

Latin America in the year of the **PANDEMIC**

REPORT



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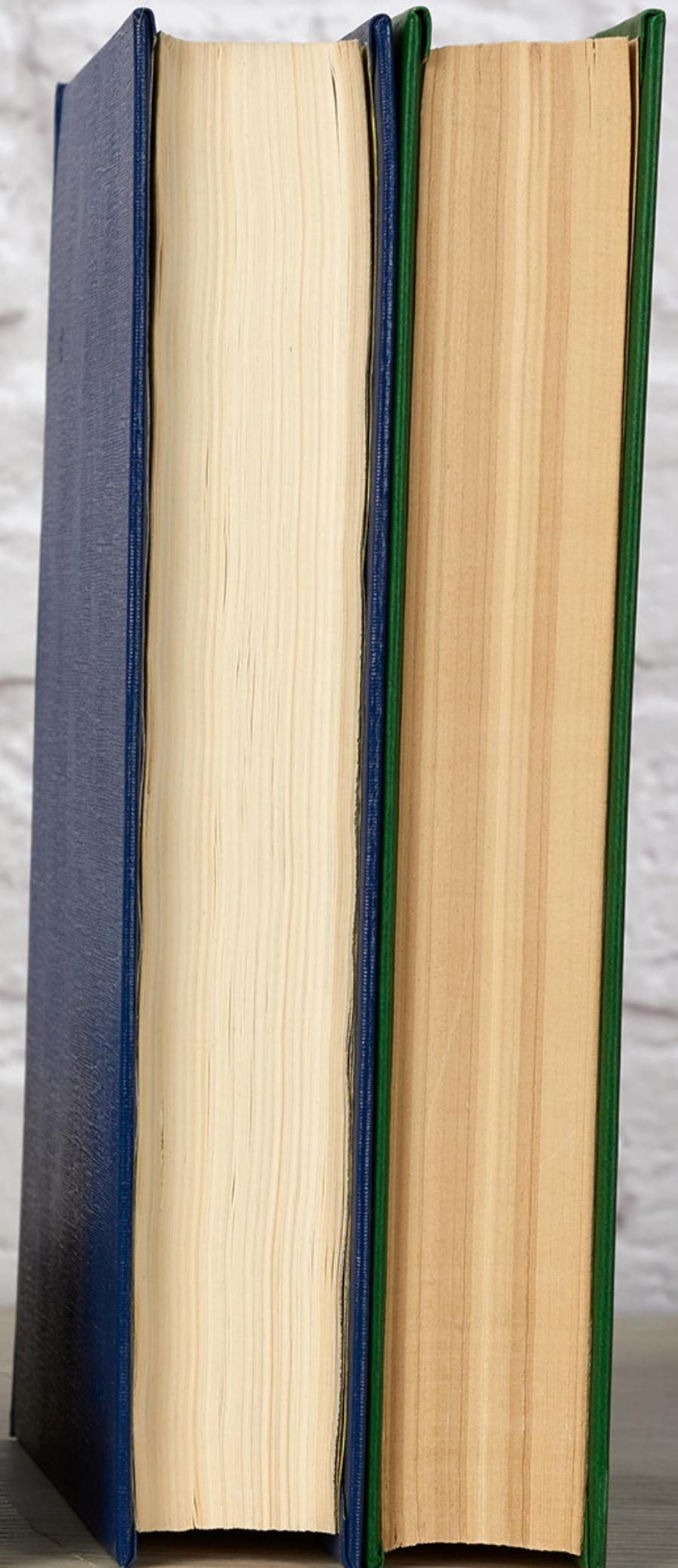
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“As regards healthcare, government action was inefficient and ineffective, but the most severe collateral damage associated with the measures taken to „fight the pandemic“ was the nearly full shutdown of the economy.”



Introduction

Bertha Pantoja
President of RELIAL

The current pandemic crisis has had a multidimensional impact in Latin America. First, it has created a serious challenge both for healthcare systems in the region and for social security institutions, which have overall seemed not to be well equipped to rise to the challenge posed by such a crisis. While hospital capacity has not been surpassed in countries across the region, management by health ministries and agencies proved to be disastrous in most countries, with very few exceptions like Uruguay, which was certainly the most remarkable case.

As regards healthcare, government action was inefficient and ineffective, but the most severe collateral damage associated with the measures taken to “fight the pandemic” was the nearly full shutdown of the economy. In a region where most people earn a living on a day-to-day basis, restrictions on work has had serious consequences, spilling over the rest of the economy and precipitating the region into what will be the worst crisis it has ever experienced.

In some Latin American countries, the year started off amid political crises already. The movement and protests demanding a new constitution in Chile, the departure of Evo Morales from power and the subsequent triumph of the MAS party in the recent election in Bolivia, the return of Kirchnerism in Argentina, and others. The pandemic has paved the way for political movements against freedom to spread across the continent, eroding democratic institutions and the rule of law, and giving governments both an excuse to disguise the seriousness of their failures and a mechanism to exercise control over the population.

This document is the result of an effort undertaken by the Liberal Network for Latin America to assess the impacts the pandemic has had on the various areas mentioned above. The healthcare component is discussed by Carlos Goedder, providing an analysis that emphasizes the importance of individual responsibility in a situation such as this one and the importance of defending the institutions that uphold liberal democracy. Subsequently, Carlos Sabino discusses the crisis from the point of view of individual liberties, pointing out the importance of putting the values associated with liberty at the forefront of any response to the crisis. The economic component is later discussed by Bettina Horst, analyzing the impacts the pandemic has had on the region and the public policy challenges facing countries as they strive for a revival of the economy. Finally, Alejandro Bongiovanni and Constanza Mazzina discuss the issue of democracy and the challenges facing Latin American countries with the resurgence of authoritarianism.

Through this report, the Liberal Network for Latin America is aiming to offer a comprehensive analysis of the social phenomenon that has arisen with the pandemic and to point at both the upcoming challenges and the alternatives to continue to uphold liberty in a world that will never be the same again.





A Much Needed Report for a Region in Distress



Siegfried Herzog

Regional Director of the Naumann Foundation Office for Latin America

The global COVID-19 crisis is presenting serious challenges for countries around the world, including how to ensure people's health, how to reduce the negative impact on the economy, and when and how to revitalize the economy. The crisis has hit particularly hard in Latin America, recording infection rates and death tolls at much higher proportions than its percentage of the global population, and having an even more serious economic impact there than in other parts of the world.

With that in mind, the Liberal Network for Latin America (RELIAL) decided to publish a substantive report addressing various aspects of the crisis with a view to improving public discourse and the development of effective and efficient solutions. We must understand what the situation entails and learn about how the virus behaves, the complexity of the disease, the modes of transmission, the preventive measures that will effectively help to curb the spread of the disease, and the potential treatments to take better care of those who are infected. There are numerous challenges: we need to be able to produce reliable data to understand the situation, but a lot of data is proving to be dubious, perhaps as a result of governments' need to give an impression of success in managing the pandemic.

Major crises certainly call for immediate government response, but countries having weak institutional frameworks and poor healthcare systems will be severely constrained in responding to them.

In addition, the situation has also set the stage for some governments to try to acquire extraordinary powers, to the detriment of civil and individual liberties, and gain worrying levels of control over institutions. Unfortunately, such an effect has been observed in many regions around the world.

There is also considerable variance between people's expectations — hoping that the government will act decisively and „aggressively“ — and the reality of the region. Demands for government measures ultimately led to coercive lockdowns and burdensome curfews. Thousands of Latin American families — who largely rely on the informal sector for subsistence, roughly 60 – 80% of the population — cannot afford to „stay home“ for weeks or months. Workers need to go out to work and earn their daily income. Public policies adopted by most governments do not account for such a reality, and the impact has thus been devastating both in health and in the economy.



We now have a better understanding of the multidimensional nature of COVID-19's impact. With this report, RELIAL has conducted a realistic assessment of where we are now, gaining a better perspective on what steps may be taken and on what urgent measures must be given priority in the region over the coming months.

The crisis has revealed a grim reality: there is a dangerous combination of weak institutional frameworks and governments having little interest in professionalizing healthcare systems. This is further compounded by a lack of cooperation between the government, the civil society sector, and the private sector, neglecting an important type of partnership that would significantly help all sectors in the region.

That is why the liberal principles and values — well-established institutions, the rule of law, the market economy, and the division of powers — have now become more necessary than ever.

“ The crisis has revealed a grim reality: there is a dangerous combination of weak institutional frameworks and governments having little interest in professionalizing healthcare systems. This is further compounded by a lack of cooperation between the government, the civil society sector, and the private sector, neglecting an important type of partnership that would significantly help all sectors in the region. ”





Healthcare and Pandemic Management Strategies

By Carlos Goedder, CEDICE LIBERTAD

“People only take an interest in their health when they end up in the hospital.”

Roberto Bolaño, *The Savage Detectives*

The global crisis that has unfolded as a result of the COVID-19 pandemic has forced us to come to grips with the fundamental problems of both individual and collective health management. We have now become more aware of our fragility, which is seemingly immune to pathogens, and of the fact that our victory over such factors will depend on our capacity for cooperation. With such disruption, the approach proposed by Marie Curie becomes vitally important: nothing in life is to be feared, it is only to be understood. Relying on our intelligence, we must keep a careful record of the facts, concepts, and measurements so we can respond to this global health emergency with a sense of realism, efficiency, and equity.

Three considerations must be made before examining the information presented below. First, it would serve no useful purpose to look at this report as a compilation of the latest statistics on the subject. Any report issued on recorded infections or (unfortunate) deaths from COVID-19 will become obsolete in a matter of hours. Alternatively, this report is aimed at both identifying key issues and trends and laying the grounds for potential measures that could contribute to a better management of the health risk associated with COVID-19. Second, this report is not intended to constitute a medical report or aimed at healthcare professionals, but the concepts are certainly discussed with rigor, offering an analysis that may be useful for any citizen wishing to stay reliably informed about the environment surrounding their health. Finally, the tenor of this report aligns with the principles of economic freedom and individual initiative, and it stands against any proposal to enhance government coercion under the pretext of protecting collective health. Furthermore, our research supports the claim that the crisis has been exacerbated by the government’s poor management of health services and by a marked partisan approach to health care.

1. An inventory of concepts

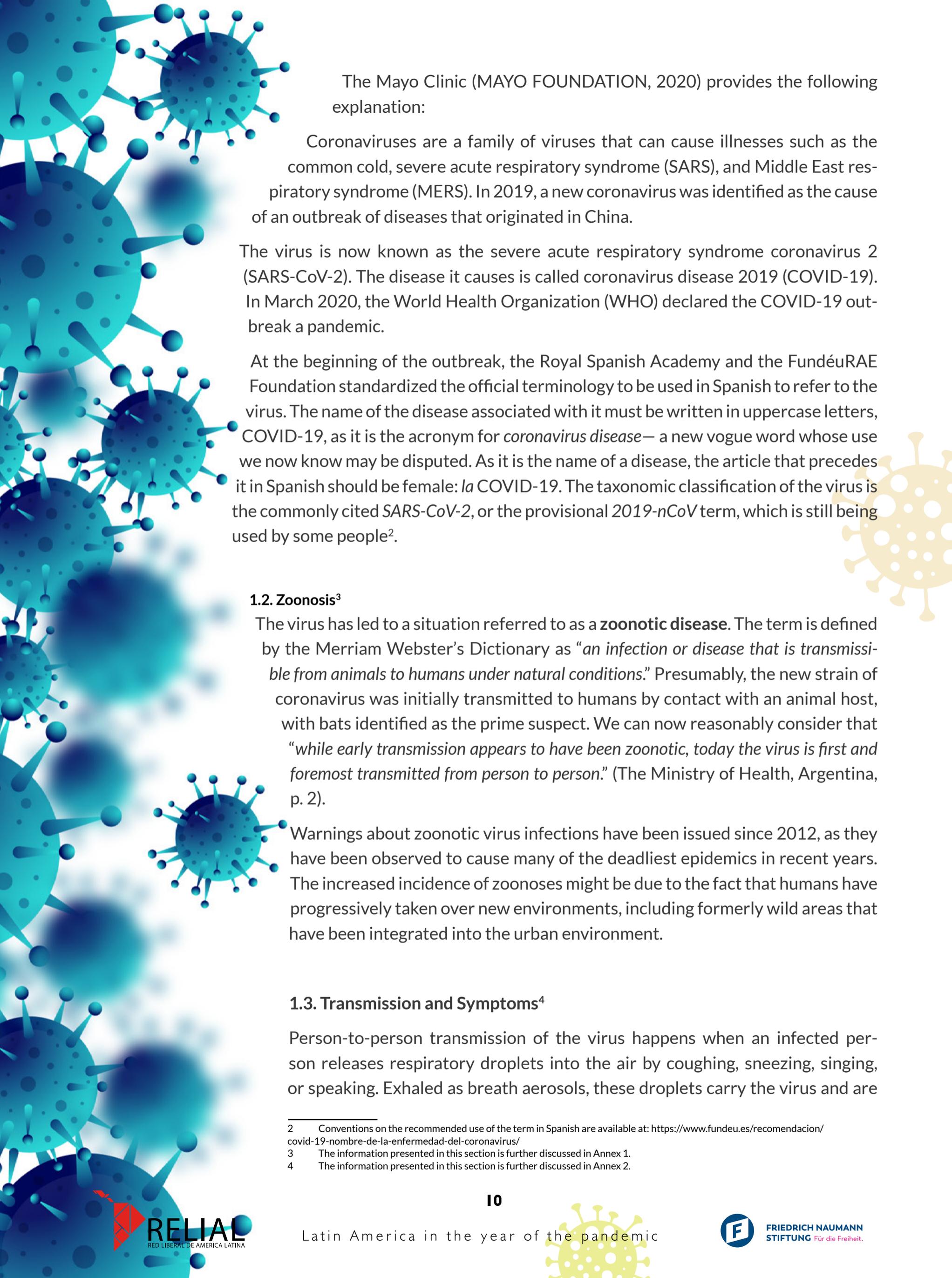
“We just have to assume the monster is everywhere.”

Mike DeWine, Governor of the State of Ohio (USA)¹

1.1. COVID-19 and SARS-CoV-2

Terms often become popular, even when they are fundamentally incorrect. And once they have been accepted, it might be arrogant and impractical to try to change them. That is now the case with the term *coronavirus*. The virus that has been wreaking havoc over the course of 2020 is one *strain* of coronavirus, but we had already been exposed to another similar strain during the SARS epidemic in 2003. We are thus mistakenly referring to *the coronavirus* as if it were “one of a kind.”

¹ The quote has been taken from SHAPIRO, Leslie et. al., October 2020.



The Mayo Clinic (MAYO FOUNDATION, 2020) provides the following explanation:

Coronaviruses are a family of viruses that can cause illnesses such as the common cold, severe acute respiratory syndrome (SARS), and Middle East respiratory syndrome (MERS). In 2019, a new coronavirus was identified as the cause of an outbreak of diseases that originated in China.

The virus is now known as the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). The disease it causes is called coronavirus disease 2019 (COVID-19). In March 2020, the World Health Organization (WHO) declared the COVID-19 outbreak a pandemic.

At the beginning of the outbreak, the Royal Spanish Academy and the FundéuRAE Foundation standardized the official terminology to be used in Spanish to refer to the virus. The name of the disease associated with it must be written in uppercase letters, COVID-19, as it is the acronym for *coronavirus disease*— a new vogue word whose use we now know may be disputed. As it is the name of a disease, the article that precedes it in Spanish should be female: *la* COVID-19. The taxonomic classification of the virus is the commonly cited SARS-CoV-2, or the provisional 2019-nCoV term, which is still being used by some people².

1.2. Zoonosis³

The virus has led to a situation referred to as a **zoonotic disease**. The term is defined by the Merriam Webster's Dictionary as "*an infection or disease that is transmissible from animals to humans under natural conditions.*" Presumably, the new strain of coronavirus was initially transmitted to humans by contact with an animal host, with bats identified as the prime suspect. We can now reasonably consider that "*while early transmission appears to have been zoonotic, today the virus is first and foremost transmitted from person to person.*" (The Ministry of Health, Argentina, p. 2).

Warnings about zoonotic virus infections have been issued since 2012, as they have been observed to cause many of the deadliest epidemics in recent years. The increased incidence of zoonoses might be due to the fact that humans have progressively taken over new environments, including formerly wild areas that have been integrated into the urban environment.

1.3. Transmission and Symptoms⁴

Person-to-person transmission of the virus happens when an infected person releases respiratory droplets into the air by coughing, sneezing, singing, or speaking. Exhaled as breath aerosols, these droplets carry the virus and are

² Conventions on the recommended use of the term in Spanish are available at: <https://www.fundeu.es/recomendacion/covid-19-nombre-de-la-enfermedad-del-coronavirus/>

³ The information presented in this section is further discussed in Annex 1.

⁴ The information presented in this section is further discussed in Annex 2.



subsequently inhaled by other people, leading to new infections. Person-to-person transmission happens quickly when people are within two meters away from each other. A recent study (STIEG, 2000) goes further to suggest that the virus may be transmitted not only by contaminated respiratory droplets but also by *aerosol* droplets, which are smaller droplets that are also exhaled by infected people and may remain suspended in the air over longer periods. The virus can literally remain suspended in the air longer when carried by these other kinds of droplets.

Prevention measures may thus be easily inferred, and most of us have already been habitually implementing them for months. They include the following⁵: “In addition to mask wearing and social distancing, using portable air purifiers is a way to reduce airborne pollutants in any closed environment. And remarkably simple measures such as opening windows to allow clean air into the room also contribute to the desired outcome of increasing ventilation.”

Once the virus enters the body, it usually settles in the cells that make up the respiratory system, including the nasal cavity and throat. Invading host cells for reproduction may take up to two weeks. Infected patients usually develop symptoms including fever, headache or dry cough, and they may also suffer from shortness of breath, body aches, loss of taste or smell, fatigue, and digestive symptoms. Patients with weakened immune systems may be more susceptible to the virus and thus develop complications, as it may travel down into the lungs and cause a build-up of fluids and mucus that will make it harder to breathe. That would indicate symptoms of pneumonia, which may be controlled over the course of one or two weeks. The body may also exhibit a response to the virus through the cardiovascular system, showing symptoms such as arrhythmia, cardiomyopathies, or increased risk of blood clotting.

According to the U.S. Mayo Clinic information and communications service (MAYO FOUNDATION, 2020), children and adults experience similar symptoms, but children’s symptoms tend to be mild. The outlook for older adults, however, is not that good, as the risk of becoming seriously ill from COVID-19 increases with patient’s age. Furthermore, the presence of the following comorbidities may worsen the prognosis for infected patients: cardiovascular disease, hypertension, cancer, chronic obstructive pulmonary disease (COPD), type 1 and type 2 diabetes, severe obesity, chronic kidney disease, sickle cell disease, weakened immune system due to an organ transplantation, asthma, liver disease, and brain and nervous system diseases. The most severe cases must be admitted to an *Intensive Care Unit*.

Due to space constraints, we will not be able to discuss in this chapter certain important issues relating to the main topic. We thus ask the reader to refer to the annexes that we have prepared: Annex 3, for example, discusses the origin and spread of this coronavirus strain from China to the rest of the world, as well as the poor management by the WHO (World Health Organization).

⁵ It might be relevant to create awareness about the rights of those who wear glasses: KN95 face masks – the typical face mask used by medical personnel that is now available to the public in pharmacies, and which seems to be the most effective – cause eyewear to fog up when we breathe.

2. Statistics on COVID-19 Infections and Deaths

At some point, the numbers get so big that they lose their impact.

I worry as we continue to mark these milestones that they just become numbers, and they stop really resonating with us as deaths.

Caitlin Rivers, Epidemiologist at the Johns Hopkins Center for Health Security⁶

BLOOMBERG (2020) published the following cumulative figures for October 7, 2020, along with the data on infections and deaths shown in Table 1 and Table 2:



(1) The total number of infections stood at 35,984,455.

(2) Of those cases, 1,052,247 people have died.

The World Bank estimated the global population at around 7.6 billion people for 2019 – to be precise, 7,673,533,972, according to the source indicated in Table 1. With this figure, the global mortality rate stands at 137 deaths per 1 million population, and the infection rate comes to 4,689 cases per 1 million population. Compiling country-specific information, Tables 1 and 2 show significant dispersion with respect to these global average values. The section entitled “Local Variations” presents a discussion that may help to understand the reasons for such variability among countries. For data on the incidence of the disease among medical personnel – which is often neglected or ignored – please refer to Annex 4 of the report.

⁶ Taken from THEBAULT, R. and A. Fowers (7/31/2020).

Country	Deaths	Infections	Population	Deaths per 1 million	Infections per 1 million
U.S.	211,513	7,535,794	330,271,026	640	22,817
Brazil	147,494	4,969,141	210,298,405	701	23,629
India	104,555	6,757,131	1,366,417,754	80	5,152
Mexico	82,348	794,608	127,575,529	645	6,229
United Kingdom	42,605	546,949	65,440,177	651	8,358
Italy	36,061	333,940	60,297,396	598	5,538
Peru	32,914	832,929	32,510,453	1,012	25,620
Spain	32,562	835,901	47,076,781	692	17,739
France	32,462	693,473	67,629,167	480	10,257
Iran	27,658	483,844	82,913,906	334	5,835
Colombia	27,017	869,808	50,339,443	537	17,279
Argentina	27,827	824,468	44,938,712	619	18,346
Russia	21,755	1,242,258	142,189,542	153	8,752
South Africa	17,103	683,242	58,558,270	292	11,668
Chile	13,090	474,440	18,952,038	691	25,034

Table 1. Countries ranked by number of deaths from COVID-19 as of October 7, 2020, from the beginning of the outbreak. Source: Bloomberg⁷. Countries ranked according to the indicator. Latin American countries are shown in bold, representing the region in which the study was conducted. Infection and death rates for the countries listed in Table 2 are taken as reported by Bloomberg and then used to calculate the population. The numbers were found to be fairly close to the estimates reported by the World Bank for 2019. For the rest of the cases, data was obtained from the World Bank's 2019 population tables and used to estimate infection and mortality rates. ⁸Peru's staggering mortality rate is correct⁹.

At the risk of sounding too emphatic, the level of dispersion shown in Table 1 is such that some might even question the validity of the figures. The typical deviation from the global average presented just above is indeed so considerable that it immediately calls for explanations, and we will thus briefly present our attempt at one. Considering the dynamism observed so far and the occurrence of a second wave during the last quarter of the year in various regions, we should expect variations in Tables 1 and 2. But, after nearly ten months of COVID-19 now, we would like to invite reflection about the dispersion observed, which will likely continue to show the same scattering trend, even among neighboring countries. It is important to pay attention to the data that is expressed as *rates* or *ratios*, as that is what makes it possible to draw comparisons between countries with very different population sizes. Chile, for example, whose population size is below 20 million, ranks among the countries with the highest death rates.

Surprisingly, and contrary to every conventional statistical logic, the tables show that China – which accounts for 18% of the world's population, with 1.39 billion in 2019¹⁰ – does not rank among the fifteen countries with the highest mortality rates for COVID-19, and that the country's death rate per million population is just 3... It would be an insult to our intelligence to claim that such a defiance of the statistical law of large numbers is the result of "A United and Disciplined Society."

Table 2 provides additional relevant data, including figures about the number of tests conducted to identify the virus, hospital bed capacities, and the date countries began easing lockdowns, when applicable.

⁷ Although it is listed in the bibliography section, we will include the reference here as well. We should note that this is a paid subscription service, although it provides free temporary access to some articles. Bear in mind that the information is updated daily, so the table presented in this report will change. The URL is the following: <https://www.bloomberg.com/graphics/2020-coronavirus-cases-world-map/?srnd=premium&oref=5wGIxq8n>.

⁸ Available online at: <https://data.worldbank.org/indicator/SP.POP.TOTL>

⁹ Colombian magazine *Semana* reported, as of October 4, 2020, a total of 32,535 deaths from COVID-19 in Peru, whose population adds to 31.99 million and thus reports a mortality rate of 101.40 per 100,000 population – equivalent to 1,014 per 1 million population. See: SEMANA, October 4, 2020, p. 49.

For a discussion on the case of Peru, we suggest reading the article published by Colombian newspaper *Portafolio* on August 20, 2020 at: www.portafolio.co/internacional/el-contagio-de-coronavirus-en-peru-es-el-peor-del-mundo-543815

The article cites a healthcare consulting firm from Lima, Videnza, which has been compiling articles recording COVID-19 infections in Peru. <https://videnza.org/tag/covid-19/>

¹⁰ Population statistics are taken from the World Bank (as is the data in Table 1).

We will discuss these tables in detail further in the report. But before that, we should certainly like to express that we feel deep sorrow for the number of deaths presented in this report. Every death deprives the world of an opportunity for improvement and does incalculable harm to humanity. In this regard, we adhere to the point of view philosopher Hannah Arendt expressed in both *The Origins of Totalitarianism* and *The Human Condition* while discussing the significance of birth, she wrote “With each new birth, a new beginning is born into the world, a new world has potentially come into being.” (BÁRCENA, 2002, p. 108). Consistent with this view, any death caused by such misfortunes as the new coronavirus constitutes a tragic disruption of the active power represented by each human life and of the effective change it has initiated in the world. If it is true that endless possibilities may arise from birth, then the loss resulting from a sudden interruption of life will be unfathomable, as well as the opportunity cost associated with it, *that which has ceased to be and that which we will miss the opportunity to know*.

We will never know whether any of the lives that have ended as a result of this situation would have come up with a solution for the scientific problem posed by the new coronavirus, especially when it comes to the death of a researcher or a doctor. We wish to emphasize as well that every death bears an emotional connection with family members, friends, and work partners, and thus, insofar as we learn about each of their stories, we may rescue them from such a tragic anonymity that undermines our quality as humanity. There is a nefarious, but nevertheless true, saying which has been attributed to a number of dictators that claims that the death of ten people is a tragedy, but the death of millions is a statistic... As long as free journalism continues to produce descriptive chronicles of what is happening with the infected people, the patients, and their close ones, the respect for individuality that we uphold as advocates of liberal ethics will prevail.

	Brazil	United Kingdom	EEUU	France	Russia	Germany	India	Japan	China
Deaths per 1 million	701	651	640	480	153	119	80	13	3
Confirmed cases per 1 million	23.629	8.358	22.817	10,257	8.752	3.873	5.152	692	62
Tests per 1,000	30,5	338,8	360,7	NA	333,8	211,7	62,7	20,4	NA
Hospital beds per 1,000	NA	2.5	2.8	6.0	8.1	8.0	0.5	13.1	4.3
Measure adopted	No national lockdown	Eased lockdown on June 8	No national lockdown	Eased lockdown on May 11	Eased lockdown on May 11	Eased lockdown on April 20	Eased lockdown on June 8	State of Emergency ended on May 25	No national lockdown

Table 2. Adapted from Bloomberg’s daily report for October 7, 2020. NA indicates that there is no information available for that element. Bloomberg’s daily report can be accessed at: <https://www.bloomberg.com/graphics/2020-coronavirus-cases-world-map/?srnd=premium&oref=5wGIXq8n>

3. Poor quality of data

We are currently dealing with incomplete information. In the U.S., CDC Director Robert Redfield estimated that the number of infections in the U.S. must in fact be 10 times larger than the number of officially reported cases. Dr. Anthony S. Fauci himself has suggested that the virus has claimed more lives than what has been reported in U.S. statistics (SHAPIRO et. al., 2020). This is partly due to a lack of uniform

reporting and counting methodologies among the various regions in the country. In some rural or lower-income areas, resources are much scarcer, making it difficult to diagnose or count infections properly. Some patients are actually dying from complications related to some comorbidity triggered by the coronavirus infection. And we must not forget about the nearly 40% of asymptomatic carriers, including people who might have not even known that they were infected with the new virus before they died, but they had some other chronic

medical condition – e.g., respiratory diseases or heart failure – that caused acute complications and a fatal outcome. In the case of the U.S., there was the additional factor of a delay in conducting tests at a significant scale, as it did not meet the standards defined by WHO until June (SHAPIRO *et. al.*, 2020).

Tim Harford reminds us of an inescapable fact: there is no universal COVID-19 statistics database (HARFORD, 9/9/2020, Section 2). He wrote: “Ultimately, [statistics] came from somewhere: somebody counted or measured something, ideally systematically and with care. These efforts at systematic counting and measurement require money and expertise – they are not to be taken for granted.” Harford cited the scientific journal *Nature*, which referred to “a coronavirus data crisis” in the U.S. (HARFORD, *op. cit.*), and pointed out the case of Spain, which stopped reporting deaths in early June.

We must consider that reporting is often done by hospitals with staff members who are ill with coronavirus, so some administrative staff and medical personnel are often on leave and must thus be replaced by auxiliary staff. Having limited time and staff, they may not give priority to reporting accurate information on deaths, as they must look after those whose life is hanging by a thread.

We do not have a global database for tests and, again, we must look at the processes that underlie the numbers. Tests have been running into bottlenecks, affecting both test results and, obviously, adequate counting. In the case of Colombia – which we are much more familiar with, and which we know has some parallels in other regions – an opinion report published on August 4, 2020 stated that the average delay to obtain test results from laboratories was three days, when they had actually committed to deliver results within 24 hours, and that the delay in the outlying provinces, including Nariño, Bolívar and Sucre, could even come to 18 – 34 days. Consequently, any statistics on infections will show a significant lag in reporting due to such delays, and tests will also lose validity (*El Colombiano*, 4/8/2020).

All these factors point to the need for cautiousness when analyzing the data – although that does not mean that discipline and commitment to improving test outcomes should be relaxed. If we do not have that kind of input, we will be “attacking a problem without understanding it,” as a late fellow scholar from CEDICE LIBERTAD, Manuel J. Cartea, used to say.

It would be naive to fail to consider the possibility of intentional statistical manipulation. It is typically governments that have access to the data and that hire the staff who measure and collect the data. Governments or authorities who fail to provide adequate primary medical care face potential election, budget, and reputation consequences. It is thus critical to have independent measurement centers managed by civil society organizations to compare and validate the figures published by government sources.





4. Is it in fact a *pandemic*?

Even if we assume a gross underestimation of the number of infections and deaths, current official figures show that, after 10 months of COVID-19 – or 11 months, depending on whether we consider that the onset was concealed to the public for one month – infections have amounted to less than 0.5% of the global population, roughly 36 million people, in a world inhabited by 7.6 billion people. Global deaths have occurred at a rate of 1 in every 36 infections, that is a 2.78% chance of death among infected patients – although we must insist on the sympathy that all these people deserve. As a percentage of the global population, the fatality rate of the disease over 10 – 11 months – depending on when we consider the pandemic started – stands at 0.13%. But we must take into account certain considerations.

We know that the number of infections may be even ten times higher, and infection rates in some countries are considerably higher than the global average. However, if this is in fact a pandemic, as it was belatedly declared by WHO, the concept must be redefined. As the pandemics humanity has faced in the past – some of which have occurred over the past 100 years – have reached greater extents and higher mortality rates.

Consider one of the most recent and dramatic cases. The crisis that arose from the notorious “Spanish flu” over a century ago. It took place at a time when transport technologies, including cars and airplanes, were already being widely used, contributing to the spread of diseases. BARRO *et. al.* (2020) reported that that influenza outbreak resulted in the death of 40 million people between 1918 and 1920. Such a terrible human cost accounted for 2.1 per cent of the global population at the time. If a similar mortality rate occurred today, the number of deaths would rise well over 150 million, a number which is comparatively larger than Russia’s entire population, or three times the total population of Colombia, Spain or Argentina. Consider in addition that penicillin and antibiotics did not exist one century ago. More recently, the H1N1 flu epidemic struck the U.S. between April 2009 and 2010, infecting 20% of the population. Nearly 60.8 million people were infected, and 12,469 died from it – although the mortality rate was lower than that of the COVID-19 outbreak, there is no denying the fact that the number of infections was overwhelmingly higher than with COVID-19. And if we go further back in the history of pandemics, according to ZACHER (2001), about 60 – 90% of the American indigenous population died in the sixteenth century from smallpox, measles and flu, which were brought by arriving Europeans and Africans. Also, nearly a third of the entire European population died in the fourteenth century as a consequence of the Black Death epidemic.

But if we come back to the present time, global estimates indicate that each year 6 million children under 5 years of age die of hunger or related diseases – the so-called “hidden hunger.” Unfortunately, governments have not considered that the “pandemic” label applies to such causes of death. Also, the HIV virus continues to claim nearly 60,000 lives annually, even when there are already treatments that can prevent a fatal outcome.

The reason we mention these facts is to provide objective grounds to assess whether the way governments have reacted – which has often been extreme, without relying on data or theory – might have led to a mistaken denomination.

The argument could be made that this has not come to a pandemic level precisely because quick action was taken, implementing lockdowns and social distancing measures. Unfortunately, there is evidence that counters that assessment, even if we disregard the fact that the measures started to be implemented systematically and globally by mid-March 2020, when the virus had already been around for at least three months. The first argument against the oversimplified view that lockdowns have saved us can be made

using Tables 1 and 2, showing countries that enforced strict lockdowns and nonetheless got similar outcomes. Colombia is a case in point. Furthermore, econometric studies have found no statistical significance for lockdowns as a factor that reduces infection or mortality rates.

A recent example is a report that was published on September 23, 2020 by the *Centro de Estudios Económicos* of Colombia's *Asociación Nacional de Instituciones Financieras*, ANIF. Their study used mortality from COVID-19 as the dependent variable and, using a sample of 73 countries, they developed an econometric model that used the following factors as explanatory variables: severity of lockdown or quarantine measures; number of Intensive Care Units per 1 million population; number of tests per 1 million population; an access to healthcare index; location of countries in relation to the intertropical zone; percentage of population over 60 years of age; prevalence of obesity or high cholesterol levels.

The findings of the study included the following conclusion, which is especially relevant to the debate whether lockdown measures – which are still being enforced in countries like Venezuela, keeping sectors like tourism, restaurant services, movie theaters and sports centers virtually paralyzed across the globe and seriously harming business and employment – in fact succeeded in “preventing” a “pandemic” (SANTA MARÍA, *et. al.*, p. 2): “An apparently counterintuitive finding is that severity of quarantine measures is positively correlated with the rates of mortality from SARS-CoV-2. It goes without saying that this does not necessarily mean that lockdowns are a determining factor of mortality from the virus. The causal power of the variable is not clear at all, especially if we take into account, among other considerations, the fact that death rates partly determine government decisions to impose lockdowns. But one thing we can say is that its effect on reducing the negative impacts of the virus is certainly not clear either. A regression analysis indicates that, even if we use the severity of lockdowns variable considering a 15-day lag, its effect on mortality rates is null at best. This finding points at a worrying observation: the fact that lockdowns have not had the expected effect of curbing the pandemic, at least as far as mortality rates are concerned.”

The variables that *do* show a statistically significant reduction effect on mortality from COVID-19 include:

- Intensive care units (ICUs) per 1 million population (expressed as a natural logarithm, that is, as an increase), with each additional ICU per 1 million population reducing the mortality *rate* by 0.01 percentage points – which is nothing to be despised.
- Each additional test per 1 million population also leads to a reduction of 0.01 percentage points in mortality rates, with a level of significance equivalent to a 95% confidence interval for this representative sample of countries.
- By contrast, a 1% increase in the population aged 60 years or over leads to a 0.15% increase in the mortality rate from COVID-19. And each additional percentage point in high cholesterol prevalence in this population is associated with an increase of the mortality rate from the new coronavirus ranging from +0.19 / +0.21 percentage points. (SANTA MARÍA S. *et. al.*, p. 2-3.)
- No statistically significant effects were found for the other variables, even when they had the expected sign.

In conclusion, the decision by governments to lock people down does not seem to have been successful in curbing the spread of the SARS-CoV-2 virus; instead, testing seems to be the right path for public policy, although it is not enough by itself, as it needs to be done quickly and test results must be delivered on time from the onset of the outbreak. And this must be coupled with increased intensive care beds capacity.

Nonetheless, if we look at death and infection rates – regardless of whether they have been grossly unreported – there is no real grounds to call it a “pandemic,” at least when we consider the historical facts. What has certainly constituted a pandemic has been the economic cost of the measures adopted, bringing a large share of the Latin American population back to unemployment and poverty.

5. Individual reactions and local nuances

How can we account for the dispersion shown in Tables 1 and 2?

Leaving possible measurement errors aside — which may be more or less intentional — first we must consider the fact that randomness and unforeseen events play a role in health outcomes. This includes both biological factors, which are the subject of natural sciences, and interaction factors that belong to the field of social sciences. This is a case where F.A. Hayek's view of complex systems is applicable, emphasizing the role of non-linear relations and effects, and considering human beings as *creative actors*. Every citizen's effort to maximize their family's health, as well as their own, will entail a process of exploration where they will make their own assessment of the relative costs (PENNINGTON, August 2020). Indeed, each person makes his own assessment of the risks, of the costs associated with time, money and energy, and of the potential benefits when deciding on a medical treatment, a procedure or a medicine that is subject to budget constraints. Out-of-pocket spending may result in a so-called catastrophic health expenditure, which occurs when the cost of a health-related condition or accident absorbs an unexpectedly high share of the household income or wealth, even damaging the patient's overall financial position. Medical insurance also considers these kinds of calculations and subjective assessments. Social Security and state aid aimed at ensuring the financing of and access to health care play a part as constraints, as data, and as factors that influence the expected outcome for each individual.

COVID-19 has had an impact on relative prices. The costs of some treatments have become unbearable, prohibitive or increasingly high. An undesired effect resulting from the COVID-19 crisis is that supply of treatments for other illnesses that have become less visible has slowed considerably, and even some patients are not having access to them. Furthermore, economic measures have reduced the income available to citizens, creating unemployment and considerable loss of business, and they could have the adverse effect of reducing spending or investment in health care, as people need to focus on covering the costs associated with food, housing, and services. Equally important is the fact that lockdowns, social distancing, and uncertainty often lead to a wider spectrum of mental or neurological diseases — as has been observed with health care personnel (see Annex 4).

Therefore, random factors are certainly going to be present in health care, and we must consider that there are countless individual actions through which people will adjust their perceptions and expected costs and benefits, resulting in behaviors that do not necessarily align with the objectives or restrictions set by governments to protect public health. Thus, solutions that favor simplicity and deliver rapid results become more valuable, including the use of face masks and frequent handwashing.





“One observation that comes as a surprise is the fact that Asia – particularly in the region where the outbreak started – has registered low infection and mortality rates and, although it accounts for the larger share of the world’s population, it does not rank in the top fifteen countries with the highest number of cases.”

One observation that comes as a surprise is the fact that Asia – particularly in the region where the outbreak started – has registered low infection and mortality rates and, although it accounts for the larger share of the world’s population, it does not rank in the top fifteen countries with the highest number of cases. Examples include India and Iran – both Asian countries, although far from China and neighboring countries – where we would have expected a higher incidence of the new coronavirus. The *Semana* magazine (October 4, 2020, p. 49) published the distribution of deaths by continent: Asia accounts for 10%. The World Bank’s population prospects for 2019 – which we have cited before – show that East Asia (China, Mongolia, North Korea, South Korea, Japan, Hong Kong, Macau, and Taiwan) and the Pacific alone account for 27% of the global population. It is a wildly disproportionate distribution. The Americas accounts for 50% of deaths from COVID-19, which is also out of proportion to its share of the global population – 13.2% according to the cited source.

The cases of Japan and South Korea will be particularly relevant for a comparative analysis of our region, and we have thus included them in Annex 5. We decided to discuss these two cases merely to provide an illustration of the type of qualitative, discourse and statistical analysis that is needed to be able to understand both the complexity of each country and the way it has responded to the “pandemic” at the government, social and individual levels. We thus invite the reader to stay away from overly simplistic explanations that attribute everything to the government’s relatively authoritarian style of enforcing sanitary measures. We must look at each country individually to understand the complexity of forces interacting to produce the outcomes they have shown, considering that government action is just one factor among others that even include chance.

6. Latin America

Table 1 shows a significant share of Latin American countries among the top fifteen countries with the largest number of COVID-19 cases and associated deaths. If we consider their population size, this could possibly make sense in cases like Mexico and Brazil – although they rank higher than other more populous countries. And the fact that comparatively smaller nations like Colombia, Peru, and Chile are ranking among them makes the result even more surprising – however much we are tempted to consider their relationship with Asia and the Pacific through trade agreements.

Health system infrastructure in these countries was already deficient before the outbreak, and such deficiency might potentially be an explanation as to the poor performance of Latin America in dealing with the COVID-19 crisis. Table 2 shows the number of hospital beds per 1 thousand population, and it might be relevant to draw further comparisons with other countries and with the global average, which is nearly 3 beds per 1 thousand population. The average in Latin America stands at 2 beds per 1 thousand. Figure 1 – taken from an ECLAC report published in April 2020 – shows Latin America at a disadvantage compared with many of the countries in Table 2.

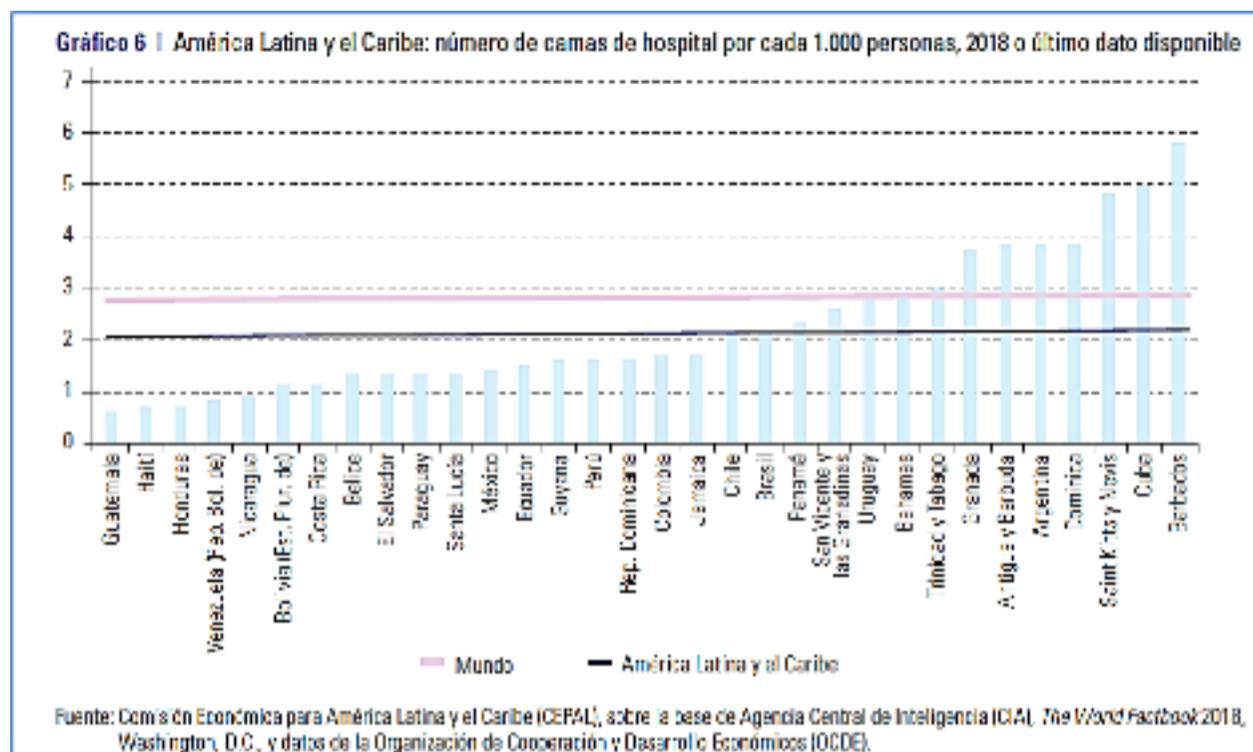


Figure 1. Number of hospital beds per 1 million population in Latin America and the Caribbean. The regional average, 2 beds, stands below the global average, 3 beds, which is skewed downwards due to the performance of poor nations in Africa. Source: ECLAC (April 2020). A comparison of the number of beds per 1 thousand with the figures for the group of countries indicated in Table 2 may offer interesting insights, with the U.S. and the UK showing a mediocre figure below 3 beds per 1 thousand, China with 4, France with 6, Russia and Germany with 8, and Japan with 13.

In the case of Latin America and the Caribbean, another factor that could explain this analysis is social precarity. The region shows the highest income inequality levels and the highest urbanization rates among emerging markets (ECLAC, July 2020, p. 3), and it has entered a cycle of sluggish growth after the commodity boom fueled by China between 2005 and 2015 died out.

The figures for the most vulnerable population groups in healthcare in Latin America and the Caribbean are the following: 85 million people aged 60 years and over (13% of the population) with 52% of them co-residing with their children; 70 million people with disabilities; indigenous peoples make up nearly 10 per cent of the population (60 million people), and afro-descendants make up 21%. (ECLAC, July 2020, p. 3 and 12).

On average, Latin American households finance 34% of total health spending out of their pockets. Public spending on health, which should be at least 6% of GDP according to the Pan American Health Organization, stands at 3.7% in Latin America and the Caribbean (ECLAC, 2020, p. 14).

Only 11 countries in the region have an unemployment insurance scheme in place: Argentina, Aruba, Bahamas, Barbados, Brazil, Chile, Colombia, Ecuador, Honduras, Uruguay, and Venezuela. Fifty-two percent of wage-workers are listed in or affiliated to a health scheme (including social security and prepaid medical plans), and the percentage drops to 34.2% for the decile with the lowest income (ECLAC, 2020, p. 11).

BLOFIELD *et. al.* (2020, p. 16) compiled a report on affiliation to social security schemes at the national level as of 2018. The following percentage of workers were reported as affiliated to a scheme: 20% in Peru; 30% in Mexico; nearly 40% in Colombia; 50% in Argentina; nearly 65% in Brazil, and 70% in Chile.

When the COVID-19 crisis struck, these countries were already beset with economic and governance problems. The populist or authoritarian regimes, or those following the Cuban Marxist ideology, have set the tone for government decisions over the century, and it would thus be naive to expect a good public policy response – except in specific cases like perhaps Uruguay. While Colombia has reported somewhat grim figures, its efforts to address the situation have been positive, expanding ICU capacity, providing direct cash transfers to households, and promoting personal care and social distancing measures. Nonetheless, even after the reactivation of industry and employment over the third quarter, the aftermath of the economic lockdown might be undermining health outcomes, as GDP dropped by 15.7% during the second quarter, and we should also point out the lack of coordination between regional and national governments – the Municipality of Bogotá has particularly remained reluctant to join efforts with the President's office.

The argument that economic deterioration leads to poorer health outcome is based on a Brazilian study that found that each percent increase in unemployment raised the mortality rate from any cause in the population by 0.5%. With a projected unemployment rate of 23%, which would mean an additional 120,000 deaths, the Brazilian government deployed \$5.6 billion in cashflow support, including direct cash transfers (*The Lancet*, 19/9/2020)¹¹.

The WHO Regional Office for Europe published a report on social determinants of health (Wilkinson, R. and M. Marmot, 2003). A key concept is the *social gradient in ill health*, revealing a higher incidence of certain health problems (stress, addiction, malnutrition), and even a shorter life expectancy, among those in the deciles with the lowest income. Health disadvantages have even been found for the middle-income class compared with those in the top income and wealth deciles.

COVID-19 infections have in fact shown such a social gradient. In Europe, for example, a second upsurge in infections took place in June in the lowest-income neighborhoods comprising a larger share of low-income immigrants: the Gütersloh district in North Rhine-Westphalia, Germany, where there is large-scale immigration from Eastern Europe; the city of Leicester in the UK, where immigrants account for 40% of the population and fall in the lowest-income decile compared with other British cities; Echinos, in the Greek municipality of Myki, where there is a large concentration of low-income Muslim immigration; 19 low-income neighbourhoods in Lisbon and the Italian municipality of Mondragone (Giugliano, July 1, 2020).

The Organization for Economic Cooperation and Development (OECD) published statistical data about its Member States for 2019. Colombia, a new member, has not yet been included in all the categories. The following figures refer to all indicators for Chile and Mexico, representing Latin American countries, to provide an insight into the current challenges, considering two countries that are listed in Table 1 among the top fifteen countries with the highest mortality rates (OECD, 2019, p. 29, 33):

- On average, 71.2% of health expenditure in OECD countries is covered through prepaid medical plans or social security schemes. This indicator stands at 50.1% for Chile, and at 51.3% for Mexico.

¹¹ This data was published by two Brazilian authors associated with Santa Casa de Misericórdia Hospital in Porto Alegre and with Universidad Federal de Ciências da Saúde de Porto Alegre, responding to an editorial by the same journal that was highly critical of the government.

- On average, health spending in OECD countries, including public and private spending, was equivalent to 8.8% of GDP – excluding investment in infrastructure. The U.S. recorded the highest value for the indicator: 16.9%. Chile spends 8.9% annually (the same level as Spain), and Mexico spends 5.5%.
- On average, OECD countries had 3.5 doctors per 1,000 population, and 8.8 nurses per 1,000 population. In Chile, there were 2.5 doctors and 2.7 nurses per 1,000 population. In Mexico, there were 2.4 doctors and 2.9 nurses per 1,000 population. In the U.S., these values stood at 2.8 and 11.7, respectively. Germany had 4.3 doctors and 12.9 nurses per 1,000 population; South Korea had 2.3 and 6.9 per 1,000 population, respectively, and Japan had 2.6 and 11.7, respectively.
- The study published by ANIF reported that diabetes was a relevant comorbidity associated with a higher mortality from COVID-19. The average number of diabetics in OECD countries was 129 per 1,000 population. Chile had 119 diabetics per 100,000 population, and Mexico ranked at the bottom among the 32 countries studied, with 249 per 100,000 population – followed by South Korea, with 245. Colombia was included in this indicator, with a rate of 62 per 100,000. The U.S. had 170 per 100,000, Italy 43, and Spain 45.

An individual analysis of each Latin American country will certainly constitute a promising and useful objective to develop a more focused report in the future.

7. A Final Invitation

We have discussed many of the various concepts and problems associated with the COVID-19 crisis. But there are still other factors that deserve attention, including the number of intensive care units (which is discussed in Annex 6) and the COVID-19 candidate vaccines (Annex 7). A key issue that must be addressed is the question about the role of the public sector in managing primary health care services or in funding access to health care schemes. These key functions of government must be aligned with participation by the private sector and must lead to the creation of systems focusing on public well-being. Effective coordination between the central government and the regional authorities would certainly facilitate closeness with service users.

This crisis will probably help to raise awareness about individual responsibility in maintaining health and about the systemic relationship among fellow citizens. At the moment, as a new wave of infections is on the rise in Western Europe and some U.S. cities, people are exhorted to adopt the recommended preventive measures relating to personal care and empathy with the health of others. The new coronavirus will likely continue to spark off new developments during at least the first half of 2021. We are thus faced with a political and civic challenge to prevent it from being used to consolidate certain political systems and interventions that will undermine democracy and quell creative individuality.

Bibliography: see Annex 8.



Individual Liberties and Rights

Carlos Sabino

A Little Bit of History

From the earliest times recorded in history, humanity has faced the onslaught of infectious diseases whose transmitters are often invisible to the human eye or extremely difficult to detect. Parasites, bacteria and viruses have historically threatened the existence of entire human communities, resulting in countless deaths and irreparable damage to people.

A measure that has typically been taken against the spread of diseases is the so-called quarantine, consisting in an imposed isolation to protect those who are at risk, and their close ones, and to prevent the transmission of those kinds of pests.

The first quarantine recorded in history was imposed by the so-called Guardians of Public Health in the Republic of Venice in 1348 to curb the spread of the infamous Black Death, also known as the bubonic plague. Passengers arriving in the city by ship were not allowed to disembark for 40 days – considering it a reasonable time for travelers to return to health... or to die. The pandemic was estimated to have killed over one third of Europe's population – about 100 million people.

Still further back in history, there was a common saying about escaping from the many plagues that swept through humanity, "*cito, longe, tarde*," a Latin expression that means "flee soon, go far away, and come back slowly." The advice was valuable to those who were in conditions to follow it, but it involved the risk of spreading the disease into other places, as those who were fleeing the plague might have been unknowingly carrying the pathogen that caused it.

In more recent times, a broader set of measures was added to quarantines to better combat epidemics. Dr. Gorgas's work in Panama earned him widespread renown because it was critical to successfully complete the construction of the inter-oceanic canal. Dr. Gorgas set out to establish sanitary hospitals where sick people could be effectively isolated, drain swamps, introduce mosquito netting, and properly build public water systems, making it possible to curb the proliferation of the mosquitoes that transmitted yellow fever and malaria.

When faced with epidemics, people – especially those less educated and more superstitious – often attributed pests to certain human or supernatural agents. People spoke of the wrath of God and divine punishment, of certain groups of people like Jews or immigrants, of the government, or of those who adhered to different religious or political beliefs. In Guatemala, for example, when it was still part of the Federal Republic of Central America, such accusations led to the demise of the government headed by Mariano Gálvez in 1838.



What is new about the current pandemic?

The situation that has arisen as a consequence of the COVID-19 pandemic is different and has no precedent in human history. The response we have observed so far to the outbreak is what you might call an “inverse” quarantine, where lockdowns have been imposed not only on those infected with the virus, but also on the entire population of countries around the world. That has been the case not only in China, where the epidemic started, but also in both democratic and authoritarian countries across all continents, regardless of their size. Why are we observing such drastic and sweeping response measures? To what extent have people’s rights and liberties been infringed? What impacts have these measures created? This chapter will try to offer an answer to the first two questions, and the third question – concerning the impacts – will be discussed in further detail in other sections of the report.

First, the point should be made that the current pandemic is not the most dangerous in the history of humanity by any stretch. The simple consideration of a number of facts will suffice to support that claim. As of October 2020, COVID-19 has infected a very small percentage of the global population, about 4 in every 1 thousand people, and its mortality rate has been relatively low – about 3%, which is well below that of other communicable diseases, both old and modern. The current incidence of scourges including tuberculosis, malaria, and even common flu (influenza) is roughly the same, or even higher. Common flu alone kills about 650,000 people every year; comparatively, current COVID-19 estimates suggest that the number of deaths caused by it will not even double that figure in 2020. Malaria, a curable disease that has long been under control, causes nearly the same number of deaths every year, and tuberculosis causes about 1.5 million deaths per year – a higher record than that of the new virus. Therefore, it is not the severity of the disease that has sparked such an intense reaction around the world. What is it, then?

First, we have to consider that the initial general reaction to the threat was simply panic. It was panic about the unknown, about something that had already been suggested about previous outbreaks of communicable diseases like SARS or AIDS but had not triggered such a





reaction. It was panic fueled by ignorance, considering that very little was known earlier this year about the key facts that enable prevention and a cure in the face of a new pandemic, coupled with other factors that will be discussed further in this chapter and that are related with the values and attitudes that have become widespread in recent times.

Significantly enough, two new conditions were added, in this case, to the already tense atmosphere. First, we are living in a world where communications travel at the speed of light, and which is thus riddled with information, both true and false, well-intentioned and ill-intentioned, leading the pandemic to become global news. Furthermore, the current globalized world made it impossible to follow the old formula of “soon, far away, and slowly.” There was nowhere to go. The whole world had been affected already, or was about to be affected, by the virus, and there were no faraway places left to run.

The other key factor contributing to the radical response observed is the role that the government has adopted around the world. Unlike what was observed just a century ago – with the outbreak of the “Spanish flu” pandemic – health care is now considered to be a responsibility of the state. All countries have state health

systems in place – often providing coverage free of charge – and the response to the pandemic was thus entrusted to the State.

With a fearful population that nevertheless demanded a swift and decisive response, governments were put in a position to act in the most extreme and rigorous manner. Some government leaders tried to respond in a more moderate and sensible manner, but public opinion for the most part opposed what was perceived as a carefree and irresponsible attitude. This brought about a set of circumstances that were highly unfavorable to individual freedoms: on the one hand, governments willing to adopt any measure to ensure that they do not come across as indifferent, and a population given to entrusting them with some of their fundamental individual responsibilities, demanding protection and safety, on the other.

This led to the adoption of certain measures ranging from the suspension of economic activities, curfews, shutdown of public transport, lockdown of elderly adults, and a prohibition of meetings – even family gatherings – to even strictly supervised full-scale lockdowns. The value and effectiveness of such measures remains to be proved on the basis of the following question: What would have happened if, instead of that approach, people had been advised to conscientiously take certain measures for their own protec-

tion, and nothing else, as is the case with all the other existing diseases? It is indeed impossible to answer that, but it is nevertheless a reasonable question that we put forward to forestall the false opinion that there was no other alternative course of action.

Be that as it may, after so many months we can now safely say that the extreme measures adopted did not prevent the spread of the pandemic, but they simply delayed it, along with their subsequent countermeasures stage. The figures reported by countries that imposed longer and stricter lockdowns are no better – and in fact generally worse – than those reported by countries where a more balanced approach was adopted. What is more, stricter measures are causing a damaging impact of incalculable proportions – on the economy, on interpersonal relationships, on the role of the State, and even on people’s health. We must not forget that the economy is not alien to people’s everyday lives: when we talk about the *economy* using abstract indicators like GDP, in reality we are referring to the activities of all economic agents, producers and consumers – i.e., the individuals who work, buy, and sell. That includes us all. Thus, there is no such opposition or tradeoff between “economy” and “health,” as those who suffer from illness are the same people as those who buy or produce goods.

The Individual and the State

Fundamental individual rights – the right to life, liberty and property – have been seriously infringed, or at least indefinitely suspended, during the months that lockdown measures and restrictions on human activity have been adopted. Will they be restored? The seriousness of the situation lies in the fact that such an infringement of rights has stemmed not only from the will of totalitarian leaders but also from the support and consent of a majority of citizens – or at least without active protest by citizens. People have chosen to react by transferring their responsibilities to the state – if not expressly, then at least without actively opposing what is being done. And then they have found that it is impossible to revert that: once a state-mandated lockdown has been imposed, the right to protest becomes virtually null; once certain economic activities are halted, there is no way business can resume as if nothing had happened.

Individual liberties associated with the freedom of movement, the right to protest, and the free use of property were thus violated by governments, which acted – and are acting – in such a way that the rulers or absolute kings of old would envy. They have done so under a mandate to protect people’s health, which was arbitrarily interpreted without any possibility for discussion, without even allowing any scrutiny by citizens.

The right to liberty is inconceivable without its direct counterpart: individual responsibility. Therefore, in the face of a pandemic, such responsibility demands that we maximize personal care measures: using personal protective equipment, staying away from any potential infectious exposures, and taking various kinds of preventive measures. Naturally, people will do that – to varying degrees – based on the available information and on their own beliefs.

That is not the problem. A person may opt for self-imposed lockdown at home, and perhaps that is what is most convenient for her under certain circumstances, but that is very different from having the State mandate that everyone must remain under lockdown. When it comes to individual rights, it is essential to distinguish between what is advisable and what is mandatory. If something is considered desirable or advisable, it is reasonable to try to convince people to do it, but the situation is very different from the moral and political point of view if people are to be forced to proceed in a certain way.



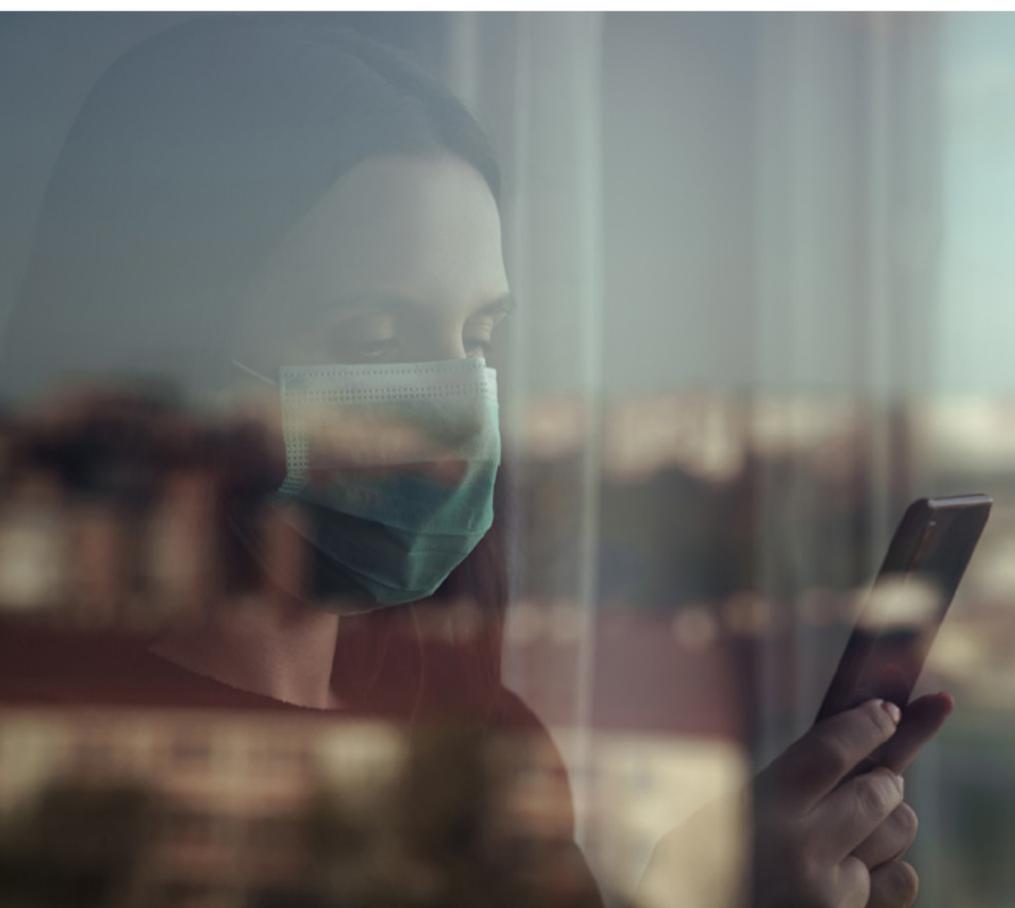
Erasing the distinction between what is voluntary and what is mandatory leads to a serious neglect of individual differences, as what may be desirable for some people may be detrimental to others. Statistics tend to be misleading in that regard, as they are mere aggregates that do not account for the specific circumstances surrounding each case. Moreover, there is also a fundamental difference: compulsory measures entail repressive punishment, fines – which may result in asset forfeiture in some cases – or imprisonment. Failure to comply with recommended measures, however, can only result in moral sanction, criticism, or denunciation by society – it will not scale up beyond that.

Government action is ultimately based on the use of force: no entity that cannot claim the monopoly of the legitimate use of physical force can be called a state, as was famously defined by Max Weber. In a state governed by the rule of law, citizens are given absolute guarantees, but when a state of emergency or calamity is declared – there may be different names depending on the national regulations – many of such rights will be subject to suspension. That is what has happened during the pandemic crisis, and that is why its consequences have been deplorable from the legal and social point of view.

Governments have been able to bypass the limits imposed by the existing regulations. In some cases, they have decided to have everyone stay in their homes, while others have applied the rule only for older adults or people suffering from certain diseases or medical conditions, like hypertension or diabetes. They have mandated that all economic activities be fully or partially halted. They have drawn an absurd dividing line between what is “essential” and what is “non-essential” in the economy. They have closed borders and limited the movement of people, vehicles, and public transport. Thus, they have abolished all basic human rights altogether in virtually all the world by restricting free movement and economic activities, introducing measures that are not even used when a state of war is declared. And to top it all, the measures have been introduced for an indefinite time, without any clear limit to get back to normal.

Faced with the uncertainty associated with a threat that is difficult to gauge, millions of people all of a sudden switched to living in a totalitarian regime for an indefinite period. The end of the restrictions imposed and the specific conditions under which they will be removed have not been established. And that is extremely relevant, because no one knows — or can know — how the pandemic will evolve. Infections may continue for a long time, and so may the deaths associated with them as long as there are no effective treatments to ensure prevention and recovery. Will we then continue with this lack of certainty for a long time, accepting such restrictions on our movement and a pauperizing economic shutdown? Will social distancing and other restrictions become the new “normal” we will have to accept in our lives?

These issues are further compounded by yet another factor, if we consider that the emergence of new diseases has been a historical constant. In addition to the ones we mentioned above, consider the terrifying polio and AIDS outbreaks in the 20th century. We must then ask: Will we go back into a right-denying lockdown in a couple of years, or any time in the future, when we are faced with a new plague? Will we then shut down our way of life and, most importantly, shut down the liberties we have enjoyed so far as something almost natural and inviolable?



The Contributing Cultural Backdrop

Indeed, two key factors were conducive to a radical large-scale response — truly unprecedented and universal — to the current pandemic. Historically, a large-scale lockdown was never imposed on entire countries, and certainly no major differences have been observed in the measures adopted by both dictatorships and democracies, with very few exceptions. The first key factor is the role the state has assumed in modern society, showing considerable differences with what it was just a century ago. The second, closely linked to the first one and more difficult to analyze, is people’s behavior, their assumptions and attitudes.

In modern societies, most of which are secular, the state has been entrusted with the ultimate responsibility for health, a mission it had only marginally taken upon itself, as it was fulfilled by both religious and private institutions. Although private healthcare services are in place in Latin America, offering high quality standards in many places, when the pandemic broke out, the vast majority of governments decided to adopt the radical measure of imposing a full lockdown. For the most part, societies willingly accepted the measures. Some demanded their implementation, while others complied without any serious complaint or opposition. Why? Because it was people’s health that was at stake in the end. In an environment marked by confusion and panic, and riddled with unreliable information, health protection opened the door for individual liberties to be drastically curtailed.

And people consented to that because risk aversion has become extremely prevalent today. In order to avoid adverse situations that only take place every so often, people often adopt behaviors, employ procedures, and use all kinds of products that ultimately carry costs that can only be covered by relatively rich societies. In the past, people traveled, had fun, and lived while often taking risks that have become unacceptable today. This recent attitude – adopted by many without much thought, although not by everyone – paved the way for such a disproportionate response to an epidemic that, although certainly lethal, has not shown the proportions observed with other terrible diseases.



Extreme aversion to risk is then further compounded by the particular nature of the current situation. It is difficult to protest measures that restrict people's liberties, as lockdown measures make it virtually impossible. Furthermore, it is one thing to protest for political reasons – e.g., against rulers who usurp powers or remain illegally in power – and another thing is to oppose a government that is restricting people's liberties supposedly in the best interest of citizens. In the latter case, those who oppose the situation may be easily regarded as irresponsible for risking exposure to dangers that are deemed unacceptable.

In addition, the impact of restrictions on liberty have been somewhat eased due to the available communication media. Online classes, home office, virtual meetings of all kinds, and other available resources that further facilitate long-distance communication have all created a conducive environment for people to put up with lockdowns for a longer period.

Human beings have always been able to adapt and perhaps find some comfort in living in a more peaceful way, away from the troubles associated with today's overcrowded cities and from a lifestyle that has been rapidly accelerating in recent times, creating stress and other personal and social problems. Perhaps we can say – merely as a conjecture that we know will be virtually impossible to prove – that the human species has now found that it can drastically change its way of living and that it should take better advantage of the technological resources available to it.

“It is difficult to protest measures that restrict people's liberties, as lockdown measures make it virtually impossible. Furthermore, it is one thing to protest for political reasons – e.g., against rulers who usurp powers or remain illegally in power – and another thing is to oppose a government that is restricting people's liberties supposedly in the best interest of citizens.”



Conclusions

The global response to the pandemic crisis has arguably been so extreme and so brutal that it has created a potential danger to liberty. The fact that measures have been imposed without much deliberation or debate, based on a unilateral decision made by a few people, begs the question about the importance we humans attach to our freedom. The indefinite prolongation of the issue is in fact heightening this concern: Will we always live like this, restricting our activities and movement whenever any new pathogen emerges – which will inevitably happen – driven by aversion to any kind of risk? Will we embrace a limited way of living – paradoxically – to avoid getting sick?

These are just questions that do not have an answer, but they are aimed at expressing genuine concerns that have arisen from the recent developments. What is certain is that certain liberties that we considered almost natural, self-evident, and inalienable have now been violated, as part of a temporary, albeit indefinite, measure and for evident – albeit highly questionable – reasons.

Considering the dangers that, for any given reason, may lay ahead, it is thus now time to reaffirm the liberal values. We must not forget that personal liberty is inextricably bound to the responsibility that each individual has over his own life. If such responsibility is entrusted to the State or to any other institution, we will thereby create a new form of slavery, which may be inconceivable right now but can be even more profound than what was witnessed in the past.



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I. The Economic and Social Impacts of the COVID-19 Pandemic

i. Economic Impact

The global economy has been hardly hit by the pandemic outbreak caused by COVID-19. Measures limiting economic activity and movement of people have resulted in a kind of hibernation of our economies. While it is still too soon to give an accurate estimate of the impact the pandemic will have on the economy, projections by the World Bank anticipate a 5.2% downturn in the global economy this year – and 7.2% in Latin America and the Caribbean.

Some countries in the region were already facing their own crises before the COVID-19 outbreak hit the continent. In some cases, they were caused by social turmoil (like in Chile, Ecuador, and Bolivia in 2019), in others by the economic slowdown that has unfolded in recent years in relation to developed countries (like in Argentina, Ecuador, and Venezuela), and then there was the oil shock of early March 2020, which kept oil prices low and was further compounded by a decline in global oil demand due to reduced economic activity..

The pandemic has unfolded unevenly across the region, and so have the response measures adopted. Consequently, the impacts among the various economies have been inconsistent.

If we look at the data presented in Table 1, the growth projections from June 2020 help us identify the countries with the bleakest forecasts for 2020,



including Peru, with a 12% negative growth rate, followed by Brazil, with a projected 8% contraction, and Mexico, Ecuador and Argentina, with negative growth rates ranging from 7 – 7.5%. The most encouraging – albeit negative – forecasts for 2020 are those for the Dominican Republic (-0.8%) and Panama (-2%).

Notably, the World Bank has made relevant adjustments in growth projections compared with those published earlier this year (January 2020). The last two columns in Table 1 show projections from January. Peru accounts for the largest drop in growth estimates, with projections from January 2020 indicating a 3.2% growth, compared with a 12% contraction forecast in June. For Brazil, projections fell from an estimated 2% growth to an expected 8% contraction. Overall, earlier this year the average growth rate for countries in the region was estimated at about 1.8%, and now it has been revised to an estimated contraction of over 7%.

Table 1: Real GDP Variation for Countries in Latin America and the Caribbean, June 2020

Country	2017	2018	2019e	2020p	2021p	Projections January 2020	
						2020p	2021p
Argentina	2,7	-2,5	-2,2	-7,3	2,1	-1,3	1,4
Bolivia	4,2	4,2	2,7	-5,9	2,2	3,0	3,2
Brazil	1,3	1,3	1,1	-8,0	2,2	2,0	2,5
Chile	1,2	3,9	1,1	-4,3	3,1	2,5	3,0
Colombia	1,4	2,5	3,3	-4,9	3,6	3,6	3,9
Costa Rica	3,9	2,7	2,1	-3,3	3,0	2,5	3,0
Ecuador	2,4	1,3	0,1	-7,4	4,1	0,2	0,8
El Salvador	2,3	2,4	2,4	-5,4	3,8	2,5	2,5
Guatemala	3,0	3,1	3,6	-3,0	4,1	3,0	3,2
Haiti	1,2	1,5	-0,9	-3,5	1,0	-1,4	-0,5
Honduras	4,8	3,7	2,7	-5,8	3,7	3,5	3,5
Mexico	2,1	2,2	-0,3	-7,5	3,0	1,2	1,8
Nicaragua	4,6	-4,0	-3,9	-6,3	0,7	-0,5	0,6
Panama	5,6	3,7	3,0	-2,0	4,2	4,2	4,6
Paraguay	5,0	3,4	0,0	-2,8	4,2	3,1	3,9
Peru	2,5	4,0	2,2	-12,0	7,0	3,2	3,5
Dom. Rep.	4,7	7,0	5,1	-0,8	2,5	5,0	5,0
Uruguay	2,6	1,6	0,2	-3,7	4,6	2,5	3,5

Source: World Bank, June 2020 and January 2020.

Notes: “p” means projected, “e” means estimated.

While projections from the World Bank for 2021 point to an economic recovery for almost all the countries reviewed, most of them will not be bouncing back to pre-pandemic levels. This might also mean that employment will only pick up back to pre-pandemic levels after 2021.

ii. Impact on Employment and Poverty

The economic downturn triggered by the pandemic will certainly cause unemployment to soar, as will the number of people living in poverty and in extreme poverty – as measured by income.

Economic projections from ECLAC suggest that the region’s unemployment rate will stand at about 13.5% by year-end 2020, 5.4% higher than the rate from 2019. This means that the number of unemployed people will likely reach 44.1 million. Nevertheless, the increase in unemployment rate – already indicating a significant deterioration of the labor market – does not account for the total impact of the pandemic on employment. A considerable percentage of those who have lost their jobs are not necessarily trying to dive back into the job market, as they feel discouraged by the reduced likelihood of finding a job during lean economic times. Thus, rather than unemployment rates, we must pay attention to job destruction rates, or else to each country’s employment rate.

In addition to job losses, the region’s high rates of informal employment also constitute a significant challenge. According to the Inter-American Development Bank (IDB), informal employment in Latin America and the Caribbean stood at 56% of the employed population by the end of 2018. This is a reality that makes the region much more vulnerable to the effects of the pandemic – also limiting the impact of the measures implemented by the various governments in the region.

A study conducted by the IDB will be relevant in this regard, as it presents estimates of job losses for 24 countries in the region, creating three possible scenarios within a one-year time frame: “short-term crisis” (a fall in output that will double that observed in 2009, and economic recovery by the end of 2020), “medium-term crisis” (a recession spanning three consecutive quarters with a negative growth rate close to -10%, and a slight improvement in the fourth quarter), and prolonged recession (a 15% recession without economic recovery in the medium term). Table 2 presents estimates for selected countries, considering the scenarios on both extremes.

The data indicates that the countries seeing the worst job losses in formal employment under the optimistic scenario (“short-term crisis”) are El Salvador with 8.6%, Panama with 8.4%, and Costa Rica and Honduras, both with 7.9%. Under the most pessimistic scenario (“prolonged recession”), the countries showing the worst fall in formal employment are El Salvador with 23.9%, and Nicaragua and Panama with 23.7%.

Another major challenge posed by the pandemic concerns the process of adaptation that workers have had to go through due to the lockdown and social distancing measures imposed by governments. While teleworking has been gaining momentum



during the pandemic, a significant share of jobs cannot adopt that kind of working model, especially informal jobs. Thus, in economies with a higher level of informality, not only is teleworking less feasible, but the measures governments can implement to support informal workers are also more limited. That is likely to widen the income gap among workers across the labor market in those countries.

Table 2: Formal job losses due to COVID-19 in Latin America and the Caribbean, by scenarios.

Country	Total employed workers pre-pandemic (millions)		% Formal Job Losses	
	Informal	Formal	Short-term crisis	Prolonged recession
Argentina	6,1	5,7	-1,2	-4,8
Bolivia	4,2	1	-2,6	-9,7
Brazil	34,1	58,3	-4,2	-14,8
Chile	2,5	5,4	-4,6	-15,7
Colombia	14,1	8,3	-4,2	-14,4
Costa Rica	0,6	1,5	-7,9	-22,4
Ecuador	4,5	3,2	-4,3	-14,4
El Salvador	2	0,8	-8,6	-23,9
Guatemala	5,6	1,3	-7,5	-21,1
Guyana	0,1	0,1	-6,1	-16,7
Haiti	3,6	0,3	-5,7	-14,9
Honduras	3,2	0,6	-7,9	-21,7
Mexico	40,9	18	-4,1	-14,4
Nicaragua	2,1	0,6	-7,5	-23,7
Panama	0,9	0,9	-8,4	-23,7
Paraguay	5,1	1,5	-3,8	-11
Peru	13,5	3,4	-3,3	-11,8
Dom. Rep.	2,6	1,7	-6,7	-18,5
Uruguay	0,4	1,2	-7,5	-21
TOTAL	146,3	116,7	-4,4	-14,8

Source: BID, 2020

Another issue that was already being discussed before the pandemic was the impact on employment of increasing automation of business processes in the region – the so-called fourth industrial revolution. This process may have accelerated in some cases this year as a result of the pandemic, potentially bringing a turning point in employment rates once restrictions of movement are lifted. And that will pose an additional challenge for job recovery in the formal economy once countries are able to revive their economies.

The sharp downturn of the economy in the region will also lead to an upsurge in poverty levels. ECLAC estimates show that the number of people living in poverty will rise by 45.4 million in 2020, bringing the total number to 230.9 million people, which represents 37.3% of the population in Latin America. Of this group, the number of people living in extreme poverty by 2020 is estimated at 96.2 million, adding 28.5 million people to this category, compared with the previous year, and accounting for 15.5% of the total population.

The sharpest increases in poverty rates are estimated to take place in Argentina (10.8%), Peru (9.3%), Brazil (7.7%) and Mexico (7.6%). If we take extreme poverty into account, estimates indicate that the worst affected countries will be Mexico (6.3%), Ecuador (5.1%) and Nicaragua (4.8%).



II. Developments and Challenges in Education and Health

Responses to the pandemic outbreak caused by COVID-19 have not only included restrictions on all economic activity and school closures affecting all educational systems, they have also led people to seek less care for conditions different from COVID-19 across health care systems. These two realities may lead to a serious deterioration in both learning processes and health among the population.

Education

According to the United Nations Educational, Scientific and Cultural Organization (UNESCO), over 1.2 billion students around the world, across all educational levels, had stopped attending in-person classes at their schools by May 2020, including over 160 million students in Latin America and the Caribbean.

Another report prepared by ECLAC and UNESCO examines the variety of possible consequences that may result from government measures affecting education in Latin America and the Caribbean as of the first week of July 2020. Of the 33 countries studied, only one (Nicaragua) has not suspended in-person classes. As of the date of writing this report, some countries (including Uruguay and Ecuador) have already returned to in-person classes.

Notably, the consequences of canceling in-person classes also include reduced access to food and nutrition for students, especially in the most vulnerable areas. Of the studied countries, 21 have continued to implement school meals programs by distributing meal kits for at-home preparation, delivering food to households, and giving cash transfers or food allowances.

Cancellation of in-person classes has also encouraged the adoption of various types of distance learning options, including varieties both with and without the use of technology. Regarding distance learning delivery modalities, most of the countries included in the report (22 out of 32) used two varieties of delivery: with internet access and without internet access. In addition, 23 countries reported using traditional broadcast media for educational programs, including radio and television. Only 8 countries reported having delivered electronic devices to maintain continuity through long-distance education.

While most countries had the necessary digital resources and platforms in place for remote connection – which, according to ECLAC, has been reinforced under these circumstances – few countries reported having national strategies using digital media. Coupled with unequal internet access, this situation may impact negatively on the most vulnerable sectors.

Along the same line of analysis, the UNESCO-ECLAC study indicates that the use of technology tools in education in fact started since the 1980s in Latin American and Caribbean countries. While countries have seen significant progress, it has nevertheless been unequal – e.g., internet access is much more widely available in urban areas than in rural areas. In 2018, only 61% of students in the region had access to a computer. In comparison, mobile internet access is more widespread thanks to the potential offered by mobile telecommunication services.

The current crisis thus presents itself as an opportunity to evaluate and rethink the existing educational model in each country, considering how learning was taking place in educational institutions. Furthermore, it also represents an opportunity because, although the circumstances were certainly premature and abrupt, schools had no other option but to start using digital tools. The internet offers a wide variety of teaching and learning resources that should be fully exploited, and thus the remote learning experience gained during these months should be integrated into educational processes on a permanent basis, at least as a way to supplement in-person classes.

Despite the progress made in exploiting the potential of distance learning in countries over the past few months, we must not forget about the harsh realities many students are facing, being unable to continue studying either due to a lack of internet access or due to other circumstances that have made it impossible to continue their studies in person. Many have been forced to discontinue their studies. That coupled with the ongoing economic crisis is likely to cause drop-out rates to soar, either because of the interruption of education during these months – already representing a challenge when returning to in-person classes – or because children and adolescents in many households will be required to go out to work and contribute to the household income. This reality will constitute an additional challenge to educational systems over the coming years.

During the pandemic outbreak, people in many countries have also been spontaneously introducing other educational delivery models or arrangements to provide care for pre-school age children, aiming to facilitate the work of those – mostly women – who take on such a role in their households. Thus, organizing between two or more families to support the educational process of their children or to provide care for them also represents an alternative that must be considered when everything goes back to the much-anticipated normality.

“During the pandemic outbreak, people in many countries have also been spontaneously introducing other educational delivery models or arrangements to provide care for pre-school age children, aiming to facilitate the work of those – mostly women – who take on such a role in their households.”



Health Care

Ningún país del mundo, y menos de la región, estaba preparado para enfrentar esta pandemia. Algunos países lograron en mejor medida adaptar sus sistemas de salud para hacer frente a los requerimientos adicionales que le imponía la llegada del Covid-19, aumentando desde la capacidad de testeo a la de atención y hospitalización.

No country in the world – not to mention in the region – was prepared to deal with the pandemic outbreak. Some countries were better able to adapt their health systems to meet the additional demand created by the COVID-19 outbreak, increasing both testing and hospital care capacity.

Most countries enhanced preparedness to respond to the COVID-19 outbreak by postponing care for other less urgent illnesses, delivering service only in cases where it was indispensable. That also creates a challenge, as all the healthcare services that could not be given – because of a lack of medical staff or hospital capacity, or because people decided to put off any regular medical procedure to avoid the risk of infection – will have to be taken care of once the outbreak is under control.

Indeed, telemedicine services have been successfully implemented in some cases, but that has only covered a very small share of the patients received before the outbreak, and thus meeting an excess demand for health care services will be part of the reality that all public systems will have to face.

There is no data available on the impact of the reduction of health care services for conditions other than COVID-19 on public health, but we can certainly expect deterioration. In addition to the reduction of routine health care services, in most cases surgical procedures and treatments were also postponed, classifying them as non-urgent or elective, but nevertheless causing an impact on the conditions and the quality of life of people.

Increased pressure on public health care systems may pave the way for increased participation by the private sector. But that will only be the case if governments are willing to rely on private networks to provide care to those who have not been able to receive it due to the outbreak. Also, telemedicine should be promoted as a form of delivery of care services after the outbreak. It represents a significant breakthrough that should be advanced in the future as a platform to supplement the traditional health care delivery systems, thereby increasing their efficiency and capacity in providing health services.

III. The Challenges of the Post-Pandemic Future: From a Charity-Based Approach to Economic Reactivation

To respond to the COVID-19 pandemic, governments have been forced to increase tax expenditures in at least one of the following four categories: (1) Increased health spending; (2) Creation of new programs, or at least an expansion of existing cash transfer programs, to support households whose income has been reduced due to the restriction to go out to work; (3) Support programs to raise liquidity for businesses and prevent bankruptcy, and (4) Support programs to stimulate economic recovery, by supporting job creation or by encouraging domestic demand.

Increasing tax expenditures is dependent on the fiscal conditions each country had before the outbreak.

However, in most cases countries financed the increased spending by using savings, by increasing debt, and in some cases by reallocating public spending – putting off programs that had not been implemented due to the pandemic or reordering priorities.

Higher tax expenditures coupled with a downturn in the economy of countries – and the resulting drop in tax revenues – will lead to an upsurge in fiscal deficit in all countries, and to a bigger government.

A key challenge governments will face is ensuring that the increased expenditures are in effect temporary, preventing them from turning into permanent programs. As economic policy removing support from certain population groups brings further complexity to the situation, countries must go back to a level of fiscal spending that in fact corresponds to their structural revenues, adopting a fiscal approach that will be sustainable over time.

Otherwise, in the medium term, countries in the region will be faced with profound fiscal sustainability problems, forcing governments to run aggressive fiscal adjustment programs and to impose cuts in targeted benefits and allowances, potentially facing political consequences.

Furthermore, the fiscal tightening countries will have to adopt in the coming months and years will open the door to the promotion of reforms that will raise the quality of public spending, redirecting spending into more urgent matters and removing – or at least shrinking – programs that traditionally favor certain lobbying groups and whose effectiveness in solving the problems they were initially targeted at is quite doubtful.

We are going through a period in which governments have taken on a rather charitable role, but we must keep in mind that such a design is exclusively intended for the current pandemic crisis. Once the measures limiting economic activity are lifted, the State must transition from implementing charity-based programs to promoting economic growth and job recovery, which is the only source of real progress and sustainable wealth creation for individuals, households, and society as a whole.

The process will certainly not be easy. The region is seeing a significant increase in the number of people living in poverty, and its economies will not be able to restore former levels of employment – at least not over the next two years, compared with the pre-pandemic levels – thus, there will be mounting pressure to maintain the major cash transfer programs. Hence the need to adopt programs that will favor an effective transition from the current charity-based model to one that promotes a revival of the economy and that addresses the additional challenge of recovering jobs with increased formality in employment.





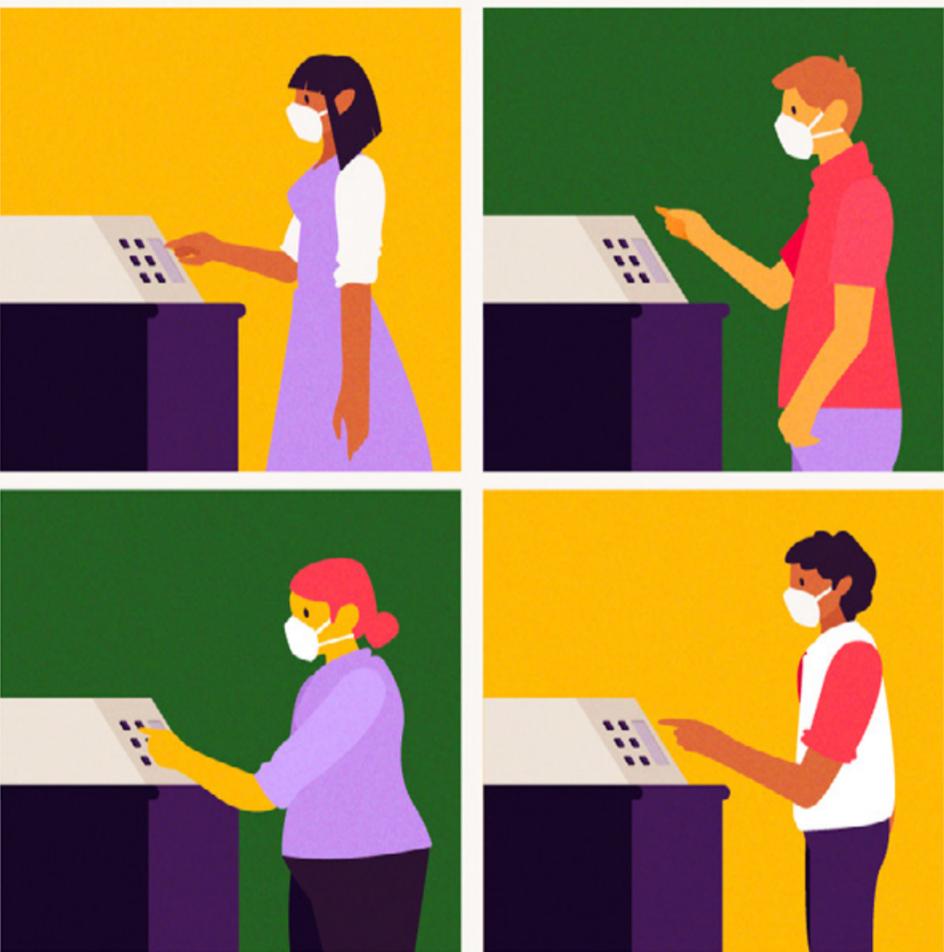
Pandemic and Democracy in Latin America

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Introduction

Latin America is one of the regions worldwide that has been worst hit by the COVID-19 pandemic. In August 2020, Latin America and the Caribbean became the region with the highest number of COVID-19 deaths, surpassing even Europe, as reported by the media. This new challenge has revealed the major social, political, and economic issues affecting all countries in the region to varying degrees. It is a situation that would predictably unmask the structural weaknesses affecting Latin American countries: just like a mythical giant with feet of clay, the region's infrastructure issues, poor development, and institutional quality were thus revealed.



The element of institutional quality will be of particular interest for our discussion, assessing how well-established and consolidated are Latin American democracies in the face of the challenges posed by the pandemic. The question may then be asked: Has the pandemic crisis created an excuse to advance populism?

While the pandemic has become a phenomenon affecting all countries around the globe, the observed responses to and management of the crisis have shown significant differences in the region. These differences point to a lack of success around the political agreements the region has tried to work out since the 1960s – and then more purposely since the 1990s. Those were regional undertakings that failed to come through, and whose dogmatic rhetoric (including that of UNASUR and CELAC) revealed the region's structural weakness.

The discussion presented below focuses on explaining how the situation has been addressed in the region. It first describes the major models adopted – particularly in Argentina, Brazil, Uruguay, and Mexico – and then examines the major sources of political tension (known as hot spots), along with the increasing pressure they put on the government sector. Finally, it considers the risks of a potential shift towards authoritarianism in the region.

Democracy and the Political Idiosyncrasies of Our Region

Latin America has traditionally exhibited a series of recurring idiosyncrasies that have run deep for decades, and the pandemic crisis has only made them all the more pronounced. This section will examine those idiosyncrasies that are common to the political culture across the region.

Thomas Clive (2009) claimed in his book *Understanding Latin American Politics* that there are six traditional structural features inherent in Latin American politics. Those features may provide the necessary framework to understand the seriousness of the current situation in the region, regardless of the data about COVID-19 or the economic recession. They represent a map to understand the politics of the region.

“There is clearly a lack of a shared political culture, by which we mean a set of shared values and beliefs with regard to the forms and the scope of politics – especially as they relate to the limits imposed on government power – or, in more general terms, the fact that the rules of the game are widely accepted and have been defined by consensus.”

First, the author refers to the *caudillo* tradition. In the context of post-independence Latin America, marked by significant problems in establishing an effective government, *caudillos* emerged as a figure that advanced centralization of authority and corporatism, having an influence that still holds sway today. That is what Dieter Nohlen (1994) alluded to when he claimed that the authoritarian gene was conceived constitutionally in Latin America, as a result of an initial aim to temporarily strengthen the executive branch in constitutional texts in order to diminish the influence of other powers. In other words, the authoritarian gene manifested itself in the region as a temporary constitutional element that was critical to move forward during the early years of government and to achieve statehood. The Latin American tragedy lies in the fact

that “the authoritarianism gene inherent in constitutionalism has grown stronger than constitutionalism itself,” turning both institutional authoritarianism and the emergence of personalist strongmen in the Executive branch into the effective political key to understand the region’s idiosyncrasies.

Second, there is clearly a lack of a shared political culture, by which we mean a set of shared values and beliefs with regard to the forms and the scope of politics – especially as they relate to the limits imposed on government power – or, in more general terms, the fact that the rules of the game are widely accepted and have been defined by consensus. Thus, the democratization process in the region did not reach all sectors, creating a context where various political cultures coexist without any one of them becoming dominant, and paving the way for the frequent clashes and recurring instabilities that have now become typical in the region.

Third, this set of circumstances is further compounded by the emergence of a multiplicity of political and economic ideologies. The fragmentation of the region’s political culture resulted in an atomization of ideological currents affecting all the left (Marxism/Communism), the center (social Democracy/Populism), and the right (Conservatism). Politics thus progresses by lurching from one extreme to the other, resulting in a lack of continuity in public policy.

Fourth, the military have played an extremely influential role in Latin America. The military is not alien to politics in the region. Just consider the example of Bolivia last year (2019), when the military sector took a clear stand and exerted a tremendous influence on how the events unfolded, resulting in the resignation of President Evo Morales and his request for asylum in Mexico. The armed forces perceive themselves as the saviors of their motherland, assuming intervention as an obligation and representing the moral reservoir of their country. They serve a key role that deserves particular attention, in both past and future developments. Unlike in the past, however, the military have more recently served as a bulwark protecting rulers, as was the case with Vizcarra in Peru, with Lenin Moreno in Ecuador, and with Sebastián Piñera in Chile. The armed forces are an indispensable ally that has kept Nicolas Maduro's dictatorship standing in Venezuela (Mazzina, 2020). As Rut Diamint pointed out, "with a different purpose, numerous presidents have relied on the Armed Forces. Now it is not the military that exerts pressure to take over politics, but it is rather the elected authorities who use them for their own projects." (2018)

The fifth point is that Latin America may metaphorically be described as a *development roller coaster*. The four factors described above clearly point to an environment marked by political volatility, which has indeed characterized Latin America. Up until 1930, there was an initial period in which the region advanced as an emerging democracy, and then it was followed by the crisis triggered by the stock market crash that year, paving the way for the emergence of a number of authoritarian governments. Later, there was the so-called second wave, spanning from the end of World War II up until 1960, followed by a period of severe repression throughout the 1970s. Finally, there was a third wave of democratization starting in the 1980s and continuing up until today. It is still unclear whether it represents a genuine democratic consolidation or is simply another upward phase of the development roller coaster. What it does indicate is the prospect of a reality that has no precedent in history, showing how democracies may divert from their path – but we will discuss that further in this chapter.





Finally, the sixth factor has to do with institutional weakness, which refers to a lack of an adequate interdependence relationship between the powers. Added to that is the personalization of politics, focusing on individual actors and, thus, on the preeminence of the executive branch over institutions, leading to an effective deinstitutionalization of liberal democracy.

The third wave of democratization has brought about an unprecedented phenomenon in the history of democratic regimes. And it has been discussed by various authors, raising questions like: *Is democracy dying?* (Malamud, 2019), *How Democracies Die* (Levitsky and Ziblatt, 2018), *Facing up to the Democratic Recession* (Diamond, 2015). The factor differentiating it from the democratic experiences of previous waves lies in the fact that, in the past, they collapsed or died all of a sudden, with the so-called *breakdowns* (the classic coup). But with the wave starting in the 1980s, they now suffer from a slow and gradual death, which is now known as democratic backsliding. The defining factor that makes this process so peculiar is the fact that democracies are dying from within, often at the hands of “elected leaders [...] who subvert the very process that brought them to power” (Levitsky and Ziblatt, 2018), and they thus “slowly bleed to death from the indignation aroused among voters and the corrosion caused by demagogues” (Malamud, 2019). In that context, democratic regimes degenerated into forms that are as imperfect as they are varied, giving rise to a new “democracy with adjectives” (Collier and Levitsky, 1997).

Now that we are clear about the major features that distinguish today’s Latin America, considering the factors described above, it may be relevant to look at a 2005 report published by the U.S. National Intelligence Council, describing the outlook for Latin America by 2020. First, the report stated that over the following 15 years, Latin American democracies were projected to experience new forms of political crisis, largely due to the weakening of political parties. It may be difficult to believe that this statement was made about 15 years ago, considering how relevant and accurate it has become today. The massive violent protest movements that took place in Ecuador, Peru, and Chile over the course of 2019 attest to the validity of the assertion. Then, the projections for certain countries in the region – like Uruguay and Costa Rica – in terms of the strength of their institutional system and their success in adapting to globalization were validated by the indicators measured by both Freedom House and Latinobarometer, with both countries ranking at the top for civil liberties and political rights. Finally, there is the factor of the emergence of personalist leaders, prevailing over an institutional organization and thus leading to cultural contradictions and fractures in Latin American societies due to the widespread appeal and recognition of charismatic leaders.

Coronavirus and Ballot Boxes

Considering the health emergency we have been experiencing in the region since March and the social distancing measures that all governments have implemented – to varying degrees – two questions inevitably arise: What will happen with the elections that were scheduled for this year? Will they be postponed? How will the opposition respond to that? Some of these questions will be addressed in this section by presenting a brief assessment of some Latin American countries.

Ten countries in the region have postponed elections, rescheduling them for the second half of the year, or even for 2021. This involves a variety of situations. The vast majority of elections come under the subnational level, but there are cases of primary and national elections, and a referendum, that still need to be rescheduled.

First, the case of Chile is attracting particular attention due to the critical importance of the referendum that had been scheduled for April 26. The referendum will ask citizens whether they are in favor of changing the country's current constitution. The decision to hold a referendum was reached in November last year, following a series of violent protests without precedent that took place throughout the country for over a month. The referendum has been rescheduled for October 25, if the health emergency allows it.

Bolivia has also come into the spotlight in the region. Following the exile of Evo Morales, the pressure exerted by the Armed Forces, and the appointment of Jeanine Añez as interim president, Bolivia's upcoming national elections are regarded as the most consequential and turbulent election in recent decades. The long-awaited election was originally scheduled for May 3, but given the health emergency, it was rescheduled for September 6 as required by law. The new date was recently changed by Bolivia's Supreme Electoral Tribunal, establishing October 18 as the "final, irrevocable, and unpostponable" date.

In the cases of Argentina, Mexico, Uruguay, Brazil, Peru, and Paraguay, the outlook has been much more serene because the elections to be held this year are at the subnational level, both municipal and provincial.

Nonetheless, it might be relevant to look at how politicians have reacted in the midst of an economic crash, at both national and international levels, and the resulting vehement demands and social pressure aimed at government leaders.



As part of an early initiative pushed by President Luis Lacalle Pou, in March Uruguay imposed salary cuts – ranging from 5 to 20 percent – for public officials earning over \$1,900. The proceeds from the cuts would go to the new Coronavirus Fund (estimated at \$768 million) to provide funds for the Ministry of Social Development, for the unemployment and medical insurance schemes, for the redistribution of contributions, and for the procurement of medical supplies. Also, the Chamber of Deputies voted on a resolution to cut out the “press and media allowance” (giving each legislator \$800) and allocate that money to the same fund. By contrast, on the other side of Río de la Plata, the opposition caucus in Argentina’s Chamber of Deputies sent a letter to President Alberto Fernández to negotiate a 30% salary cut for public officials, aiming to create a pooled fund to counter the impact of the pandemic on the most vulnerable sectors, just like that in Uruguay. The Argentine President, however, rejected the proposal and criticized its supporters for serving partisan interests.

By the same token – highlighting the contrast between the two government styles – Uruguayan President Lacalle Pou has recently presented the 2020-2025 budget, which provides that neither tax rates nor public spending will be increased despite the country’s fiscal deficit, which is currently running at 6.5% of GDP as a consequence of the negative impacts of the pandemic. Conversely, as a response to the crisis, political leaders in Argentina decided to print currency and push through a bill entitled “social solidarity and economic reactivation during the national emergency,” levying a one-time extraordinary tax on “large fortunes” to finance public spending.

The two cases provide examples of opposing approaches and styles in addressing the same problem regarding the economic response to the crisis: while the government on one side of Río de la Plata decided to cut back on spending and allocate a share of its genuine income to cope with the emergency, on the other side of the river the tax burden imposed on citizens is being increased, as an extraordinary measure, and politicians are showing no signs of any implementation of the much demanded cut within the government sector.

Governance in the Context of the Pandemic Crisis: The Hot Spots of Social Conflict



If we look at the most relevant measures and restrictions implemented by governments in Latin America to address the epidemiological emergency, there are two key elements that stand out to account for why lockdown measures have had varying results among the countries in the region: the timing of lockdown measures and the state of the local economy.

As a first example, consider the strategy of the Argentine government, opting for an early and prolonged nationwide lockdown that required a suspension of all activities, except for those labeled as essential. Both the formal and the informal economy were severely affected as the months passed, and sectors did not seem to become more flexible. A gradual reopening of activities was eventually announced, introducing a phased plan for the

provinces and municipalities with lower daily infection rates. This strategy has proved to be the most ineffective so far — after over 180 days of lockdown, the number of infections surpassed half a million people. Under the pretext of coping with the pandemic, liberties were severely curtailed.

In Brazil, the Ministry of Health recommended social distancing measures at the national level, but the Supreme Court announced that states and municipalities had full autonomy to control the level of activity and social distancing measures. A key element to keep in mind about this approach is the fact that it affected the formal economy, but the informal sector did not shut down at any time.

In Mexico, the federal government announced that all non-essential activities would be suspended starting in March. It introduced a plan establishing different levels of risk according to the hospital bed occupancy rate indicator. The red level of risk means the infection rate is high, and thus the strictest level of restrictions is needed. The orange level of risk enables the opening of activities, including restaurants and hotels, as long as businesses follow the established guidelines (limited number of people). And the yellow level of risk enables a nearly full reopening of activities following the established health care guidelines.

The strategy undertaken in Uruguay shows figures (46.6 infections per 100,000 population) ¹[update, 59 as of 1/10 At <https://www.worldometers.info/coronavirus/?>] that support the idea that it is the most effective and successful strategy in the region. A key element was the fact that the government did not impose any mandatory lockdown on the population, but rather appealed to public responsibility. Businesses chose not to open, even if it was not mandatory to do so. In addition, political leaders showed great empathy towards the emergency situation, advancing the creation of a coronavirus fund financed with a 20% salary cut on public offices including the president, ministers, and legislators.

Latin America is still a long way off from overcoming the social, economic, and political crises that erupted with massive protests last year (2019) in countries including Chile, Ecuador, and Bolivia — in addition to the long-standing conflict in Venezuela. On the contrary, the crisis caused by the pandemic will only exacerbate and create new forms of conflict. The following section will thus identify the conflict hot spots within the region.

First is the scenario that has been playing out in Venezuela, which is the most worrying case. The situation that has unfolded around its democratic regime represents the most telling example of what we discussed earlier about experiencing a slow death of democracy. The country's political leadership cultivated their own authoritarian attitudes, eroding the values of liberal democracy and paving the road for the establishment of an authoritarian regime. Specifically concerning the management of the pandemic, a report published by Human Rights Watch entitled "A Police State Lashes Out Amid Covid-19"² sets forth that the government is using the state of emergency to undertake a spate of arbitrary arrests, prosecutions of critics, and abuses against detainees.

Another hot spot deserving attention is Santiago de Chile, considering the massive protests that took place last year — many of them turning violent and having no precedent in the country's recent history. As a response to the pressure exerted by citizens, the government scheduled a referendum to ask them whether they were in favor of a potential reform of the constitution. In view of the reverberation and the momentum that has built up in that context, the country is expected to potentially turn into a hotbed of new social expressions.

1 <https://www.rtve.es/noticias/20200831/paises-muertos-coronavirus-poblacion/2012350.shtml>

2 <https://www.hrw.org/es/news/2020/08/28/venezuela-estado-policial-avanza-en-el-contexto-del-covid-19>



With the exile of Evo Morales and the pressure brought to bear by the armed forces, Bolivia also stands out as a hot spot in Latin America. The national election scheduled for October will take place in the midst of a highly turbulent social and political environment that is already filled with anticipation.

Finally, the economic factors that are at play in Argentina also emerge as a particularly relevant component. The costs of maintaining a prolonged and inflexible lockdown for business, the currency printing policy and the upsurge in public spending on countless social benefits, inflation, and the rising US Dollar exchange rate values all constitute significant factors that will have alarmingly damaging consequences. In this context, the country's economic and social outlook points to a looming crisis marked by protests and an increasing pressure on government leaders. The current Peronist government will be faced with an unprecedented situation: it will not be able to throw the blame forward into the future.

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What Lies Ahead in the Future: The Dangers of Authoritarianism in the Region

As we mentioned earlier in this chapter, the death of democracy does not happen all of a sudden today as it did during much of the 20th century. Instead, it goes through a gradual process that takes place inside the regime's own functioning, following a process of deterioration that may unfold at varying speeds and varying levels of depth in each case. The outcome is nevertheless always the same: a democracy stepping through the doorway to authoritarianism.

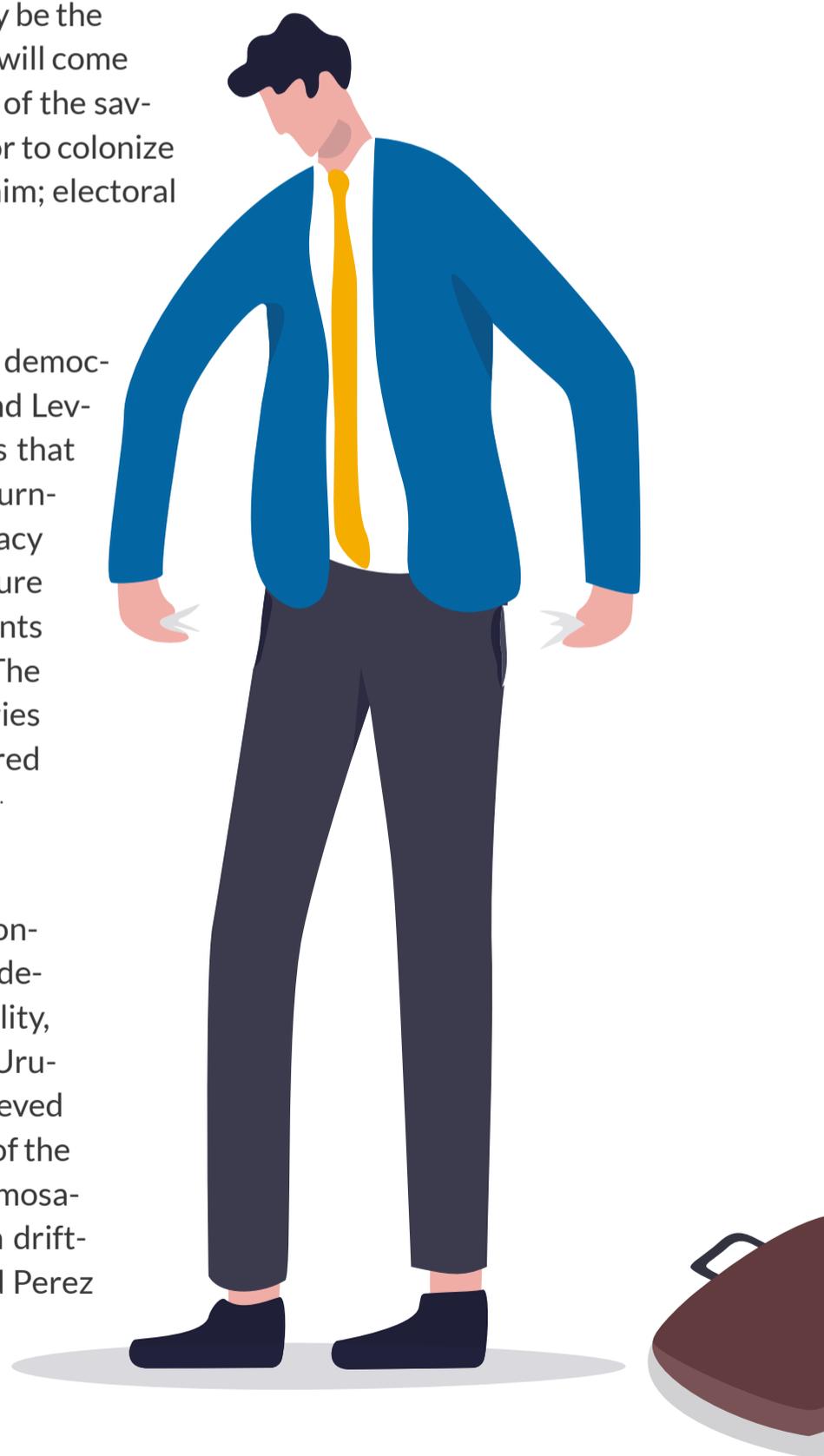
We thus consider it relevant to pay attention to certain behavioral indicators that may warn us about looming authoritarian tendencies (Levitsky and Ziblatt, 2018). First, a rejection or a reluctant acceptance of the democratic rules. Second, denial of the legitimacy of political opponents. Third, toleration or encouragement of violence. And finally, readiness to curtail civil liberties of opponents, including the media. A leader's manifestation of only one of the four indicators is enough to indicate an authoritarian

tendency. It is often politicians who claim to represent the voice of the people, encouraging political polarization between two sides that are not only antagonistic but also irreconcilable: on one side is the people, whom they claim to represent with all legitimacy through the agency of one single person, and on the other is the anti-people, made up of an organized and manipulative oligarchy.

It is critical to identify the key features of the populist approach, as it constitutes the gateway to authoritarianism in Latin America and leads to a “deinstitutionalization of liberal democracy” (Serrafero, 2013). First, antagonistic relationships with the opposition are primarily based on the idea that the exclusive representation of the people can only be fulfilled by the ruling leader and his party. Thus, the other parties can only represent interests that are alien and antagonistic to the people. Second, the executive branch will typically hog the limelight. Thus, if his party dominates the ruling majority in the legislative branch, it will fulfill a legitimizing role, otherwise (if it represents the opposition), it will constantly be the object of obstruction. Thus, the leader (often charismatic) will come across as an indispensable element, embodying the figure of the savior of the nation. Finally, a third element will be an endeavor to colonize the judicial branch so that it will not wield a veto against him; electoral majorities must determine their own fate.

The category that best describes today’s Latin American democracies is the so-called *democracy with adjectives* (Collier and Levitsky, 1997). The historical developments and approaches that have shaped Latin American democracies have created a turning point where they depart from the ideal liberal democracy model towards an imperfect model of democracy. This feature – developed from the structural level – ultimately accounts for the political instability and volatility in the region. The poor quality of democracy in most Latin American countries thus reflects on the region’s democracy scores, as measured by Freedom House, falling below the average at 70 points³.

“Contemporary Latin America is the result of a complex concatenation of deteriorations, slumps, and advancements in democracy. Except for the three countries showing a high-quality, long-standing democratic legacy (Chile, Costa Rica, and Uruguay), there are few countries in the region that have achieved long-standing advances in democracy since the beginning of the new millennium. Thus, the coming years will likely form a mosaic of varying democratic pathways in the region, having a drifting democracy as its distinctive keynote” (Mainwaring and Perez Liñán, 2015).



3 <https://freedomhouse.org/explore-the-map?type=fw&year=2020>

This outlook is further compounded by the fact that democracy has largely failed to meet the expectations of the Latin American people, who have in fact reported that they are increasingly dissatisfied. So far, dissatisfaction has turned into apathy, into disinterest, and into a “Whatever...” kind of attitude. But it may also set the scene for the emergence of the caudillo brand of personalism, for lesser subtypes of democracy that border on authoritarianism or are openly and blatantly authoritarian, clinging to a distorted representation and to a veneer of democracy.

Dissatisfaction with the promises of democracy has now become widespread: according to Latinobarometer, 7 in every 10 Latin American people believe that democracy does not work. Only 2 in every 10 people feel satisfied with it. Satisfaction with democracy has steadily declined from 44% in 2008 to 24% in 2018. No country in the region has a satisfied majority. Only three countries are close to having one in every two satisfied people: Uruguay with 47%, Costa Rica with 45%, and Chile with 42%. In Brazil, only 9% said they were satisfied, compared with 20% in Nicaragua, and 12% in Venezuela. In this context, democracy is no longer the only choice. We are standing on the brink of the breakdown of democratic consensus, which prevailed through the initial decades of the democratic transition. And we should be paying particular attention to this. Disappointment must not turn into disappointment in democracy because, as Tocqueville warned, despotism is the greatest danger in the times of democracy. A feeling of weariness in democracy, coupled with unease about the economy – as a result of the pandemic or bad decisions – may contribute to the emergence of leaders who uphold the authoritarian discourse and practices. Thus, the real danger is that democracy will continue to deteriorate, moving from a democratic stagnation or recession to a new brand of authoritarianism, as was the case – to a large extent – with the governments that emerged under the banner of 21st Century Socialism, whose rhetoric concealed its true authoritarian and antidemocratic essence.







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