they respond to the unique challenges it poses. Simplification of the pandemic, dramatization of the crisis, forging of divisions, and invoking of knowledge claims were identified as its essential features.[128] In this essay, we first established that healthcare is fundamentally a moral right and that the main bearers of its correlative duty of provision are governments. We then noted that a government is excused to provide for the healthcare needs of the people if their limited capacities and structures make them incapable of doing so, or if this duty is overridden by a stronger moral duty. It follows from this that to fulfill its moral duty, the government needs to manage these constraints. And insofar as medical populism leads to the mishandling of these constraints in a way that is not morally

[122] Lasco (2020): 1420.
[123] Béland, Rocco, Seggato et al. (2021).
[124] Ibidem.
[125] Rutledge (2020).
[126] Ibidem.
[127] Ibidem: 79–80.
[128] Lasco (2020): 1418–1419.

justified, medical populism leads to a government's failure to discharge its moral duty of healthcare provision and, correlatively, to the violation of its people's moral right to healthcare. We illustrated this by citing the governance style of Bolsonaro, Duterte, and Trump and, more specifically, how medical populism contributes to the construction and implementation of their pandemic responses, as discussed in recent literature.

The pandemic has exposed how ubiquitous politics is in public health, and this reality has moral import, especially in a crisis. In their analysis of agile and adaptive forms of governance, Janssen and Van der Voort cite four lessons we can learn about governance from our pandemic experience, and these could serve as a guide for governments in managing the relevant constraints to fulfill their moral duty with respect to public health.[129] First, there is no single best strategy, as responses can change over time. Second, it is necessary to adapt but ensure stability at the same time. Third, adaptability is essential to mobilize society. Finally, it is important to have a variety of response strategies available. Finding the balance between an agile and adaptive form of governance is perhaps the style that best ensures that our moral right to healthcare is not violated, and that the government's moral duty of healthcare provision is fulfilled.

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References

Arguelles C.V. (2021), "The Populist Brand is Crisis: Durable Dutertismo Amidst Mismanaged COVID-19 Response," *Southeast Asian Affairs* 2021: 257–274.

Barberia L.G., Gómez E.J. (2020), "Political and Institutional Perils of Brazil's COVID-19 Crisis," *Lancet* 396 (10248): 367–368.

Batino C., Jiao C. (2020), "The Philippines Has Just 2,000 Virus Testing Kits and Cases are Rising," URL = https://www.bloomberg.com/news/articles/2020-03-10/philippines-has-just-2-000-virus-testing-kits-as-cases-rise?srnd=premium [Accessed 30.05.2022].

Béland D., Rocco P., Segatto C.I., Waddan A. (2021), "Trump, Bolsonaro, and the Framing of the COVID-19 Crisis: How Political Institutions Shaped Presidential Strategies," *World Affairs* 184 (4): 413–440.

Bonikowski B., Gidron N. (2016), "Multiple Traditions in Populism Research: Toward a Theoretical Synthesis," *APSA Comparative Politics Newsletter* 26 (12): 7–14.

Brubaker R. (2017), "Why Populism?," *Theory and Society* 46 (5): 357–385.

Brubaker R. (2020), "Paradoxes of Populism during the Pandemic," *Thesis Eleven* 164 (1): 73–87.

Buchanan A. (2009), "Health-Care Delivery and Resource Allocation," [in:] A. Buchanan, *Justice and Health Care: Selected Essays*, Oxford University Press, Oxford: 37–76.

[129] Janssen, van der Voort (2020).

Calonzo A., Jiao C. (2020), "Philippines Now Has Worst Covid Outbreak in Southeast Asia," URL = https://www.japantimes.co.jp/news/2020/08/07/asia-pacific/philippines-coronavirus-southeast-asia/ [Accessed 15.01.2023].
Canineu M.L., Muñoz C. (2021), "The Toll of Bolsonaro's Disastrous Covid-19 Response [EN/PT]," URL= https://reliefweb.int/report/brazil/toll-bolsonaro-s-disastrous-covid-19-response-enpt [Accessed 30.05.2022].
Cohen S. (2011), *Folk Devils and Moral Panics*, Routledge.
Corella Á.S. (2018), "The Political, Legal and Moral Scope of the Universal of Human Rights: Pending Issues," *The Age of Human Rights Journal* 11: 1–23.
Daniels N. (1981), "Health-Care Needs and Distributive Justice," *Philosophy and Public Affairs* 10 (2): 146–179.
Daniels N. (1985), *Just Health Care*, Cambridge University Press, Cambridge.
Daniels N. (2001), "Justice, Health, and Healthcare," *The American Journal of Bioethics* 1 (2): 2–16.
Daniels N. (2009), "Is There a Right to Health Care and, if so, What Does It Encompass?," [in:] *A Companion to Bioethics*, H. Kuhse, P. Singer (eds), John Wiley & Sons Ltd, Oxford: 362–372.
David R. (2020), "Optics of Power vs Voice of Science," URL = https://opinion.inquirer.net/128030/optics-of-power-vs-voice-of-science [Accessed 15.01.2023].
de Arruda R.G., de Menezes T.A., dos Santos J.M.A., Paez A., Lopes F. (2021), "The Effect of Politician Denialist Approach on COVID-19 Cases and Deaths," *EconomiA* 22 (3): 214–224.
de Lara-Tuprio E.P., Estuar M.R.J.E., Sescon J.T. et al. (2022), "Economic Losses from COVID-19 Cases in the Philippines: A Dynamic Model of Health and Economic Policy Trade-Offs," *Humanities and Social Sciences Communications* 9: 111.
Delanty G. (2020), "Six Political Philosophies in Search of a Virus: Critical Perspectives on the Coronavirus Pandemic," URL = http://www.lse.ac.uk/european-institute/Assets/Documents/LEQS-Discussion-Papers/LEQSPaper156.pdf [Accessed 25.01.2023].
Department of Health Republic of the Philippines Health Technology Assessment, "Universal Health Care Act," URL = https://hta.doh.gov.ph/universal-health-care-act/ [Accessed 15.05.2022].
Fried Ch. (1976), "Equality and Rights in Medical Care," *Hastings Center Report* 6 (1): 29–34.
Gostin L.O., Koh H.H., Williams M. et al. (2020), "US Withdrawal from WHO is Unlawful and Threatens Global and US Health and Security," *Lancet* 396 (10247): 293–295.
Greer S.L. (2017), "Medicine, Public Health and the Populist Radical Right," *Journal of the Royal Society of Medicine* 110 (8): 305–308.
Hapal K. (2021), "The Philippines' COVID-19 Response: Securitising the Pandemic and Disciplining the Pasaway," *Journal of Current Southeast Asian Affairs* 40 (2): 224–244.
Harman E. (2016), "Morally Permissible Moral Mistakes," *Ethics* 126 (2): 366–393.
Hedges K., Lasco G. (2021), "Medical Populism and COVID-19 Testing," *Open Anthropological Research* 1: 73–86.
Hobsbawm E.J. (1990), *Nations et nationalisme depuis 1780*, Gallimard, Paris.
Janssen M., van der Voort H. (2020), "Agile and Adaptive Governance in Crisis Response: Lessons from the COVID-19 pandemic," *International Journal of Information Management* 55 (102180).
Jones P. (2013), "Moral Rights, Human Rights and Social Recognition," *Political Studies* 61 (2): 267–281.

Laclau E. (2005), "Populism: What's in a Name?," [in:] *Populism and the Mirror of Democracy*, F. Panizza (ed.), Verso Books, London, New York: 32–49.
Lasco G. (2020), "Medical Populism and the COVID-19 Pandemic," *Global Public Health* 15 (10): 1417–1429.
Lasco G., Curato N. (2019), "Medical Populism," *Social Science & Medicine* 221: 1–8.
Mabaquiao N.M. (2020), "Justice in Healthcare: Welfare and Equal Opportunity," *Asia-Pacific Social Sciences* **Review** 21 (2): 197–212.
Mabaquiao N.M., Dacela M.A.L. (2022), "Moral Right to Healthcare and COVID-19 Challenges," *Asia-Pacific Social Science Review* 22 (1): 78–91.
Moffitt B. (2016), *The Global Rise of Populism: Performance, Political Style, and Representation*, Stanford University Press, Stanford.
Mudde C. (2017), "Populism: An Ideational Approach," [in:] *The Oxford Handbook of Populism*, C. Rovira Kaltwasser, P.A. Taggart, P. Ochoa Espejo, P. Ostiguy (eds), Oxford University Press, Oxford: 24–47.
Mudde C., Rovira Kaltwasser C. (2017), *Populism: A Very Short Introduction,* Oxford University Press, Oxford.
Mudde C., Rovira Kaltwasser C. (2018), "Studying Populism in Comparative Perspective: Reflections on the Contemporary and Future Research Agenda," *Comparative Political Studies* 51 (13): 1667–1693.
Müller J.-W. (2016), *What is Populism?,* University of Pennsylvania Press, Philadelphia.
O'Neill O. (2005), "The Dark Side of Human Rights," *International Affairs* 81 (2): 425–439.
Ostiguy P. (2017), "Populism: A Socio-Cultural Approach," [in:] *The Oxford Handbook of Populism*, C. Rovira Kaltwasser, P.A. Taggart, P. Ochoa Espejo, P. Ostiguy (eds), Oxford University Press, Oxford: 73–97.
Patel N. (2020), "Why the CDC Botched its Coronavirus Testing," URL = https://www.technologyreview.com/2020/03/05/905484/why-the-cdc-botched-its-coronavirus-testing/ [Accessed 30.05.2022].
Pavel C.E. (2019), "Healthcare: Between a Human and a Conventional Right," *Economics and Philosophy* 35 (3): 499–520.
Perry M.J. (2020), "The Morality of Human Rights," *Human Rights Quarterly* 42 (2): 434–478.
Pillay N. (2008), "Right to Health and the Universal Declaration of Human Rights," *Lancet* 372 (9655): 2005–2006.
Recio-Román A., Recio-Menéndez M., Román-González M.V. (2022), "Political Populism, Institutional Distrust and Vaccination Uptake: A Mediation Analysis," *International Journal of Environmental Research and Public Health* 19 (6): 3265.
Rogers S.L., Cruickshank T. (2021), "Change in Mental Health, Physical Health, and Social Relationships during Highly Restrictive Lockdown in the COVID-19 Pandemic: Evidence from Australia," *PeerJ 9* (e11767): 1–28, URL = https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8310621/pdf/peerj-09-11767.pdf [Accessed 15.10.2022].
Rovira Kaltwasser C., Taggart P.A., Ochoa Espejo P., Ostiguy P. (2017), *The Oxford Handbook of Populism*, Oxford University Press, Oxford.
Ross W.D. (1930), *The Right and the Good,* Hackett.
Rueda D. (2020), "Is Populism a Political Strategy? A Critique of an Enduring Approach," *Political Studies* 69 (2): 1–18.
Rutledge P.E. (2020), "Trump, COVID-19, and the War on Expertise," *The American Review of Public Administration* 50 (6–7): 505–511.
Speed E., Carter S., Green J. (2022), "Pandemics, Infection Control and Social Justice: Challenges for Policy Evaluation," *Critical Public Health* 32 (1): 44–47.

Speed E., Mannion R. (2020), "Populism and Health Policy: Three International Case Studies of Right-wing Populist Policy Frames," *Sociology of Health & Illness* 42 (8): 1967–1981.

Speed E., Mannion R. (2021), "Performing Populist Health Policy: The Case of the English National Health Service," [in:] *Managing Healthcare Organisations in Challenging Policy Contexts, Organizational Behavior in Healthcare*, R. Kislov, D. Burns, B.E. Mørk, K. Montgomery (eds), Palgrave Macmillan, Cham: 49–66.

Sreenivasan G. (2012), "A Human Right to Health? Some Inconclusive Skepticism," *Aristotelian Society Supplementary Volume* 86 (1): 239–265.

Teehankee J.C. (2022), "The Philippines in 2021: Twilight of the Duterte Presidency," *Asian Survey* 62 (1): 126–136.

Tohăneanu C. (2015), "Could Ross's Pluralist Deontology Solve the Conflicting Duties Problem?," *Revue Roumaine de Philosophie* 59 (1): 109–124.

UP COVID-19 Pandemic Response Team (2020), "Estimating Local Healthcare Capacity to Deal with COVID-19 Case Surge: Analysis and Recommendations," URL = https://up.edu.ph/estimating-local-healthcare-capacity-to-deal-with-covid-19-case-surge-analysis-and-recommendations/ [Accessed 28.05.2022].

Velasquez M.G. (2014), *Business Ethics: Concepts and Cases: International Edition* (7th edition),Pearson Education Limited, Edinburgh.

Vranas P. (2018), "'Ought' Implies 'Can' but Does Not Imply 'Must': An Asymmetry Between Becoming Infeasible and Becoming Overridden," *Philosophical Review* 127 (4): 487–514.

Walby S. (2021), "The COVID Pandemic and Social Theory: Social Democracy and Public Health in Crisis," *European Journal of Social Theory* 24 (1): 22–43.

Weyland K. (2017), "Populism: A Political-Strategic Approach," [in:] *The Oxford Handbook of Populism*, C. Rovira Kaltwasser, P.A. Taggart, P. Ochoa Espejo, P. Ostiguy (eds), Oxford University Press, Oxford: 48–72.

Wolff J. (2012), "Global Justice and Health: The Basis of the Global Health Duty," [in:] *Global Justice and Bioethics,* J. Millum, E. Emanuel (eds), Oxford University Press, Oxford: 78–101.

Yamey G., Gonsalves G. (2020), "Donald Trump: A Political Determinant of Covid-19," *BMJ* 369:m1643.

Zuchhino D., Abed F. (2021), "'Covid Can't Compete.' In a Place Mixed in War, the Virus is an Afterthought," URL = https://www.nytimes.com/2020/12/20/world/asia/covid- afghanistan-coronavirus.html [Accessed 28.05.2022].