THE STATE'S MANAGEMENT OF THE PANDEMIC: REFLECTIONS ON THE LATIN AMERICAN EXPERIENCE

Oscar Oszlak*

ABSTRACT: The COVID-19 coronavirus pandemic is a typical problematic issue that meets the characteristics of a 'wicked problem'. This paper analyzes some aspects of the state's management of this crisis, the policies and technologies adopted by different governments to face it and try to solve it, the strategies and power resources used and the factors that conditioned the results achieved. The work highlights the great number of variables that contribute to explain the successes and failures produced in different countries, as well as the weight that can be attributed to the institutional capacity of governments. This conceptual examination of the subject is illustrated with special reference to the experience of Latin American countries.

Keywords: *COVID-19, wicked problems, institutional capacity, power resources, government strategies*

At the beginning of 2020, the first real and only World War in history was unleashed. This war was launched against a common enemy –the COVID-19 coronavirus– and involved and mobilized the entire humanity. Although a year and a half later, this war has not yet concluded, it seems that its final battles are now being fought. Curiously, it has also been a kind of Civil War, in which this invisible enemy could hide within all and any human being. Without a doubt, this has been a contest like no other, in which, among the few available weapons, stood out, first, the physical isolation from any possible contact with said enemy and, at a later stage, medical armies inoculating the population with presumably protective vaccines, until reaching the so-called 'herd immunity'.

* Senior Researcher at the National Council for Scientific and Technical Research based at the Center for State and Society Studies, Argentina.

Social life seemed to disappear and human interaction was almost reduced to the realm of the nuclear family. Isolating the population from contagion required early and energetic action by governments which, in many cases, generated social reactions, raised serious doubts about the effective enforcement of public liberties that were protected by constitutional norms, and even called into question the democratic nature of many political regimes.

Never before had society been faced with such a dilemma that involved choosing between health and the economy; between maintaining or reducing the normal rhythm of economic and social activity, which seemed to be the main source of contagion and spread of the disease. These were all difficult decisions to make, by the way, because prioritizing health policies to contain the high morbidity and mortality caused by the pandemic required the paralysis of economic life, which, in the long run, could be even more lethal than the disease itself, even in terms of human lives, beyond the greater hardships for material and psychological life that entailed the suspension of productive activity or the social cost in terms of learning by an entire generation of students.

As in no other time, except in periods of conventional warfare, had societies experienced such a profound sense of collective anguish in the face of the human and material costs recorded in everyday chronicles, without the ability to foresee the end of this nightmare. Nor had they been so aware of the decisions and actions of their governments, who were suddenly turned into irreplaceable protagonists in this contest. All over the world, populations anxiously followed their governments' meetings, announcements and decisions from day to day. They celebrated those actions believed to be correct and harshly criticized those judged to be ineffective, harmful or inequitable. On many nights, applause or the noise of saucepans resounded from windows and balconies, expressing agreement or disagreement. Citizens had never manifested themselves in such a massive and instantaneous way.

Today, the end of this war seems near, because science, with the decisive contribution of the state, managed to produce the weapons that will probably allow us to win it, even when other equally lethal enemies may emerge in the future. Right now, hundreds of vaccines are being tested and placed on the market, allowing a massive immunization that will surely end the current pandemic. We are, then, close to starting a new state of normality that, as predicted, will not be the same as the one that existed before this health crisis. In part, because the crisis forced the search for scientific and technological solutions to mitigate its effects, accelerating innovation processes that otherwise would not have occurred or would have been much slower. Also, because the adoption of these solutions is here to stay and, therefore, will generate permanent changes in educational, labor, business and managerial routines and practices.

The disruption of economic and social life that the pandemic produced, highlighted the capacities (Mazzucato and Kattel, 2020) of state institutions, but also their shortages, to face and solve its most critical aspects: ensuring the confinement of the population, expanding and specializing health infrastructures, assisting the most vulnerable social sectors, responding remotely to the requests and demands of citizens or issuing new rules and regulations at the speed required by the abrupt changes in the evolution of the health crisis.

This paper will analyze some aspects of the state's management of the crisis generated by the COVID-19. It will address the issue starting with a characterization of this pandemic as a socially problematic issue, suggesting the reasons why it can be considered a 'wicked problem' and, in this sense, identifying which possible solutions should have been tried to solve it. The conceptual examination of the subject will be illustrated with special reference to the experience of the Latin American countries. No attempt will be made to describe the public management process during the pandemic or to provide a narrative of its successes or failures. Instead, it considers that the experience of this health crisis offers a magnificent opportunity to deepen the study of public policies and state management around issues that affect practically all facets of social interaction, a topic to which this paper aims to contribute with the reflections that follow.

THE PANDEMIC AS AN ISSUE

Along with O'Donnell, we have defined public policies as position stances (and, today I would add, also as courses of action), adopted by state actors in the face of socially problematized issues (Oszlak and O'Donnell, 1976). Normally, these issues[1] become public and are incorporated into the state agenda 1) when they are raised by certain social actors, whenever they consider that their needs, interests, rights or values are undermined or neglected by the state, or 2) whenever state institutions adopt decisions and mobilize resources in anticipation to the emergence or aggravation of certain social problems. Also, by omission, a state can choose not to act or intervene in the face of a problem, for a wide variety of reasons, which still turns this position into a public policy.

Given the truly exceptional characteristics of this issue, it is worth asking whether, conceptually, the pandemic can be characterized as 'perverse' or 'wicked'. Although the definitions of this concept are varied, there is coincidence that these are difficult or impossible problems to solve for, at least, the

1 The term 'issue' refers to a topic or problem susceptible to debate or discussion.

following reasons: 1) the knowledge about them is incomplete or contradictory; 2) there is a large number of people whose opinions about their possible solutions diverge; 3) the economic cost of solving them is high; and 4) these types of problems are closely intertwined with other problems. Let's see if the pandemic responds to these features defining a wicked problem.

First, since it is a new virus of uncertain origin, what we knew about its characteristics and the ways to combat it were gradually obtained, even though, right from the beginning, we knew that isolation and vaccines would be the main weapons to prevent this disease. In the past, the production of effective vaccines took years. This period was reduced to just a few months, given the haste with which the different testing stages were carried out and the magnitude of resources that were mobilized worldwide. However, uncertainty was the distinguishing feature in the different stages of the cycle of public policies adopted in each country: it was difficult to decide which vaccines to choose among the dozens that were on the market; whether to wait or not until these vaccines were approved by the health regulation authorities; or to choose between different criteria to privilege certain populations that were to be vaccinated earlier. In addition, other drugs or alternative treatments emerged that were subjects of controversy, and a variable part of the populations of different countries decided to reject inoculation, which generated policy measures that ranged from the offer of varied material or symbolic incentives (nudges)[2], to the plain and simple adoption of repressive measures.[3]

Second, the COVID-19 was also the subject of intense controversies, that largely transcended the field of sanitary authorities and led to the contradictory effects attributed to the different policies that tried to combat the virus. Choosing between 'health and economy' was the dilemma that all governments faced from the beginning. Very early on the pandemic, governments were forced to quickly establish advisory committees mainly made up by experts from different sectors (health, population, economy, work, education), although in general, epidemiologists and infectologists prevailed. Likewise, sectoral committees were formed, with some degree of participation from academics, as well as social and business organizations. This types of units, both formal and informal, was reproduced in subnational governments (e.g., provinces and municipalities) with which –in addition to the direct

2 A 'nudge' is a stimulus, in the form of a variety of behavioral options, that tends to predictively alter people's behavior without prohibiting them from making other decisions or significantly modifying implicit economic incentives. For example, in some countries people were encouraged to get vaccinated by offering them drinks or food (Israel) or by installing vaccinations on beaches (United States).

3 In France, for example, President Macron decided to approve the display of a "health passport" for being allowed to carry out a large number of procedures or to access certain places, also opening the possibility of firing unvaccinated personnel from their jobs.

representatives of the affected sectors that developed an intense task of defense and promotion of their interests– they ended up creating a dense map of actors with contradictory demands, interests and political affiliations.

Thirdly, few issues on the state agenda incur, for their resolution, a cost similar to that which countries allocated to combat the COVID-19 –a cost that was increased by the oligopoly exercised by the companies that produce vaccines, one of the main components of the global cost of pandemic care.[4]

In order to fully characterize the COVID-19 pandemic as a 'wicked problem', it is evident that it more than meets the fourth of the aforementioned criteria (its interconnection with other problems) by simultaneously and recursively affecting a wide variety of areas of public policy, which explains the need to make decisions on various fronts (health, logistics, labor, educational, production, security), while, at the same time, discriminating on the basis of territories, age or occupational criteria. Few issues on the state agenda exhibit this decidedly troublesome feature.

Whether we consider it 'wicked' or not, the pandemic is, at the very least, an exceptional issue since, as it also occurs with natural phenomena (earthquakes, forest fires, floods or hurricanes), the lives and material assets of a population were suddenly, almost without any prior notice, threatened, thus demanding immediate responses and state interventions without the explicit demands from any actor, only because it is a natural responsibility of the state's role before society.

But just as the initial impact of this issue affected populations as a whole –since practically no one can escape the possibility of contracting the coronavirus disease or any of its various strains– the rapid spread of the virus immediately created a population segmentation in terms of vulnerability to the infection, illness and death: the elderly or people with comorbidities; young people that, even if infected, could go through the disease with low mortality rates; practically immune children or people exposed to contract the virus by their activity. Other circumstances, unrelated to these age or occupational distinctions, also created differential impacts. For example, the insular condition of some countries, which facilitated border control and early detection of the virus; the availability of a robust and territorially extended health infrastructure, which allowed for a faster identification, care and

4 Recently, the *People's Vaccine Alliance* estimated that vaccinating the whole world could be at least five times cheaper if pharmaceutical companies did not abuse their oligopolistic position regarding vaccine production and distribution (OXFAM, 2021). The Pfizer / BioNTech and Moderna companies are charging governments up to $ 41 billion above the estimated cost of production. Israel paid $ 28 per dose for these vaccines (almost 24 times the potential production cost), while Colombia, a country heavily affected by the virus, paid for them an estimated overprice of $ 375 million (OXFAM, 2021). These amounts obviously do not include costs incurred in logistics, cold chains or vaccination personnel, as well as other direct or indirect costs.

treatment of patients; or the relative centralization of policies to respond to the pandemic, which accelerated the decision-making process and avoided the possible conflicts that usually arise in federal political-institutional systems or where, as a result of the fragmentation of power, it is difficult to coordinate or reach policy agreements.

Therefore, although it is true that the pandemic generated an epidemiological threat to the world population as a whole, its differentiated impact created a complex social stratification which required an equally differentiated response from the state, which, in turn, also developed different segmentations and imbalances due to these responses to the pandemic, thus raising new position stances and courses of action. For example, promoting the isolation and confinement of the population interrupted certain economic activities, but not others, thus reducing production, increasing unemployment and generating greater impoverishment and social inequality. Facing the impact of these consequences, new state policies sought to mitigate them, partly through subsidies to companies or unconditional transfers to vulnerable sectors, which did not always reached all potential beneficiaries. Or, as another illustration, the decision to close schools, opting instead, after a prolonged quarantine, for virtual teaching modalities that were not accessible to all children and young people due to their social situation, thus aggravating the situation of social exclusion and leading to look for other remedial solutions ('bubbles', free distribution of computers, special protocols, classes with alternate presence, etc.).

The effects and impacts of the variety of 'corrective' or 'fine-tuned' policies were not limited to producing a reduction in the inequalities or imbalances generated by previous measures. These also aimed to maintain or, if possible, to improve the legitimacy that governments enjoyed based on their exercise of public management during the pandemic. Almost everywhere, this legitimacy suffered enormous ups and downs in citizen approval, depending on the expectations generated by the announcements by the authorities about the measures to be adopted and the results generated by them (or by the non-timely adoption of certain decisions), which sometimes led to extremely varied expressions of support or rejection. In part, the variety of reactions, and their expression in the approval rates of a government's management, also depended –in addition to the correctness or not of certain policies– on each country's political-electoral conjunctures and the degree of the relative hegemony of parity of forces between party coalitions. In circumstances such as these, the discursive strategies of the competing sectors and the communication and dissemination policies (which dominate content in the media and social

networks in times of enormous uncertainty, such as those that characterize a pandemic like the one we are analyzing) become particularly important.

POLICIES ADOPTED AND DECISION-MAKING PROCESSES

Other aspects of the state management of the pandemic that are worth reflecting upon concern the policies and characteristics of the decision-making process that were adopted –topics that I will analyze in this section. Regarding the first aspect, I will identify the different types of policies adopted and the various instruments of implementation. And, in regard to the decision-making process, I will consider the role played by the different actors involved, the advisory organs and bodies, the unusual acceleration of the times in which states commonly make decisions, and the more authoritarian or democratic nature of this decision-making process.

As a first observation, I will point out that the pandemic response required the application of a combination of policies implemented through substantive technologies and support (or managerial) technologies. Since this distinction is not obvious, I will clarify its meaning. In any policy area, different positions and courses of action can be adopted aiming towards the solution of certain issues that I will call 'substantive' (e.g. agricultural stagnation, wage arrears, tax evasion or, as in this case, a pandemic control). Each of those issues requires the application of specialized knowledge for its solution, as well as 'core technologies', in the sense proposed by Thompson (1967). These are applied at the 'technical' level of the organizations and, metaphorically speaking, correspond to the 'factory' of the organization, where the production function is carried out and inputs are transformed into outputs (goods, services, regulations). There is where substantive policies are adopted and implemented through technologies such as agricultural research and extension, labor negotiation, tax control or mass vaccination, just to illustrate some possible responses to the problem areas proposed as illustrations.

In turn, the 'support technologies' correspond to those that Thompson (1967) places at the managerial level of an organization and Barzelay (2003) calls 'public management policies', among which this author includes the planning, financial management, labor relations, organization and methods, hiring, etc. Any resemblance to the old and well-known PODSCORB is not a coincidence: it is simply the different ways in which we, authors, call the functions carried out at that part of an organization where the production of

goods and services is designed and controlled, inputs (personnel and material goods) are obtained or assigned and products are delivered.

It could be argued that the substantive technologies in the fight against the pandemic were mainly related to four major areas of public policy: 1) health care (experimentation, vaccine production, tracking of infected, hospitalization, treatment, vaccination), 2) regulation of social behavior (particularly in matters of compulsory confinement, control of occupation, employment, circulation and transportation), 3) containment and social assistance (subsidies and monetary transfers to companies in difficulties and vulnerable families) and 4) information and communication which, in such an exceptional and uncertain situation, become critical (monitoring and communication of the number and location of victims, press campaigns, protocol design and dissemination).

In each of these areas of public policy, more or less rigorous criteria of selectivity and scope had to be applied –not always successfully–, considering the differential effects of the pandemic on different groups of people. A situation as exceptional as a health crisis tends to generate or accentuate various forms of social inequality, by virtue of two basic circumstances: 1) the different degree of vulnerability to the pandemic by different strata of the population, which required, for example, the prioritization of care for the elderly, people with comorbidities, families living in overcrowded houses, passengers on means of transport that did not offer adequate distance; and 2) the differential impact of government measures, according to their effects on the stoppage of activities or the need to reassign personnel to attend essential services (e.g. informal workers, public employees, personnel employed in companies that had to suspend their activities as a result of more or less prolonged quarantines).

Therefore, it was necessary to formulate and implement 'fine-tuned' policies that had to consider the differential situation of the population against the virus and, therefore, make decisions such as priority vaccination for the elderly, medical personnel or other groups; total or partial prohibition of certain economic and social activities that, due to the place in which they are carried out and the risk of human contact involved, negatively affect those who offer or demand them (shops, transportation, public shows, schools, etc.).

Many of the public policies adopted by governments during the pandemic were designed to mitigate or correct the effects on people and sectors that had to suspend their normal activities, their mobility or were exposed to other restrictions, thus creating various forms of inequality. Some of these policies consisted of monetary transfers to families that lost their sources of income or to companies that had to close and cover the payment of their personnel's salaries. Other forms of compensation or solutions to partial problems faced

by sectors affected by the pandemic consisted of the prohibition of dismissals of personnel, forgiving money lending interests, the automatic extension of contracts or prohibiting the suspension of home services due to non-payment. In general, these measures were adopted to varying degrees and for varying periods, depending on the availability of resources by governments and the relative severity of the pandemic spread in each case.

Support technologies –which make the implementation of substantive technologies feasible– continued to fulfill this role during the pandemic but, generally speaking, had to adapt to the emergency and, in many cases, underwent significant changes. The technologies that were hit the hardest include financial management, digitization, maintenance, logistics, purchasing and supplies, and personnel management. In general, they suffered some type of change or adaptation as a result of the obstacles or demands created by this exceptional situation. As an illustration of those that underwent the greatest changes, I will point out the following:

a) The widespread adoption of telework, which implied changes in logistics, digitization and personnel management.
b) Procurement, whether direct or without bidding, that, for urgency reasons, determined the suspension of procedures established in the state procurement and supply processes, thus creating opportunities for corruption.
c) The reassignment of personnel functions due to the need for new tasks demanded by the fight against coronavirus, or the reinforcement of work teams overwhelmed by the demand for services.

In the following section, I will return to the analysis of policies and technologies used to combat the pandemic. But first, I will deal with a pending issue: the role of the different actors responsible for solving this critical issue.

To put it in a resounding way, and at the risk of exaggeration, perhaps there is no other problem of a planetary scope, such as the COVID-19, whose solution depends so much on the behavior of each individual. From the human experience in treating past pandemics, it is well known that voluntary isolation and the lack of peer contact is the most effective way to prevent a disease and stop its spread. It is difficult to imagine another social problem with a global scope in which each and every person could be the protagonist of its solution. But for multiple reasons, and despite all the preaching and quarantines, the isolation, social distancing and global confinement of the population are impossible objectives to meet, which entails a significant risk of premature death from other causes. It goes without saying that, in order to achieve this,

it would be necessary to suspend all forms of collaborative work, educational activities, collective transportation or care for other health problems, where human contact is unavoidable. Therefore, it was necessary for the power and intervention of states everywhere to be placed at the service of minimizing the contact between people by all available means, in addition to developing other prevention and health care activities.

Almost everywhere, the decisions and actions against the pandemic concentrated in the executive branch of the State. This was natural, given the territorial and population scope that the spread of the disease was acquiring. But how were the decisions made? How were governments advised? How were actions coordinated in order to respond to the multiple challenges that arose in social, health or economic matters?

These questions are especially relevant considering the turbulent nature of the issue to be resolved, which was reflected in the uncertainty that accompanied each stage of the public policy cycle that attempted to solve it. First, because there was no real knowledge of the nature of this issue, since there was only rudimentary information about how to prevent its spread and treatment and –since it is a permanently mutating virus–, it became a mobile enemy. Second, because it required making decisions in multiple fields of action, not only for reducing the magnitude and virulence of the disease but, at the same time, to mitigate its most deleterious consequences on multiple aspects of social activities. Third, due to the speed and the extent with which the virus wreaked havoc, it required quick and not always effective actions in which every decision was subjected to a logic of trial and error. And fourth, because the implementation of policies required a coordinated action between multiple governmental actors whose respective actions could have important consequences in terms of political legitimacy and electoral chances.

When reviewing the experiences of different countries during the year and a half that has elapsed since the beginning of this health crisis, the large number of variables that intervened in each case stand out to explain the different styles of leadership, decision-making and management that were adopted. Much depended on each country's territorial extension, population size, political system's characteristics, distribution of powers between central and subnational governments, relative robustness of health systems and idiosyncratic culture of its inhabitants. But it all also depended on the certain country's degree of confrontation between political forces, moment in their electoral cycle and the ideological orientations of its leaders, including their international political alignments.

In addition to the ministers of health, that virtually turned into czars in the fight against the pandemic, a large number of leaders appealed to specialists in order to base their critical decisions on mandatory preventive isolation, the suspension of schools, the closure of shops or the gradual reopening of activities. While health specialists rose to prominence, they were not the only ones to contribute to the planning, design, and communication of government action. In a survey conducted in 19 Latin American countries (Legislative Directory, 2020), different types of units (working groups, committees or councils) were identified in playing a role in this process. Around 20% of these units have functioned informally, that is, without the issuance of any decree, resolution or official norm to govern the constitution of their members, the form of their appointment, the adequacy or probity requirements that they had to meet, or the accountability for their actions.

Even in those units with some official endorsement, many of these aspects are not clearly specified, which makes it difficult for citizens to monitor their activities. According to different countries, expert committees were created exclusively in health and other areas, covering different sectors (e.g., employment, tourism, telecommunications, finance, transportation). Some specialized in problems that were specific to single sectors (for example, in labor, to decide which sectors or companies to benefit from employment subsidies). Some units were even created to adapt the processes of contracting goods and services by establishing direct purchase procedures or creating special funds. The participation of the academic sector, social organizations and private as well as business sectors was much lower. The report by Directorio Legislativo indicates that, in the few cases in which committees included this kind of representatives, there were difficulties in their relationship with the governments due to restrictions on access to public information or various disagreements.

Another notable absence in the decision-making process was that of the Legislative Power. Generally speaking, legislatures played a reduced role in managing the pandemic. Directorio Legislativo reports that only 10% of the measures adopted in relation to COVID-19 emanated from the legislative power, which shows the almost exclusive nature of the Executive in said management.

As for governors and mayors, their role depended, among other factors, on the political-economic gravitation of the provinces and municipalities[5] they governed, their leadership styles and their affinities or confrontations with the heads of their national Executive Power. Other important factors were whether territories had or did not have international borders and the moment of the

5 I choose these generic names, knowing that sub-national political jurisdictions may have, depending on the country, other names, such as states, departments, municipalities, etc.

political-electoral cycle in which the statistics of deaths, the infected, the hospitalized and the vaccinated population from COVID-19 weighed on how did citizens assessed their leadership.

Another actor that should have played a crucial role in managing the pandemic but, instead, turned out to be quite irrelevant, was the international community. Both the United Nations and the many regional and multinational bodies saw their activities practically paralyzed. As Burci (2020) points out, COVID-19 provoked nationalistic and unilateral reactions rather than international cooperation and coordination, further exacerbating existing rivalries and divisions, and creating new divisions, even among close allies.

A final aspect to consider is the more or less democratic style exhibited by different political leaderships in solving the issue. This is a subject covered by a large number of works (Flinders, 2021; Elstub et al., 2020; Kurlantzick, 2021). Particularly, because both the health emergency and the haste with which it was necessary to decide and act before it, some rulers were led to put aside procedures normally accepted or expected in a democracy. Aside from the importance in terms of the characterization of the current political regime, what is also in question is the effectiveness and relative successes that a democratic or authoritarian management of the pandemic can produce.[6]

POWER RESOURCES AND STRATEGIES OF POLITICAL ACTION

Another singularity of the pandemic is that it has turned the entire world into a scenario where human survival itself is threatened and where the actions of countries to combat the virus are not sufficiently articulated or collaborative; a scenario where there are other dramas unfolding aside from the health issue,

6 In this regard, a recent paper (Chih-Wei Hsieh et al., 2021) analyzes the performance of the National Team for the Prevention of Epidemics of Taiwan, the successful experience of a collective synergy between the government and society in the fight against COVID-19, which was presented as a model of collaborative governance between a central government, local governments, private companies and citizens. In the opinion of the paper's authors, the control of epidemic outbreaks can only be successful if a system is integrated in this way, which would demonstrate that liberal democracies can control and counter the pandemic without resorting to authoritarian methods of containment. It is interesting to note that the aforementioned work expands the concept of the 'whole-of-government approach' developed in Great Britain to refer to collaboration networks that can be established between all actors, state and civil society, whatever their jurisdiction or place of residence. However, in order to consider the possible application of this model in other contexts, certain singularities that make Taiwan a special case, perhaps even unique, should be considered: its insular nature, the learning obtained in the management of a previous pandemic, the particular idiosyncrasies of its society and the nature of the country's political regime. Schwak (2020) adds some elements that ratify the uniqueness of the Korean case. He highlights, for example, that the country has a communal political culture, inherited from the social unit of the village, with a strong influence of Confucianism and a notable trust in the government. He also highlights the learning gained from mistakes made in 2015, during the management of the Middle East respiratory syndrome pandemic.

since most people may suffer other hardships or see other interests and values affected in addition to becoming a potential victim of this illness. In this sense, COVID-19 has created a context in which the very policies adopted by states to combat it give rise to multiple issues that each actor tries to resolve according to the power resources at their disposal and their possibility for developing effective action strategies to solve them. In turn, as we have already seen, certain social reactions and forms of collective action tend to cause the rectification of decisions or the adoption of new ones, which makes the scenario even more problematic and complex.

By resources of power, I refer to the means that social actors use when they decide to act, thus producing political consequences. These are material or immaterial elements that allows a political actor to prevail over another or others, in situations where their respective positions differ or are potentially in conflict. The literature agrees that the ability to exercise coercion; access and use of information; the possession and use of material goods; and ideological control, summarize the main sources of power.[7] The type and amount of these resources varies from one actor to another. But its possession and use does not necessarily ensure the desired results. This depends on the relevance of its use in each circumstance,[8] of the eventual enhancement or mutual cancellation of the effects resulting from the use of two or more resources,[9] or even the mere possession of a resource, even when it is not effectively employed.[10]

It is also possible to point out that the various types of power resources are not necessarily interchangeable. The effectiveness of its use will depend on the objective sought and the political action strategy being considered. Not all resources are of equal 'value' in all circumstances. In a way, when deciding upon a certain course of action, political actors evaluate their power resources in terms of expenditures and capitalizations, of flows and stocks. And in doing so, they evaluate which strategies are deemed most appropriate to achieve their desired ends.

These reflections suggest the convenience of incorporating into our analysis, the diversity of action strategies used by different actors during the pandemic. I am referring to those decisions and behaviors that both state and social actors, and their organizations, adopt to make their preferences prevail over the options available to resolve this issue. In principle, it would seem

7 For example, see Ilchman (1984) and O'Donnell (1984).

8 For example, it is not always possible or convenient to use coercion, even when its control is extensive, since it may imply a loss of legitimacy.

9 As Apter (1970) pointed out, the more coercion is exerted by a government, the less contextual information is received. But the possession of information and material resources is often effective in prevailing in a confrontation.

10 Thus, the threat of coercion, due to its dissuasive nature on the eventual reaction of the person on whom it is exercised, can be as effective as its specific use.

that four strategies would make it possible to account for these different modes of action, which I will call: 1) isolation; 2) care; 3) compensation; and 4) communication.

These various strategies are closely linked with the four major areas of public policy suggested above in the fight against the pandemic, which are oriented, respectively, the regulation of social coexistence, the treatment of health, the containment and social assistance, and communication and public information. The first two, aimed at preventing the disease and caring for the infected, were based on the long experience of humanity in the face of similar health crises: to achieve maximum isolation from the population and to care for the sick using the recommended treatments by the current level of scientific and technological development available. The third type of policies tended to correct and compensate, as far as possible, the effects –particularly the economic ones– generated by the adoption of preventive measures, especially those of isolation and compulsory confinement, while communication and information policies served to announce the measures adopted by governments, to report on the ravages caused by the disease, to persuade the population to take extra care and, indirectly, to provide indicators on the results of the results of the policies tried. I will briefly review each of these strategies.

The isolation strategy seeks to minimize the spread of the virus through various measures designed to avoid physical contact between people, be it through preventive distancing, the mandatory use of masks or chinstraps in public spaces, population confinement in their homes, the reduction of circulation on specific days or schedules, the closure of establishments and borders, or the suspension of shows and mass events, among other measures. The care strategy includes all those measures aimed at strengthening the health infrastructure like the disinfection of public spaces, the detection of infected people, the care and treatment of the sick and, especially, the mass vaccination of the population. Compensation includes a number of palliative measures that aim to mitigate the adverse consequences produced of certain strategies, especially by the isolation strategy, due to its differential effects on the population's activities and income. Prominent among them were the subsidies made to companies in order to cover the payment of salaries of confined personnel, the granting of interest-free or reduced-rate loans, the reinforcement of food distribution to social organizations and poor households, the unconditional transfers to unemployed and vulnerable families and, at times of smoothing the contagion and death curve, various measures of partial or gradual opening of socioeconomic activities. Finally, the communication strategy that sought to keep the population informed about the vicissitudes of

the pandemic, its speed of spread, the number of victims, internees, vaccines acquired and inoculations carried out, protocols to observe and extreme care.

Adopted by governments and complied by social actors with varying degrees, the measures classified according to these different action strategies, require for their effective implementation, all the resources of power described above, although some of them predominate in each different strategy.

Thus, coercion or threat of coercion is the main resource to ensure isolation, as it backs the prohibition or limitation of circulation, demanding people to respect the limit in capacity within premises and means of transportation, the compliance with mandatory isolation periods and the payment of fines or the threat of arrest and imprisonment. These measures were also used in health care, as in the requirement of swabs or the exhibition of health passports; in compensation measures, by providing for the automatic extension of contracts, the freezing of prices or rates and the employer obligation to continue paying the salaries of personnel who remain confined; and even in communication strategies, such as the compulsory assignment of spaces in radio or television media for the dissemination of official information related to the pandemic.

Material resources were, without a doubt, the essential power resource in the care strategy, since they served to finance research on possible disease treatments, to expand and update health infrastructure, to pay for larger staffs and, above all, to acquire vaccines and other supplies required in vaccination campaigns. But these resources were also very necessary to finance the costs of compensation measures, communication and dissemination campaigns and, even, the largest expenditures in materials and cash for logistics and security activities for imposing the mandatory isolation.

Information, seen as a power resource, allows to know the characteristics of the virus, its mutations and the most effective treatments against it; to identify sources of infection and monitor infected and sick people. It also serves to build databases and computer platforms for the registration of beneficiaries of economic aid, in order to provide support for activities carried out through teleworking and for the population to know and permanently update their knowledge about the scope of their rights and duties within the context of the pandemic.

Lastly, ideological resources play a fundamental role in the announcement of different policies, in order to legitimize them before public opinion, either to persuade the population about the importance of isolation, to highlight the efforts made by governments in their struggle to preserve life or to meet the needs of the most vulnerable social sectors and, very often, to compare the country's government strategy with those adopted by others with different political-ideological orientations.

Let us review the arguments developed so far. I began this paper by stating the reasons why I consider that the COVID-19 pandemic could be considered as social issue that could be categorize as a 'wicked problem'. I then classified various public policies adopted by governments to combat the pandemic, as well as the substantive and support technologies used to implement them. I also analyzed the role played by different actors in the decision-making process. Finally, I suggested a possible classification of the action strategies and power resources used by political decision-makers, according to the nature and objectives of the measures they adopted. The treatment of the factors that could explain the relative success or failure of governments in the fight against the coronavirus remains pending, a topic that I will address in the final section of this paper.

SUCCESS OR FAILURE INDICATORS

Although few social problems have generated so much information and indicators on the pandemic and its management, it is not easy to provide definitive evidence on the successes or failures of the policies adopted to control or reduce its consequences. First of all, for the simple fact that, when these lines were written, the pandemic was not over yet, and because its different waves show that, in some apparently 'successful' countries, the results turned out to be short-lived, when a new strain or new wave make them go back in the various rankings that form the day by day account of this health war's vicissitudes. And secondly – although there are surely other reasons–, because certain geographic, demographic, cultural and even ethnic factors can explain comparatively greater successes, without the result necessarily or mainly depending on the public policies adopted. For example, island territories; countries with small areas and populations;[11] age composition with a predominance of young people, less prone to contracting the virus; the validity of a culture of trust or deference towards the government; recent experience of another pandemic; relative importance of 'anti-vaccine' sectors; or even, reduced weight of ethnic or racial minorities.

With these exceptions, I will analyze some statistical indicators available on the web, which allow us to appreciate the COVID-19's virulence and effects, as well as the performance of different countries in the application of control measures. Particularly, I will refer to the experience of Latin American countries, using recent indicators of a series of variables, which can serve as the basis for a comparative analysis (Table 1).

11 For instance, very small and low populated countries, such as Malta, Maldivas, Katar and Iceland, are today the ones heading the ranking in terms of proportion of vaccinated people with one or two doses.

TABLE 1. INDICATORS ON THE INCIDENCE OF COVID-19 IN LATIN AMERICA

Countries	No. of deaths per million habitants	Fatality Rate %	No. of confirmed cases	% of vaccinated habitants (2 doses)	Stringency index
Argentina	2414	2,1	5.052.884	22,32	75,93
Bolivia	1558	3,8	480.229	17,78	56.48
Brazil	2679	2,8	20.245.085	23,62	56,94
Chile	1905	2,2	1.625.467	68,16	74,07
Colombia	2429	2,5	4.852.323	27,15	53,71
Costa Rica	1032	1,2	424.472	17,00	54,63
Cuba	361	0,8	483.710	26,80	65,28
Dominican Republic	367	1,2	345.118	43,07	60,19
Ecuador	1806	6,5	491.831	27,38	60,19
El Salvador	431	3,1	90.129	29,91	32,41
Guatemala	625	2,7	398.990	3,00	50,00
Haiti	51	2,8	20.389	1,00	50,93
Honduras	852	2,7	312.192	5,45	78,70
Mexico	1929	8,2	3.020.596	22,88	72,69
Nicaragua	30	1,9	10.251	5,19	2.78
Panama	1614	1,6	444.695	19,77	62,04
Paraguay	2167	3,4	456.064	4,01	49,07
Peru	5987	9,3	2.128.516	20,85	74,07
Uruguay	1728	1,6	382.873	69,29	48,15
Venezuela	134	1,2	314.480	3,86	97,22
South America	2583	n.d.	n.d.	n.d.	n.d.
World	561	n.d.	n.d.	n.d.	n.d

Note: Data as of 08/14/2021.

Source: Johns Hopkins University of Medicine. Coronavirus Research Center. Coronavirus.jhu.edu/data/mortality and Global Change Data Lab, Our World in Data, https://ourworldindata.org/coronavirus

An eloquent indicator of the severity of the pandemic is the 'case fatality rate' (known by the acronym CFR), which results from dividing the number of deaths by the number of confirmed cases. Countries around the world have

reported very different case fatality rates, which may be due to: 1) differences in the number of people screened, since a greater number of tests allows to identify more people with milder cases, thus reducing the case fatality rate; 2) mortality tending to be higher in older populations, as has already been pointed out; 3) mortality increasing as the health system reaches a point of collapse due to lack of beds, respirators and other care resources; 4) a deliberate underestimation by some countries, as we will see shortly. And probably other factors that are still unknown.

If the world's case fatality rate (2.1%) is compared with the average in Latin America (3.1%), one can observe that, in this region, the number of deaths in comparison to the total number of confirmed patients is almost 50% higher. But these values are strongly influenced by cases in some particular countries, such as Peru (9.3%), Mexico (8.2%) and Ecuador (6.5%), which are not only significantly higher than in the rest of the region, but are among those who head the world statistics in this area.[12] The comparison between the world statistics of deaths per 100 thousand inhabitants also shows a marked disparity, since the average for Latin America (151.50 x 100 thousand inhabitants) almost triples the world's average (55.4 x 100 thousand inhabitants) .

Although, once again, the case of Peru (606.41) raises the average, it is appropriate to consider another factor that could be affecting this result: the deliberate underestimation of the number of patients and / or deaths which, in some cases, are notoriously eye-catching. Nicaragua stands out with only 197 deaths declared (1.9% fatality), which is equivalent to 3.01 deaths per 100 thousand inhabitants; o Venezuela, with 3,733 deaths (1.2% fatality) and 13.09 deaths per 100,000 inhabitants –figures that are strongly disputed by other sources.[13] In other words, the average for the region could be worse, unless the underestimation in the world as a whole is greater than in Latin America.[14]

A curious case is that of Cuba, a country that reports the lowest fatality rate in Latin America (0.8%), despite being the one with the highest average age in the region, i.e., a high proportion of the population that is much more

12 Only in June 2021, the COVID-19 death toll in Peru tripled the number registered until then, which placed the country at the head of the world and also raised the total number of deaths per 100,000 inhabitants to a record figure (606.41).

13 For example, Observatorio Ciudadano, a monitoring platform made up of doctors, specialists and members of civil society that aims to 'fill the information gap' in official data which states that Nicaragua accumulated 4,818 cases of COVID-19 and only 144 deaths during a certain period. But Observatorio Ciudadano reports 10,205 infections and 2,707 deaths in that same period, a huge difference. PAHO has repeatedly demanded to audit the official figures reported by the government. In the Venezuelan case, the opposition to the government, as well as medical corporations, have repeatedly denounced the notorious underestimation of cases and deaths. Also in Haiti, the statistics of deaths from COVID are greatly underestimated (barely 5.05 cases per 100,000 inhabitants). Suffice to compare them with those of the neighboring country of the same island, the Dominican Republic, where deaths are five times higher.

14 Whichever be the case, it is significant that the average for South America is almost five times higher than the world average.

susceptible to contracting the disease and dying from it. The country is recognized for the high quality of its health infrastructure, which would partly explain its better care for the sick and the fewer number of deaths. However, in recent months, a notable deterioration and virtual collapse of Cuban hospitals, as well as a notable increase in the number of cases, have been reported in that country. The number of fatalities also grew, to the point that, in July 2021, their monthly number was close to 50% of deaths from COVID-19 during the entire pandemic.

Table 1 also shows the figures that estimate the so-called 'Stringency Index', which is made up by a series of metrics related to the degree of rigor implicit in the measures of containment, isolation and suspension of activities adopted by governments.[15] In relation to a maximum value of 100, Venezuela (97.22) tops the list, a number that makes it a virtually immobilized country in terms of the pandemic. It is followed in rigorousness by Honduras (78.70%), Argentina (75.93), Chile (74.07) and Mexico (72.69), with numbers that seem believable if one considers the prolonged quarantines, flight suspensions and restrictions on the mobility of people reported by the press. The high rate in Cuba (65.28) can also be explained, given the strong reduction in foreign tourism, the strict monitoring and identification of cases, and the discipline and isolation of the country's population. Most of the other countries are around 50% rigorous but, once again, the case of Nicaragua is surprising since, as a result of its *laissez faire* campaign and the return to 'normality' promoted by its government, it obtained a minimum solitary figure of 2.78%.

Other available statistics provide information on other policies adopted by different countries such as the closure of schools, the cancellation of events and meetings, the confinement to homes, the use of face masks, public information campaigns, international and domestic flights, testing and identification of close contacts, vaccination policies and financial support.

Almost everywhere, the question of whether or not to close schools was a controversial decision and the countries not only adopted different policies in this regard, which went from total closure or selective openings at certain educational levels or geographic areas, to simple recommendations to subnational governments to make partial openings or even to make no closures at all, as it only occurred in Nicaragua. Furthermore, all of these decisions underwent successive changes during the pandemic.

There were also four types of decisions in regard to the closing of businesses and the cancellation of events and meetings. Currently in the region, there is

15 This Index is based on the following nine metrics: school closings; closures of work places; cancellation of public events; restrictions on public gatherings; public transport closures; confinement demands; public information campaigns; restrictions on internal mobility; and international travel controls.

no single case in which some sort of measures haven't been adopted. Only Uruguay seems to simply 'recommend' closures. Most are distributed between countries that require the closure of some activities and countries that require it for most, except for essential activities (Chile and Venezuela).

Today, Ecuador, Peru and Uruguay are the only countries that 'recommend' confining its populations to their homes. In all others, there are certain restrictions (at least, in some localities) when leaving home, with exceptions for daily exercise, necessary purchases and essential travels. There are no longer cases in which strict confinement at home is ordered, as it was during the pandemic's most dramatic moments.

On the mandatory use of chinstraps or masks, we have little information. Its use is only recommended in (again) Uruguay. In Argentina, Chile, Colombia, Cuba, Ecuador, Costa Rica and Honduras, they must be used in certain public spaces or in situations where social distancing is not possible. And in Brazil, Peru, the Dominican Republic, Mexico, Venezuela and Guatemala, they must be used within all public spaces.

Most of the countries in the region do a more or less systematic tracking of close contacts. Bolivia appears in the statistics as the only country that does a limited tracking, while Brazil does not do any direct tracking. Regarding vaccination, the statistics show very different situations (Table 1). Uruguay (69.29%) and Chile (68.16%) top the ranking of the population fully vaccinated against COVID-19 (with both doses), while in some of the largest countries in the region (Brazil, Argentina, Mexico), the percentages almost coincide (between 22% and 24%). A minimum proportion fully vaccinated is verified in Paraguay (4.01%), Venezuela (3.86%), Guatemala (3.00%) and Haiti (1.00%).

Finally, in terms of financial support to workers who lost their jobs or to vulnerable families, the vast majority of the region's governments adopted compensation policies that generally covered less than 50% of the lost income. The only countries in which this type of payment was not available were Mexico, Guatemala, Costa Rica, Cuba and Nicaragua. Outside the region, many countries offered compensation in excess of 50% of the lost income.

CONCLUSIONS

At the time of drawing up the conclusions for this paper, a year and a half has passed since the COVID-19 pandemic began. As a result of the global and systemic crisis that it originated, the management capacity of governments around the world has been compromised. To a greater or lesser extent, all of them adopted policies of population isolation and closure of activities;

detection, monitoring and care of the disease; partial compensation of the negative externalities produced by the virtual cessation of activities; and public communication, with the purpose of informing, preventing and convincing the population about the required or desired behaviors before this emergency. Thus, they designed various action strategies and put into play all the power resources at their disposal in order to achieve the common result that they all sought: to contain the spread of the disease, to care for and rehabilitate the sick, to minimize the number of fatalities and to reduce the negative effects of the adopted policies.

The statistics of the pandemic eloquently demonstrate that the achieved results were very different in each country, as was the intensity or timeliness of the policies adopted. The degree of isolation and confinement of the population not only shows differences between countries, but also that the rigor of the adopted measures varied successively depending on phases, outbreaks and new strains of the coronavirus. The tracking of people possibly infected with the disease and the number of tests carried out, as well as the rate of vaccination, also varied from country to country. In some of them, state intervention in saving closed businesses or families and workers without income was extensive and generous, while in others it was non-existent. There were governments that organized intense communication and dissemination campaigns, while others completely dispensed with them.

In part, the choosing of the different strategies depended on the particular juncture in which the pandemic surprised each different country. Although the health crisis everywhere required the diversion of budgetary resources to meet the direct and indirect costs of the health crisis, the starting conditions of each country (or the baseline, if you prefer) were very different: the magnitude of their fiscal deficit, income level and distribution, situation of foreign exchange reserves, unemployment rates and informal work or the degree of dependence of their marginal sectors on unconditional state transfers, among other factors. The infrastructure and the logistical capacities available in each country also had an important weight, especially in terms of health, transport and communications.

We also pointed out differential factors of an infrastructural nature, such as size, number of population and the insular nature of some countries, which may have had some influence on the results that each of them achieved in their fight against the virus. We could even add other distinctive factors, such as international alignments, time of the pre-electoral process, predominant cultural values, degree of democratization and trust in the authorities, and so on.

Although it is far from being exhaustive, this list at least leaves us closer to being able to isolate and attribute part of the explanation for the dissimilar results that different countries have achieved so far, in this unique pandemic war, to the relative institutional capacity of their governments. What is left out?

Perhaps the most relevant institutional capacity, in a scenario as complex and 'wicked' as this, is to exercise a strategic leadership, i.e., to offer the necessary leadership and inspiration to generate and implement a shared vision, a mission in which society as a whole can see itself identified in a collective will to achieve a common goal. But this also implies other capacities, which must be previously institutionalized and cannot be improvised in the midst of a crisis. For example, those of planning, programming, negotiating, coordinating, monitoring and controlling –or those of innovating, communicating and convincing, subordinating political speculation.

I am not sure whether the consideration of the aforementioned set of factors would help explain, on a case by case basis, the varied results that countries and their governments have achieved in containing the pandemic and its consequences. In any case, the analytical effort deployed in this paper points to future work to deepen this line of inquiry.

On the other hand, there remains the wide field of counterfactual speculation that academia, the press and political opposition pose daily: What would have happened…

- If quarantines and confinements had been less extended, thus reducing the serious negative economic consequences of immobilizing the productive activity.
- If a much more selective closing of schools had been arranged earlier, thus avoiding the irrecoverable pedagogical and social costs imposed on a whole generation of students.
- If instead of assuming demagogic and supposedly reassuring behaviors –such as publicly denying the threat of the virus or referring to it as a simple flu– some political leaders had shown more responsible attitudes.
- If while negotiating with the great world powers that produce vaccines, certain countries had set aside their political-ideological alignments, thus favoring the urgency in the acquisition of vaccines and being able to immunize their population quicker.
- If some governments had prevented or reduced corruption in public procurement processes, clandestine vaccinations and other conflicts of interest, through a firmer exercise in management control.

- If, as Varoufakis (2021) imagined, instead of undermining confidence in the European Union (or, for that matter, in any other multinational organization), COVID-19 had convinced its leaders that it was an opportunity to overcome years of acrimony and fragmentation, thus catalyzing a more solid and integrated bloc to the world.

We could continue imagining other possible situations, but the counterfactual reasoning must be contrasted with the evidence produced by the case studies in future research on this exciting topic.

REFERENCES

Apter, David E. (1971). *Choice and the Politics of Allocation: A Developmental Theory.* Yale University Press.

Burci, G. L. (2020). COVID-19 y la gobernanza de organizaciones *internacionales, Revista de Derecho de Organizaciones Internacionales, 17* (3), 485-491 doi https://doi.org/10.1163/15723747-01703001

Chih-Wei H., Mao W. & Natalie W. M. Wong (2021). A whole-of-nation approach to COVID 19: Taiwans's National Epidemic Prevention Team. *International Political Science Review 2021*, Vol. 42(3) 300–315.

Directorio Legislativo (2020). President's advisors on COVID-19. June 1, 2020.

Elstub, S. E., Shan-Jan S. L. & Maarja L. (2020). Coronavirus and Representative Democracy, *Representation*, 56:4, 431-434, DOI: 10.1080/00344893.2020.1843108

Flinders, M. (2021). Democracy and the Politics of Coronavirus: Trust, Blame and Understanding. *Parliamentary Affairs*, Volume 74, Issue 2, April 2021, pp. 483–502, https://doi.org/10.1093/pa/gsaa013

Ilchman, W. and Uphoff, N. (1970). *The political economy of change.* Berkeley, University of California Press.

Kurlantzick, J. (2021). COVID-19 and its effect on inequality and democracy: a study of five large democracies. Discussion paper. Council of Foreign Relations. Retrieved from https://cdn.cfr.org/sites/default/files/report_pdf/kurlantzickdp_final_1.pdf

Mazzucato, M. and Kattel, R. (2020). COVID-19 and Public-Sector Capacity, *Oxford Review of Economic Policy*, Volume 36, Issue Supplement_1, 2020, pp. S256–S269, https://doi.org/10.1093/oxrep/graa031

O'Donnell, G. Apuntes para una teoría del Estado: enfoques críticos. In Oscar Oszlak, comp.; *Teoría de la burocracia estatal.* Paidós.

Oszlak, O. and O'Donnell, G. (1974). Estado y Políticas Estatales en América Latina. Doc. CEDES/G.E.CLACSO/4. Retrieved from https://www.redalyc.org/pdf/907/90711285004.pdf

Oxfam International (2021, July, 29). Los monopolios de las vacunas hacen que el costo de vacunar al mundo contra el COVID sea al menos 5 veces más caro de lo que podría ser. Retrieved from https://www.oxfam.org/en/press-releases/vaccine-monopolies-make-cost-vaccinating-world-against-covid-least-5-times-more

Schwak, J. (2020). A Democratic *tour de force*: How the Korean State Successfully Limited the Spread of Covid-19. Asie. Visions 117. Center for Asian Studies, November.

Thompson, J. D. (1967). Organizations in Action: Social Science Basis of Administrative Theory. New York, McGraw-Hill.

Varoufakis, Y. (2021). Una COVID contrafáctica para Europa. Project Syndicate. Retrieved from https://www.project-syndicate.org/commentary/covid19-counterfactual-stronger-more-integrated-europe-by-yanis-varoufakis-2021-04/spanish