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Pandemic and sociosanitary policies in Latin America

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Abstract. This paper analyzes the health and socio-economic policies adopted by six Latin American countries during the SARS-CoV-2 pandemic: Argentina, Brazil, Chile, Colombia, Mexico, and Peru. It proposes the hypothesis that the behavior of the pandemic and the decisions taken depended on the relations between relevant situational factors—namely, the profile of the government and state elites—and structural elements such as state capacities, sociodemographic characteristics, and human development indexes. This article adopts a comparative analytic strategy and employs a combination of quantitative and qualitative methodologies.

Keywords: pandemic, public policy, state capacities

Introduction

From February 26, 2020, when the first case of SARS-CoV-2 in Latin America was identified, the region's governments implemented a series of sociosanitary policies. As the pandemic went on and lockdowns were enforced, the economic, social, and human consequences became apparent. Historical problems afflicting health systems as well as poverty, unemployment, and inequality became topics of debate, and, in the best outcomes, the focus of government intervention. Though the response to the pandemic was primarily a biomedical one, propagation has also been a function of social behavior conditioned by economic and social structures as well as public policies (Nercesian, Cassaglia, & Morales Castro, 2020). The history of pandemics and their social effects has been explored in the social sciences employing different approaches. Thus, there have been important studies that examine the political role of pandemics in processes of conquest and colonization (Cook, 1998; García Caceres, 2003; Guerra, 1988; Navarrete, 2019). For instance, Benedictow's "The Black Death, 1346--1353: The Complete History" is a substantial contribution to the study of pandemics at the start of early modernity, an age of social and economic changes that put an end to the dominance of feudalism.

Of the 20 worst pandemics in the history of humanity, 17 occurred under capitalism. Therefore, studying the relationship between both phenomena, and in particular the formation of capitalism in Latin America, is a necessary undertaking (Ansaldi, 2020). Accordingly, a series of talks organized by Frank Molano Camargo, "Capitalismo, Pandemia y Naturaleza" (2020), analyzed the relationship between the economic cycles of capitalism, nature, and pandemics such as malaria, human immunodeficiency virus, and SARS-CoV-2. The main focus was the relationship between cycles of accumulation, reorganization of the capitalist system of accumulation, and the emergence of new diseases.

Other historical analyses of pandemics have taken into account the social impact of diseases, as well as the incorporation of new concepts and how these are integrated into public policies. In the 19th century, cholera epidemics occurred as new concepts such as hygiene, public health, and urban reform were coming into use. (Briggs,1961; Pascual, 2017; Rosemberg & Golden, 1992). These types of concepts revealed the relationships between sanitary issues and the socioeconomic and living conditions of popular sectors, which bore the brunt of pandemics. A study relevant to Latin America is Armus (2003), which analyzes disease treatment with a focus on health institutions as well as economic, political, and social structures. Another salient study is Cueto (1997), which

examines pandemics in Peru based on three variables: the impact of disease and the biological and ecological factors behind it; the techniques and policies applied by the state to combat it; and social responses. Fiquepron (2020) stresses the problem of class relations and the inequalities accentuated by epidemics, as well as state actions to tackle these critical phenomena. For the Argentine case, there are outstanding studies from a historical perspective: Ramaciotti & Rayez, (2020) focus on the relationship between health policies and the state, while Belmartino (2009) explores the notion of critical junctures in medical intervention—that is, moments of institutional adjustment involving multiple factors such as the correlation of forces between social actors, the established rules of play, and predominant organizational forms.

In this article we take a complex and multifaceted approach to exploring the phenomenon of the SARS-CoV-2 pandemic, taking into account not only the dimension of health but also economic, social, political, and state-related issues. The study of public policies provides a glimpse into the state in motion, disaggregating the structure into a specific social process and observing its actors, classes, class factions, organizations, and, ultimately, individuals (Oszlak & O'Donnell, 1981). The structuring of needs, the political agenda, and pre-existing socio-economic conditions were crucial to the responses of Latin American states, and so different paths can be discerned from one country to another. For example, taking health policy as a variable, one possible characterization is to group national cases into "deniers" (Brazil and, in a sense, Mexico), "gradualists" (Chile and, to an extent, Colombia), and "strict" (Argentina, Peru) (Belardo & Herrero, 2020). Regardless of these differences, health is a key determinant of well-being that is linked to economic growth, poverty, and levels of inequality, and is influenced by equity and the efficiency of public actions within this sphere (Lustig, 2008). Our hypothesis is that the evolution of the pandemic and the management of the health crisis were a product of political decisions on the part of governments, but also of the structural traits of countries, state capacities, sociodemographic characteristics, and human development indices. In this study we will focus on six national-level cases—specifically, those countries with the highest infection rates in the region. First, we study state powers and health policies related to pandemic control; and second, the socioeconomic tactics pursued to mitigate the economic impact.

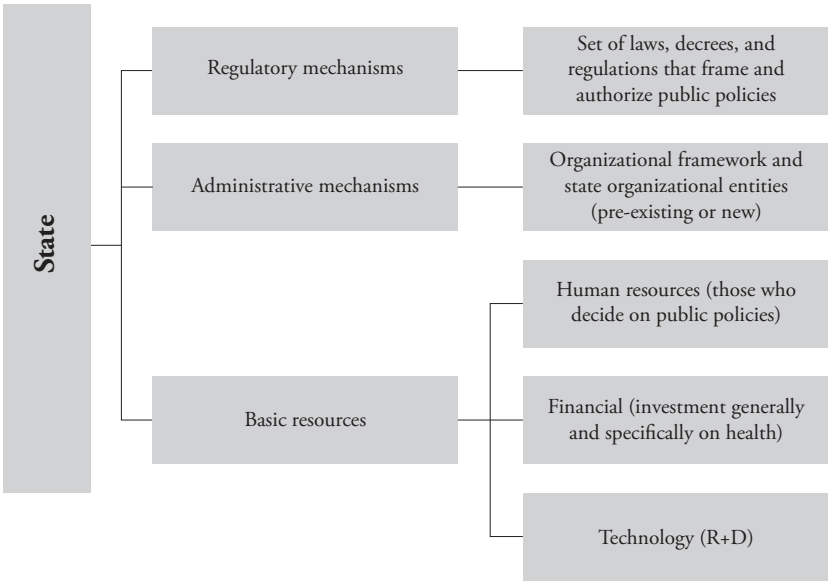
Public responses to the pandemic, in terms of the strategies adopted, went through different stages. In the first, amid uncertainty and lack of knowledge of the virus, measures involved lockdowns, mobility restrictions, and general care measures. The second stage, when knowledge of the virus was

more advanced and methods for mitigating its propagation had improved, was characterized by increased testing, better treatment of patients, and socioeconomic policies of broader scope. Thereafter, the emergence of vaccines gave rise to a third stage in which the actions taken were oriented toward vaccine production, purchase, distribution, and application. This third stage was still ongoing at the time of writing, so in this article we focus on the first two.

State capacities, public policy instruments, and health policies

State capacities refer to the tools available to a government to implement a series of public policies and prevent, resolve, or ameliorate society's problems. To implement their plans, states avail themselves of a group of instruments known as "regulatory mechanisms," "administrative mechanisms," and "basic resources." The first relates to the set of regulations and laws; the second, to a pre-existing or new organizational structure; and the third, to the concrete opportunities for policy activation enabled by human, financial, and technological resources (Isuani, 2012). The process of configuring these instruments responds to a wide range of socio-historic questions related and not related to the state, and to the various social actors that make up societies. Essentially, these are powers that are historically accumulated and established, and deployed in response to urgent problems.

Figure 1 State capacities



Source: compiled by authors.

With few exceptions, practically all countries in Latin America introduced pandemic-response policies, albeit of differing degrees of magnitude, scope, and prospects of compliance. The ideological profile of the government is an important variable, as it constitutes one of the dimensions of the administrative mechanisms and defines those who, ultimately, make the public policy decisions. Countries also possess a set of attributes that have been constructed historically, over the centuries: Is the state weak or strong? Is centralization strong or weak? Is the state federal in which local authorities either revolve around or exert pressure on the central government? What are the historical characteristics of investment in the areas of health, science, and technology? What are the characteristics of the health systems? Based on the structural elements and state capacities that influence the behavior of the pandemic, we group together the countries as follows:

Table 1
State capacities, human development, and type of economy

	Large economies	Medium-sized and small economies	
	Low human development	High human development	Low human development
Strong states	Brazil and Mexico	Argentina	-
Weak and/or privatized states	-	Chile	Colombia and Peru

Source: compiled by authors

In the historical sociological tradition of Lechner (1977) and Oszlak (1978), revisited by Ansaldi and Giordano (2012), the conception of state formation belongs to a broader historical process of "social creation" that is integral to processes such as nation, market, class, and ideology. As well as being entwined with class relations—in addition to class conflict—and, ultimately, the economy, the state is an institution that exhibits the attributes (Oszlak, 1978) or, in Therborn's (2016) terms, the great apparatuses of statehood: governmental, administrative, judicial, and repressive. In this article we draw on Ansaldi and Giordano's (2012) characterization of the historical composition of the state, based on the intersection of multiple variables, to build a typology. We consider strong states to be those in which robust economies, large governmental apparatuses (national and provincial/state/departmental), and complex administrative apparatuses (due to the size of the country) coexist with the commensurate judicial and repressive structures. They can be distinguished from small or weak states whose socio-historical processes of state integration have been more complex, their economies medium to small, and their state apparatuses less complex. The

case of Chile is an unusual one; although state formation came early and centralization of power was swift, military dictatorship and an enduring neoliberal model gave rise to a state that is strong in terms of the exercise of authority but weak when it comes to infrastructural capacity to penetrate the various dimensions of civil society. It should be noted that these are sociologically understood "types" that mark out tendencies and allow for better reflection regarding the phenomena in question.

Following detection of the first cases of SARS-CoV-2 in the region, the health measures implemented, such as declarations of states of emergency, closure of borders, implementation of mandatory lockdowns, and suspension of in-person classes, were similar across all countries. After Peru, Argentina was the second country to adopt early sanitary standards that stressed the concept of care.[1] The country ordered the closure of its borders on March 15, 2020, and a mandatory lockdown five days later. Argentina put in place what several countries in the regionb called Mandatory Preventative Social Isolation (Aislamiento Social Preventivo y Obligatorio, ASPO) until November 7 in the Autonomous City of Buenos Aires and its surroundings, in which 37% of the country's population, 40% of its GDP, and 30% of its poverty are concentrated.[2] Although the lockdown was one of the strictest and most extensive in the region, recreational and economic activities gradually resumed. Google's Community Mobility Report for the Buenos Aires Metropolitan Area[3] points to drastic changes in the use of leisure sites (-34%) and public transport (-37%), and in workplace attendance (-33%).

Although in-person classes were called off on the same day as the border closure, under Argentina's federal system some provinces partially reintroduced them thereafter. According to data from the Economic Commission for Latin America and the Caribbean (ECLAC), the Argentine government allocated 3.9 percent of its GDP to addressing the pandemic (CEPAL, 2020). In turn, Pan American Health Organization (PAHO) data estimated the number of intensive care unit (ICU) beds at 18.68 per 100,000 inhabitants at the time the pandemic started.[4] Argentina has the second-highest

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1 For example, the smartphone app that permitted exceptional movement was called Cuidar ("care"), and, in various press conferences as well as official communications, reference was made to the paradigm of care.

2 Ministerio del Interior, Obras Públicas y Vivienda. *Cocamba*. Retrieved from https://www.buenosaires.gob.ar/sites/gcaba/files/modulo_12_-_suarez_lastra.pdf

3 Google. (March 9, 2021). *Cambios en la movilidad. Buenos Aires*. Retrieved from https://www.gstatic.com/covid19/mobility/2021-03-09_AR_Buenos_Aires_Mobility_Report_es-419. pdf

4 According to data from the Organization for Economic Development and Cooperation (OECD) health spending in the United States, at 17 percent of GDP (2019) and the number of ICU beds

level of investment in research and development (R+D) in the region, after Brazil. Moreover, according to the United Nations Development Program (UNDP, 2020) (Table 2), the country has one of Latin America's highest health capacities in terms of medical personnel, hospital beds, and current health spending.

Moreover, after the pandemic started, health systems were expanded—in terms of overall capacity and the number of ICU beds, which increased by 37 percent.[5] Despite its federal system, coordination of public policies was effective on a national scale. Unlike the majority of countries in the region, Argentina's social distancing provisions and robust health system spared its health infrastructure from collapse.

For its part, Brazil, under the presidency of Jair Bolsonaro (2018-), pursued a strategy of denial (Belardo & Herrero, 2020), choosing to underestimate the scale of the pandemic and disbelieve scientists despite being the country with the highest R+D investment in the region and the track record of its knowledge development and public universities. Unlike Argentina, and despite having a similar federal structure, in Brazil there were considerable discrepancies between the pandemic-response policies of the central government and those of the different states, although lockdown measures, cancellation of face-to-face classes, postponement of large-scale activities, and the total closure of borders were never established at the national level. On the contrary, it was Brazil's state-level authorities that exercised decision-making power. The Google Community Mobility Report for the country's most populous states—São Paulo,[6] Minas Gerais,[7] and Rio de Janeiro[8]—reveals a marked reduction in the usage of leisure spaces, but a much lower decrease in the use of public transport and travel to work in comparison with Argentina.

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at 28.8 per 100,000 inhabitants (2018). Germany leads the European Union, with spending of 11.7% (2019) and 33.9 ICU beds per 100,000 inhabitants (2017). The average spending of the OECD countries is 8.8 of GDP, while there are 15.9 ICU beds for every 100,000 people.

5 Argentina.gob.ar. (Tuesday, July 7, 2020). *El país aumentó en un 37% la cantidad de camas de terapia intensiva durante el aislamiento social*. Retrieved from https://www.argentina.gob.ar/noticias/el-pais-aumento-en-un-37-la-cantidad-de-camas-de-terapia-intensiva-durante-el-aislamiento

6 Google. (March 9, 2021). *Mudanças na mobilidade. Sao Paulo:* Retrieved from https://www.gstatic.com/covid19/mobility/2021-03-09_BR_State_of_São_Paulo_Mobility_Report_pt-BR.pdf

7 Google. (March 9, 2021). *Mudanças na mobilidade.Minas Gerais.* Retrieved from https:// www.gstatic.com/covid19/mobility/2021-03-09_BR_State_of_Minas_Gerais_Mobility_Report_pt-BR.pdf

8 Google. (March 9, 2021). *Mudanças na mobilidade. Río de Janeiro.* Retrieved from https:// www.gstatic.com/covid19/mobility/2021-03-09_BR_State_of_Rio_de_Janeiro_Mobility_Report_pt-BR.pdf

In addition to these differences between local and national authorities, the health ministry changed hands on three occasions—at time of writing the incumbent was General Eduardo Pazuello, a man with no experience in the field of public health. Brazil's health spending is relatively high in comparison with other national governments, albeit below levels that would be expected given the country's territorial and socio-demographic dimensions. According to data published by the Pan American Health Organization (PAHO), Brazil has 8.0 ICU beds per 100,000 inhabitants and investment in private healthcare that exceeds public-sector levels (OPS, 2020).

The Brazilian government has repeatedly stressed the importance of keeping the economy active, a concern that is also reflected in the 4.6% of GDP assigned to tackling the economic fallout from the pandemic (CEPAL, 2020). The lack of coordination over health policy between national and local governments, an insufficiently robust health system, and ignorance of the implications of not implementing lockdown measures brought the health system to a halt in several states—such as Amazonas, Pará, Ceará, Pernambuco, Maranhão, and Rio de Janeiro—at critical points during the pandemic.[9]

In Chile, the government of Sebastián Piñera (2018–) confronted the pandemic amid low approval ratings and a general perception that his government, and the country's political system as a whole, lacked legitimacy. Shortly before the first cases of Covid-19 were diagnosed, the country was in the throes of social unrest and policies of state repression. Although Chile closed its borders on March 18, 2020 and postponed in-person classes (which were gradually restarted in October), the government was slow to introduce a lockdown, only doing so in May (two months after Argentina, Colombia, and Peru) when its health system was on the brink of collapse.

To ensure compliance with its confinement measures, Chile declared a state of emergency, implemented various curfews, and deployed the military, which played a key role in certain areas.[10] The Google Community Mobility Report[11] for the Santiago Metropolitan Area indicates that usage

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9 El Litoral. August 5, 2020). *Colapsa el sistema de salud en seis estados brasileros.* Retrieved from www.ellitoral.com/index.php/id_um/238618-colapsa-el-sistema-de-salud-en-seis-estados-brasieros-tanto-la-red-publica-como-la-privada-internacionales.html

10 Rojas Sasse, E. (March 31, 2020). *América Latina: el coronavirus favorece la militarización de la seguridad pública.* DW. Made for minds. Retrieved from https://www.dw.com/es/am%C3%A9rica-latina-el-coronavirus-favorece-la-militarizaci%C3%B3n-de-la-seguridad-p%C3%BAblica/a-52974691

11 Google. March 9, 2021). *Cambios en la movilidad. Región Metropolitana*. Retrieved from https://www.gstatic.com/covid19/mobility/2021-03-09_CL_Santiago_Metropolitan_Region_Mobility_Report_es-419.pdf

of leisure facilities changed to a lesser extent than in Argentina and Brazil (-25%). The report did show that there was greater variation in the use of public transport than in Brazil, but less than in Argentina.

Although the Chilean government announced that 5.7% of the country's GDP would be allocated to the pandemic response (CEPAL, 2020), these resources were not enough to prevent the collapse of its health system. The country's public investment in R+D before the pandemic was 36%, just one point above the 34.9% that the private sector spent in this sphere. In the health sector, private and public expenditures were practically equal (UNESCO, 2021). According to PAHO figures (OPS, 2020), Chile has a shortage of ICU beds: just 6.4 for every 100,000 people. Moreover, its ratio of health professionals (nurses and doctors) is among the lowest in the region. Despite a dramatic reduction in mobility,[12] the failure to impose an early lockdown and the comparative limitations of Chile's health system combined to overwhelm the health infrastructure in the Santiago Metropolitan Region—home to 37% of the population (Nercesian, Cassaglia, & Morales Castro, 2020).

In Colombia, despite political centralism, the failure of the Iván Duque administration (2018–) to adopt efficient early sociosanitary measures and its lack of awareness of actions taken at the local level sparked clashes with sub-national authorities. The government was hesitant about closing its air borders and imposing a lockdown, only implementing these respective measures on March 23 and 25, 2020. Meanwhile, in-person classes were canceled on March 16, and remained so for the rest of the year. A few weeks after imposing its ASPO, Colombia witnessed the phenomenon of the *trapos rojos* ("red rags")—a movement that sought to draw attention to the lack of food and resources for vulnerable classes, of whom 47.5% worked in the informal sector.[13] The movement was instrumental to the replacement in May of the blanket lockdown with localized confinement measures, which, it was hoped, would boost economic activity while decongesting a health system that was often on the verge of paralysis.[14]

As is the case in Chile, Public and private investment in R+D and healthcare are of a similar magnitude in Colombia. According to the PAHO (OPS,

12 Google. March 9, 2021). *Cambios en la movilidad. Santiago de Chile.* Retrieved from https://www.gstatic.com/covid19/mobility/2021-01-03_CL_Santiago_Metropolitan_Region_Mobility_Reprt_en.pdf

13 See https://www.dane.gov.co/files/investigaciones/boletines/ech/ech_informalidad/bol_geih_informalidad_ago20_oct20.pdf

14 D.W Made for minds. *Bogotá: se acerca el colapsa sanitario.* Retrieved from https://www.dw.com/es/bogotá-se-acerca-el-colapso-sanitario/av-54382205

2020), prior to the pandemic Colombia had the third highest number of ICU beds in the region after Uruguay and Argentina (10.54 per 100,000 inhabitants). Although the country's testing policy gained international recognition,[15] social assistance and the resources assigned to tackling the emergency proved insufficient. ECLAC (CEPAL, 2020) points out that Colombia allotted only 1.7% of its GDP to the crisis—much less than other countries in the region such as Argentina, Brazil, Chile, and Peru. It is important to stress that despite the relaxation of the lockdown, inhabitants of the major cities—especially Bogotá, where 20% of Colombians live—continued to socially distance; according to the Google Mobility Report,[16] the capital city witnessed dramatic reductions in the use of public and recreational spaces. Social behavior and localized lockdown measures helped to keep the health system running.

Upon taking office in 2018, Mexico's President López Obrador signaled a departure from 40 years of neoliberal continuity. His administration did not enforce border closure or lockdown measures, though it did suspend in-person classes. Mexico has a federal structure marked by stark contrasts between geographical areas, ethnic groups, and socioeconomic levels (Lustig, 2008). It has a level of investment in healthcare (public and private) that is far below what would be expected given the size of its economy. According to the OECD,[17] before the pandemic Mexico had just 124,000 hospital beds. Nor does Mexico have R+D investment to match the size of its territory or its economy. The health policies that Mexico put in place in response to the pandemic were somewhat lax and limited in scope; there was no official lockdown, and inhabitants were not required to remain in their homes. Government recommendations on keeping a "safe distance" were inadequate; the Google Community Mobility Reports[18] reveals that Mexicans were among those who least respected social distancing in Latin America.

Peru was quick to close its borders and implement a mandatory lockdown (on March 15 in both cases). The confinement remained in place until July 1—a total of 107 days—although certain activities were permitted from May onwards. Meanwhile, in-person classes at schools and universities were suspended on March 11, and these measures continued until the end of the year.

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15 Organización Panamericana de la Salud. *Colombia*. Retrieved from https://www.paho.org/sites/default/files/colombia_caso_respuesta_covid19_julio_2020.pdf

16 Google. (March 9, 2021). *Cambios en la movilidad. Bogotá.* Retrieved from https://www.gstatic.com/covid19/mobility/2021-01 03_CO_Bogota_Mobility_Report_en.pdf

17 See https://stats.oecd.org/Index.aspx?DataSetCode=HEALTH_REAC

18 See https://www.google.com/covid19/mobility

Peru's public health emergency unfolded in parallel to a critical political situation. President Martín Vizcarra (2018-2020) was impeached for "moral unfitness," and was succeeded by the interim administrations of Manuel Merino (which lasted five days) and Francisco Rafael Sagasti (2020–). Even though Peru took early measures to control the spread of the pandemic, implementing a strict lockdown that included curfews, the country's health systems and installed capacities were quickly overwhelmed. Peru has one of the region's lowest rates of R+D investment in the field of health. According to PAHO (OPS, 2020), at the time this report was published, Peru had 2.58 ICU beds for every 100,000 inhabitants. Despite the government's sizable investment in its pandemic response—around 4.8% of GDP (CEPAL, 2020)—and its efforts to enforce social distancing, Peru's informal labor rate of around 70% (Nercesian, Cassaglia, & Morales Castro, 2020) and its precarious health system were conducive to rapid propagation of the virus. The Google Community Mobility Report for Lima[19] yields similar values to those of Chile. Community circulation of the virus, the high rate of infections, and the paucity of ICU beds engulfed Peru's health system.

19 Google. (March 9, 2021). *Cambios en la movilidad. Gobierno Regional de Lima*. Retrieved from https://www.gstatic.com/covid19/mobility/2021-03-09_PE_Lima_Region_Mobility_Report_es-419.pdf

Table 2
Investment in health and R+D

	Argentina	Brazil	Chile	Colombia	Mexico	Peru
Population total (2020)	45,196,000	212,559,000	19,116,000	50,883,000	128,933,000	32,972,000
Global economic ranking (2018)	24	9	40	37	15	49
USD per capita on private health (2017)	959	389	692	311	255	211
USD per capita on public health (2017)	359	539	690	148	240	121
Total USD per capita on health (public and private sectors)	1,318	928	1,382	459	495	332
% GDP allocated to R+D	0.5%	1.3%	0.4%	0.2%	0.5%	0.1%
Public investment in R+D (% of total investment in R+D) (2014)	74.0%	54.9%	36.0%	42.0%	60.8%	-

Sources: Compiled by author based on World Bank and World Health Organization (WHO) and ECLAC data.

Table 3
Human development and health systems

		Argentina	Brazil	Chile	Colombia	Mexico	Peru
Human development	Human development index (HDI) (2018)	0.830	0.761	0.847	0.761	0.767	0.759
	HDI adjusted for inequality (2018)	0.714	0.574	0.673	0.585	0.595	0.612
	HDI inequality (%) (2018)	14.0	24.5	20.5	23.1	22.5	19.4
Health system	Doctors per 10,000 inhabitants (2018)	39.6	21.5	10.8	20.8	22.5	12.7
	Nurses per 10,000 inhabitants (2018)	26	97	9	13	29	14
	Public health spending (% GDP) (2016)	50	22	22	15	15	16
	Hospital beds per 10,000 inhabitants (2018)	7.5	11.8	8.5	5.9	5.5	5.1

Source: UNDP (2020)

Socioeconomic policies

The pandemic cost in human lives, social isolation, and restrictions on the mobility of people and the circulation of goods placed economic precepts under strain. The resultant health crisis deepened the global economic recession—which had been dragging on since the international financial crisis of 2008 (Dörre, 2020)—to levels similar to those of the Great Depression of 1930 (Acosta & Guijarro, 2020).

In Latin America, the slump was aggravated by the historic vulnerability of its economies. According to ECLAC projections, the region's GDP was poised to shrink by 5.3% in 2020. To put this into historical perspective, these figures are equivalent to the crisis of 1930 (5%) and World War I (4.9%), and of a greater margin than the downturn in 2009 (2%) (Katz, 2020). The scale of the crisis in the region is related to the confluence of four factors: the collapse of the prices of raw materials; the recession in China, Latin America's main trading partner, which caused a drop in demand; foreign currency shortages due to dwindling tourism and high volumes of remittances; and the deterioration of global value chains, to which Central America, with its intensive use of unskilled labor, is particularly vulnerable. To make matters worse, the region's borrowing capacity diminished.

Unemployment, informal employment, and poverty all compounded the situation. In many cases, overcrowding and deficiencies in the provision of water and health services hampered compliance with preventative social distancing and hygiene measures (Nercesian, Cassaglia, & Morales Castro, 2020). Moreover, the health emergency overlapped with the prevalence of other infectious diseases such as dengue. The disadvantages of Latin America in these areas is reflected in the healthcare coverage gap. The region's average investment in health is 2.2% of GDP, well below the six percentage points recommended by the WHO and in contrast to the near-10% average recorded by the advanced economies (Katz, 2020).

Table 4
Social indicators

Country	Extreme poverty* (% population)	Poverty* (% population)	Gini index	Informal employment (% total employment)	Unemployment (average annual rate)	Slums, squatter settlements or inadequate housing (% urban population
Argentina	1.0 (2018)	9.6 (2018)	0.414 (2018)	49.4 (2019)	9.8 (2019)	16.7 (2014)
Brazil	4.4 (2018)	19.9 (2018)	0.538 (2019)	45.0 (2015)	11.9 (2019)	22.3 (2014)
Peru	0.3 (2017)	3.7 (2017)	0.454 (2017)	29.2 (2019)	7.2 (2019)	9.0 (2014)
Colombia	4.1 (2018)	27.8 (2018)	0.529 (2019)	62.1 (2019)	9.9 (2019)	13.1 (2014)
Mexico	1.7 (2018)	23.0 (2018)	0.475 (2018)	-	3.5 (2019)	11.1 (2014)
Peru	2.6 (2018)	22.1 (2018)	0.429 (2019)	68.4 (2019)	3.9 (2019)	34.2 (2014)
Latin America (average)	4.4 (2018)	24.1 (2018)	0.460 (2019)	-	8.0 (2019)	21.0 (2014)

* Population living on less than 1.9 dollars per day.
* Population living on less than 5.5 dollars per day.
Source: Compiled by authors based on CEPAL. World Bank, and International Labor Organization (ILO) data.

In this framework the state has been a prominent economic promoter, going against the neoliberal dogma of free-market regulation. Nonetheless, the various approaches to pandemic management applied in the region have laid bare differing conceptions of the role of the state (Fantozzi, 2020). One style of governance is that of Brazil, where economic activity was accompanied by an official discourse that turned a blind eye to the human cost. President Jair Bolsonaro downplayed the health consequences of the pandemic, pushing for the early resumption of both commercial activity and human mobility and even contravening the subnational measures taken by the different states. The result is that Brazil has recorded the lowest long-term fall in GDP and, at the same time, the highest per capita death rate.

In Argentina, the government took the opposite position. The official discourse was strongly state-centric, stressing the importance of public policies in tackling the pandemic and prioritizing the mitigation of its social effects over ameliorating the economic impact. Unlike Brazil, the public strategies were designed at central government-level and coordinated together with the governors of provinces. At the level of both discourse and governance, there was a degree of vertical articulation and coherence that was sustained over time. This meant that the Argentine government took responsibility for the results of health policies, and for the inevitable decline in economic activity.

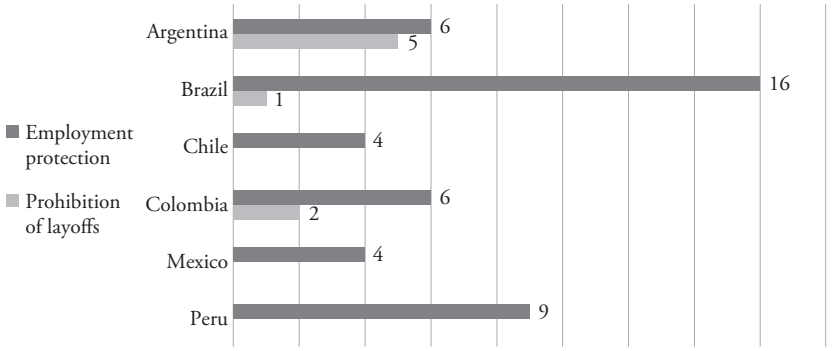
The other countries lay somewhere in the middle of these two extremes, constituting hybrid cases in which government provisions and discourse fluctuated between containing the social implications of the pandemic and maintaining some degree of economic activity. Depending on their state capacities, these countries exhibited a socio-centric approach that, unlike the statist conception, placed more emphasis on the responsibility of civil society vis-a-vis the pandemic.

On the socioeconomic policy front, Latin American countries allocated resources to offset the drop-off in commercial activity. However, state aid was well below that of the so-called core economies; the United States and Japan, for instance, allocated around 10% and almost 20% of GDP, respectively, to economic stimulus whereas in Argentina, Brazil, and Mexico this figure ranged between 0.7% and 3.5% of GDP (Katz, 2020). How much capital was dedicated to economic recovery varied from country to country, but in general terms, itwas targeted at wage earners, employers, and the most marginalized sectors.

The social effects of the pandemic resulted in greater labor flexibilization, accompanied by wage reductions, suspensions, and layoffs. The labor crisis

was considerable in the region as a whole, but its scale in each country depended on the level of informality.

Figure 2
Employment policies



Source: Compiled by authors based on ECLAC data.

In this domain, there have been two styles of pandemic management. On the one hand, Brazil implemented a battery of regulations aimed at sustaining economic activity, which were heavily skewed toward employers and contained only limited provisions for job protection. A notable introduction was Provisional Measure (PM) No. 927 (implemented on March 22, 2020 and in force until July 19), which permitted individual agreements between employer and employee regarding arrangements for teleworking, advance annual leave, holidays, collective leave, and flextime, and so on.[20] As part of the Emergency Program for Sustaining Employment and Income (PM No. 936, sanctioned by Law No. 14,020 on July 6, 2020), the federal government enacted the Emergency Job Support Program (PM No. 944), which financed the equivalent of two months' pay for workers in companies with a turnover between 360,000 and 10 million reais (USD 68,000 and 1.9 million) per year. Only the employers subject to this program were prohibited from dismissing workers without cause.

By contrast, Argentina was the only country that introduced blanket restrictions on layoffs,[21] first implemented on March 31, 2020 for a period of 60 days (Necessity and Urgency Decree [NUD] No. 329) and renewed in

20 System whereby employees do not receive paid overtime for work days of more than eight hours, but are instead compensated by way of reduction of future work days within a period of one year.

21 Colombia introduced similar measures, but these only applied to private firms contracted by the state (Decree No. 488, Ministry of Labor [MinTrabajo]).

May, September, and November.[22] When it came to furloughing employees, the federal government, the Argentine Industrial Union (Unión Industrial Argentina, AIU), and the General Labor Confederation (Confederación General del Trabajo, CGT) negotiated the payment of at least 75% of the corresponding net salary (Resolution No. 475, Ministry of Labor, Employment, and Social Security [MTESS]). Although Argentina implemented fewer protection mechanisms, those it did put in place were focused on job protection and workers' income.

Table 5
Coverage of social and employment protection programs, protection measures during the pandemic, interannual variation in unemployment and informal employment rates[23,24]

	Argentina	Brazil	Chile	Colombia	Mexico	Peru
Population covered by social protection and employment programs (total population %) (2016)	53.6	46.2	12.3	34.3	34.3	35.1
Social protection and employment measures taken during the pandemic	25	32	15	21	7	22
Unemployment rates 2019/2020 (interannual variation)	+1.4	+1.2	+3.6	+6	+1	+3.7
Informal employment (% total employment) (2019)	49.4	45.0	29.2	62.1	-	68.4

Source: Compiled by authors based on UNESCO, ECLAC, and World Bank data.

On comparing the year-on-year change (2019--2020) in the unemployment rate and the percentage variation in the number of beneficiaries of social protection and employment policies, it can be seen that the two countries whose social policies have the greatest scope in population terms--that is, those with the largest state capacity (Argentina and Brazil)--also exhibit the lowest change in the unemployment rate. Mexico likewise does not present a significant change, although its economy continued to func-

22 In June, provisions were established for double severance pay in case of dismissal, and subsequently extended until the end of the year.

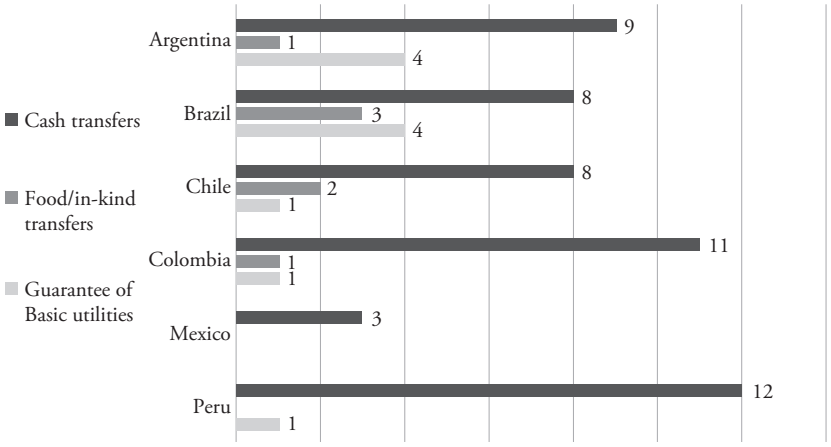
23 Google. *COVID-19 and human development.* Retrieved from https://datastudio.google.com/u/0/reporting/abd4128c-7d8d-4411-b49a-ac04ab074e69/page/qk3NB

24 See https://www.ilo.org/wcmsp5/groups/public/---americas/---ro-lima/documents/publication/wcms_764630.pdf

tion given the paucity of public health measures. In turn, social protection policies in Colombia and Peru were more modest in scope, coinciding with a greater increase in unemployment rates.

When it comes to social support for the most vulnerable, assistance plans have been scaled up in order to provide emergency funding to people in the most vulnerable sectors, many of whom saw their income sharply reduced. In some cases, this aid also reached the middle classes in the form of relief from recurring payments such as rent, mortgages, and utilities.

Figure 3
Social protection policies



Source: Compiled by authors based on ECLAC data.

There were two main approaches to emergency coordination: targeted and universal. Peru and Colombia took the former approach, implementing the largest number of measures aimed at non-exchange transfers for certain sectors of the population and even territories that were particularly vulnerable. In Peru, the state paid beneficiaries of the social programs of the Ministry of Development and Social Inclusion (MIDIS) in advance, as well as approving transfers to 800,000 self-employed workers, workers earning less than 2,400 soles (658 USD) employed by companies with a staff of up to 100 whose activities had stopped entirely (Urgency Decree [DU] No. 72), and some 1 million rural families. Moreover, the state disbursed a "Universal Family Bonus" to over 8 million people who had been beneficiaries of different subsidies previously paid by the government. It also transferred funds to the regional government of Cusco to deal with the health emergency, and to other municipalities to acquire consumer staples. In Colombia, extra income was provided for beneficiaries of social

programs (Legislative Decree [LD] No. 533, MinTrabajo), in addition to a "Solidarity Income" of 160 thousand pesos (USD 46) for about 3 million informally employed informal sector families who were not beneficiaries of these programs (LD No. 518, Ministry of Finance and Public Credit [MinHacienda]) and a bonus of two payments of 80,000 pesos (USD 23) for around 500,000 rural families (Decree No. 486, Ministry of Agriculture and Rural Development [MinAgricultura]).

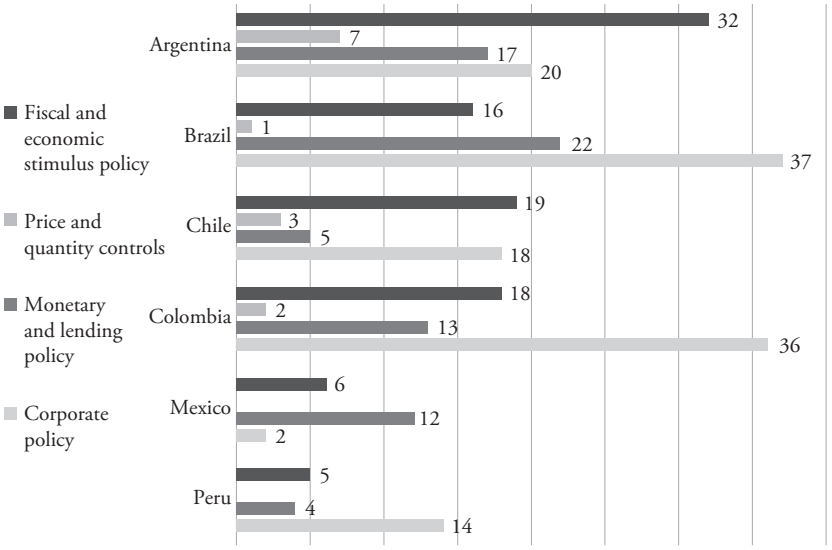
For their part, Argentina and Brazil took a universal approach to emergency social coverage. This is because both countries have more robust social protection systems than the other countries studies, characterized by programs such as Universal Child Allowance (Asignación Universal por Hijo, AUH) and Family Basket, respectively. In Argentina the family allowance system and the requirements for receiving economic assistance were altered in order to extend access to the AUH and the Universal Pregnancy Allowance (Asignación Universal por Embarazo, AUE), (NUD No. 840). Additional bonuses worth around 3,000 pesos (USD 50) were given to recipients of AUH-AUE and other social programs, retirees and pensioners, and about 550,000 people with incomes equivalent to half the minimum wage or below. Finally, payments of 10,000 pesos (USD 140) in Emergency Family Income (Ingreso Familiar de Emergencia, IFE) were made to monotax payers, informal workers, and beneficiaries of AUH-AUE and the Student Support Program of Argentina (Progresar). The various unemployment benefits were extended until December 31 (at 70% of their initial value after May 31).

In Brazil, Law No. 13,982 (April 2, 2020) provided for emergency aid in the form of 600 reais (USD 114) per person for a total of three months, aimed at informal workers and social security contributors with a total family income of less than three times the minimum wage. Recipients of other social programs or unemployment benefits were excluded, with the exception of Family Basket beneficiaries, who would receive the emergency aid instead if the amount received proved to be greater. The benefit was then extended for two more months until September (Decree No. 10,412), when the government introduced residual emergency aid for disbursement in up to four installments of 300 reais (USD 57) until December (PM No. 1,000).

Argentina and Brazil took the greatest number of measures to assure the continuation of basic utilities on a universal basis. In Argentina, providers were prohibited from suspending and/or cutting off electricity, gas, running water, fixed and mobile telephony, and internet and cable TV for non-payment until 2021 (UND No. 543), while rates were frozen for the same period (UND No. 690). Brazil vetoed cutoffs of electricity in cases of

non-payment (Resolution No. 878, National Agency of Electrical Energy [Agência Nacional de Energia Elétrica, ANEEL]) and assumed the cost to beneficiaries of the Social Electrical Energy Tariff (Tarifa Social de Energia Elétrica, TSEE) (PM No. 949), which includes some 9.8 million families with a per capita income of less than or equal to half the minimum wage or who are recipients of social assistance benefits.

Figure 4
Economic policies



Source: Compiled by authors based on ECLAC data.

When it comes to economic policies, two approaches can be identified: one oriented toward policies favorable to the business sector—through credit instruments, for example—in order to maintain business activity and profitability; and another more holistic perspective aimed at alleviating the decline in economic activity by way of expansionary fiscal policies and economic stimuli in which consumption is regarded as an important variable, including through price and provisioning control.

With the exception of Argentina, the countries studied here opted for the first modality. Brazil, Chile, Colombia, Mexico, and Peru reduced their reference interest rate and opened multiple lines of credit for the various productive sectors, including, to a greater or lesser extent, SMEs. These measures were accompanied by exemptions and deferrals of levies on foreign trade, transactions, and employer pension contributions for the productive sectors. Chile, Colombia, and Peru applied subsidies

in response to downswing in certain sectors, such as tourism and local transportation.

Like Brazil, Colombia, and Peru, Argentina introduced a business protection program that covered part of the payroll of employees who could not go to work because of mobility restrictions and the health emergency in general: the Emergency Assistance Program for Labor and Production (Asistencia de Emergencia al Trabajo y la Producción, ATP) (Administrative Decision [DECAD] No. 1133). With the creation of the Production Recovery Program (Programa de Recuperación Productiva, REPRO) (Resolution No. 938, MTEySS), coverage was extended to those companies not included in the critical sectors defined by the ATP, but which nonetheless experienced a decrease in activity.

Argentina, like other countries in the region, introduced tax exemptions and soft credit lines, particularly for SMEs, as well as methods to stimulate demand supported by pre-existing public policies. Its government increased public investment in infrastructure by the equivalent of 0.5% of GDP, in addition to extending the credit line available as part of the Argentine Bicentennial Credit Program for Single Family Housing (PROCREAR) in order to boost the construction sector.

It also targeted consumption by extending the "Ahora 12" credit program. Argentina was the only country that implemented extensive price control measures covering food, toiletries, and medication and medical supplies (Resolution No. 100 Ministry of Productive Development [MDP]), as well as rent freezes, extension of lease agreements, and suspension of evictions (UND No. 320). Both resolutions were extended until January 31, 2021.

The recession in each of the countries meant a reduction in the tax collection opportunities available to the state under current tax systems. Given this situation, the main alternatives were indebtedness or the introduction of new taxes. As noted above, in a context of capital flight, the option of taking on debt carries risks and conditions that are detrimental to countries in the medium term. Regardless, Peru, Colombia and Brazil have chosen this path. Argentina, on the other hand, whose access to international credit is more limited due to the country's recent history, chose another option: the introduction of a tax on large fortunes. On December 4, 2020, Congress approved the Law of Solidarity and Extraordinary Contribution whereby individuals who have declared assets worth more than 200 million pesos as of the promulgation of the law are required to pay 2% of the total amount. The tax allows the government to raise the funds it needs to deal with the emergency (about 3.8 billion dollars) through this small levy on the assets of 15,000 wealthy individuals. But although the tax does not place a significant

burden on this sector, which contributes little given the regressive nature of the system and hides three-quarters of its assets abroad, the initiative met with stiff resistance.

Conclusions

In this article we analyzed the development of state policies implemented during the pandemic, taking into account health and socioeconomic measures. We chose the six countries with the highest number of infections in Latin America as our case studies: Argentina, Brazil, Chile, Colombia, Mexico, and Peru. These nations exhibit differences in terms of state capacities, sociodemographic characteristics, human development indices, and the ideological profile of their governments and state elites. Argentina adopted strategies early on to control the pandemic that included comprehensive health measures, strict and prolonged lockdowns, and expanded healthcare funding. Its government implemented socioeconomic policies aimed at alleviating the effects of the economic recession, such as expansionary fiscal management and stimuli by way of price and supply controls in which consumption was regarded as an important variable. The provisions were largely channeled through existing social protection mechanisms accessed by a large sector of the population. Although these policies were not enough to offset the inevitable decline in economic activity or the deepening inequalities, Argentina's health system did not collapse. Brazil and Mexico are two countries with large economies, strong states, and limited human development. For various reasons, the governments of both took a less proactive position on the pandemic which, in the case of Brazil, could even be characterized as denial. It prioritized commercial activity over health policies and, therefore, the drop in GDP was smaller. But this decision translated into a higher death rate and overwhelmed health systems. Bolsonaro downplayed the consequences of the pandemic while maintaining economic activities and population mobility, going against the stances of some Brazilian state governors. Mexico, a country with precarious human development indicators, limited investment in health, high rates of informality, and a long neoliberal tradition introduced no strict health measures or socioeconomic strategies aimed at diminishing the effects of the crisis.

Chile is a low-to-middle-income economy with a strong centralist state and high human development indices, but privatized social services in various spheres. Its socio-economic policies were intermediate: measures ranged from containing the impact of the pandemic to sustaining economic activity. The late introduction of a total lockdown coupled with a

precarious health system led to the collapse of this system in some parts of the country.

Colombia and Peru are low-to-middle-income economies, weak states with several areas of privatization, high rates of informal employment, and low human development. Colombia's health structures were not swamped, partly because of successful management of its testing strategy and communication logistics, although there was a significant deterioration in social indicators. In the case of Peru, early implementation of strict sanitary measures was not enough to prevent collapse of the health system in a country in which this infrastructure was already precarious, state capacities are weak, and informality is high. As far as socioeconomic policies are concerned, both countries took a less statist and more sociocentric approach centered on holding civil society accountable for the pandemic response.

Except for Argentina, whose comprehensive approach to sustaining the economy had mixed results given pre-existing conditions (such as long-term external restrictions), the rest of the countries oriented their economic policies towards maintaining high levels of business activity and profitability through credit instruments.

The profile of public efforts to mitigate the health, economic, social, and human crisis caused by the pandemic varied from country to country based on the various situational factors, such as governmental political decision-making, long-term state capacities, the pre-existing health infrastructure, and economic and social indicators. The coronavirus pandemic gave rise to a series of questions regarding the role of the state and the severity of inequalities in the countries with the world's highest levels of inequality. This dramatic experience should provide us with the possibility of rethinking existing institutional frameworks in terms not only of health and social security, but also of government policies as a whole.

Acronyms and initialisms

Administrative Decision (DECAD), Argentina
Argentine General Labor Confederation (Argentina Confederación General del Trabajo, CGT)
Argentine Industrial Union (Unión Industrial Argentina, UIA)
Bicentennial Credit Program for Single Family Housing (PROCREAR), Argentina
Compulsory Social Preventive Isolation (Aislamiento Preventivo Social Obligatorio, ASPO)
Economic Commission for Latin America and the Caribbean (ECLAC)
Emergency Assistance for Work and Production (Asistencia de Emergencia al Trabajo y la Producción, ATP), Argentina
Emergency Family Income (Ingreso Familiar de Emergencia, IFE), Argentina
International Labor Organization (ILO)
Legislative Decree (LD), Colombia
Ministry of Agriculture and Rural Development (MinAgricultura), Colombia Ministry of Development and Social Inclusion (Midis), Peru
Ministry of Finance and Public Credit (MinHacienda), Colombia
Ministry of Labor (MinTrabajo), Colombia
Ministry of Labor, Employment and Social Security (MTEySS), Argentina
Ministry of Productive Development (MDP), Argentina
National Electrical Energy Agency (Agência Nacional de Energia Elétrica, ANEEL), Brazil
Organization for Economic Co-operation and Development (OECD)
Pan American Health Organization (PAHO)
Productive Recovery Program (Programa de Recuperación Productiva, REPRO), Argentina
Provisional Measure (PM), Brazil
Small and medium enterprises (SMEs)
Social Electrical Energy Rate (Tarifa Social de Energia Elétrica, TSEE), Brazil
Student Support Program of Argentina (Programa de Respaldo a Estudiantes de Argentina, Progresar)
Universal Child Allowance (Asignación Universal por Hijo, AUH), Argentina
Universal Pregnancy Allowance (Asignación Universal por Embarazo, AUE), Argentina
United Nations Educational, Scientific and Cultural Organization (UNESCO)
Urgency and Necessity Decree (UND), Argentina
Urgency Decree (UD), Peru
World Health Organization (WHO)

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