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Social harm, neoliberalism and the Covid-19 pandemic in Latin America

Daño social, neoliberalismo y la pandemia del Covid-19 en América latina

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Abstract

This article seeks to uncover how harms in Latin America generated under the neoliberal model over more than four decades ago enhance the negative impacts of the Covid-19 pandemic. Taking Santiago and Bogotá as examples, the article scrutinizes how neoliberal harms directly impact health systems given the state's incapacity in achieving public health goals and a rise in access segregation to health services due to Covid-19. Higher levels of contagion and deaths and the policies' poor effectiveness are linked to the previous social harms produced by neoliberalism in the region. The links between Covid-19 and inequality and poverty, especially regarding informality, low educational levels, overcrowding, and the limitations on access to services are uncovered.

Keywords: Neoliberalism, harm, inequality, poverty, privatization, Covid-19 pandemic impact.

Resumen

El presente artículo trata de poner en evidencia cómo los daños que se han fraguado en las economías y las sociedades de América Latina a lo largo de más de cuatro décadas de vigencia del modelo neoliberal, potencian ampliamente los impactos negativos de la pandemia del Covid-19. Tomando como ejemplos a Santiago y Bogotá, se examina cómo los daños del neoliberalismo actúan, por un lado, de forma directa sobre los sistemas de salud, mediante el total desmonte de la capacidad para atender objetivos de salud pública y la segregación del acceso. Por otro lado, cómo los daños económicos y sociales del modelo se traducen en altos niveles de inequidad y pobreza, principalmente en dimensiones como la informalidad, los bajos niveles educativos, el hacinamiento y las limitaciones de acceso a servicios, que no sólo producen mayores niveles de contagio y de muertes, sino que también limitan la sostenibilidad y efectividad de las políticas.

Palabras clave: Neoliberalismo, daño, inequidad, pobreza, privatización, impacto de la pandemia.

Introduction

Five decades after the adoption of the neoliberal model in Chile, it has been realized that not only its assumptions were untrue, but that the adoption of its principles did enormous damage to people's flourishing. In Latin America, these harms have resulted mainly in maintaining an unacceptable level of inequality and the worsening of various poverty dimensions, including informal employment. In Chile and Colombia, the health systems' neoliberal reforms led to the total dismantling of the States' capacity to meet public health objectives. While adopting private insurance policies governed by the profit motive among Latin American governments, the poor population is discriminated against access to insurance and quality services. In this context, at the arrival of the Covid-19 pandemic, Latin America in general (and Chile and Colombia in particular) presented the lowest figures among the OECD countries regarding hospital beds, medical personnel, intensive care units, laboratories and health facilities. Regional governments have been pressured to perform enormous investments to update health infrastructure to deal with the Covid-19 crisis. However, there has been little faith in the private sector, which throughout these decades has profited from health systems, being low interest in taking care in a crisis like the present one. In other words, governments did not have at any time the option of adopting policies to reduce the impact of the pandemic from public health perspectives, such as those adopted in some countries in Europe and Asia (massive tests, infection tracking, epidemiological fence). They only have the resource of temporary confinement of the population to generate a period during which the health system could be updated. However, the high informal employment levels seem to nullify the effectiveness and sustainability of quarantine restriction measures. In sum, the harms caused by neoliberalism to society and the health systems in the two countries under study seem to greatly enhances the pandemic's impacts.

This article has three sections and uses the social harm approach to analyze the consequences of neoliberalism in the region while making visible how these harms have been amplified in the Covid-19 pandemic. The first section explains and typifies the damage that neoliberalism has caused in Latin American societies and economies. The second section analyzes the harms caused by the breakdown of the health systems in Chile and Colombia. The third section shows empirical evidence of the relationships between different harms' dimensions, especially informality and poverty

and contagion and death levels caused by the Covid-19 pandemic. The article concludes by stating the importance of building a harm reduction agenda at the Latin American level and the imperative need to return to the public health goals lost after neoliberalism.

Covid-19 pandemic, social harm and neoliberalism in Latin America

The SARS-CoV-2 virus appeared in Wuhan's city in the People's Republic of China in December 2019. This virus moves through Asian and European countries during the winter of the northern hemisphere and reaches Latin American countries towards the end of the southern cone summer season. On March 11, 2020, the World Health Organization recognized Covid-19 as a global pandemic (OMS, 2020). Covid-19, as a disease caused by SARS-CoV-2, has left not only nearly 9 million infected in the region but also 300 thousand deaths (OPS, 2020).

Since then, what has happened in the countries leads us to believe that it is a health pandemic and a social one. Its massiveness, spread speed, and lack of immunity against the virus provide its "health pandemic status" (OMS, 2020). The "social" aspect is associated with the massive harm that the disease has caused to human flourishing. Here we are not only referring to the disease, its consequences and the deaths that it has caused, but also to the high unemployment rates, the deterioration of regional economies, the restrictions on the freedom and mobility of people, the psychosocial consequences of confinement, and the indebtedness of families. Covid-19, as a disease, has come to challenge the health systems of the region. It offers us an opportunity to reflect on the current Latin American social fabric and the social harm that has occurred and consolidated due to neoliberalism.

We use the social harm approach to "connect the dots" between neoliberal social structure and the current pandemic. This approach offers us an alternative lens that allows us to understand, for example, that the 300,000 deaths of people by Covid-19 in Latin America (OMS, 2020) are not natural events, nor are they part of the "lottery of life". This type of harm is not completely attributable to the irresponsible behaviour of individuals who do not exercise self-care practices and respect for quarantines. To a large extent, the pandemic and its ravages on human flourishing seem to be linked to more structural harm that had been brewing in the Latin American region.

The social harm approach will help us make visible how the processes and dynamics forged in the heart of the social fabric may hinder indivi-

duals' flourishing (Parraguez, 2017: 38). Although harms usually appear in front of our eyes as injuries already in progress (inequality, segregation, distrust, among others), these would result from processes, relationships, and dynamics that individuals through practices and institutionalization schemes are forging systematically over time in such societies. Even though there are events that for many people can be considered "irritating", "unpleasant", "annoying" or "unethical", these ultimately are not necessarily harmful. What separates harms from what is not, is its systematicity in constraining human flourishing (Hillyard and Tombs, 2004). The idea of systematicity in harms will be key for understanding societal injuries under neoliberalism.

Like all forms of capitalist organization, neoliberalism has strategies for reducing social harm while generating other forms of constraint on human flourishing (Pemberton, 2016). What is interesting about this type of society is that - as Springer (2015: 7) indicates, *"neoliberalism does not exist as a finite end state"*. It always seems to have an adaptive capacity which would allow it to continue operating regardless of episodes of deep socio-economic crisis (Peck, 2010). In the Latin American case, the history of neoliberalism begins in 1973 in Chile in the context of a military dictatorship led by Augusto Pinochet (Taylor, 2006; Harvey, 2007). However, neoliberalism was consolidated in the region during the eighties and nineties through the Washington Consensus policies (Puello, 2015). Neoliberal schemes have been moving from hard neoliberalism to a "neoliberalism with a human face" (Atria, 2013). An issue that shows its adaptive features, even when some harms and injuries continue to persist.

The dynamics of generating social harm in the region are intertwined with the general characteristics through which neoliberalism recast social relations and the relations between the state and citizens. As we know, neoliberalism has to do with a way of understanding development (Hill, Wald & Guiney, 2016), citizenship, social value and discourse aspirations (Lewis, 2016). Neoliberalism reconfigures the relations between state and private property by focusing on marketization, deregulation, liberalization and privatization (England and Ward, 2016). The state architecture of this paradigm reconstitutes social relations so that the links between State-Market-Family tend to provide greater responsibility to individuals regarding their social security.

In 1989 the region decided to adopt neoliberalism through prescriptive policies designed in Washington to receive financial aid from the World Bank and the International Monetary Fund. The accumulation of external

debt and the consequent economic collapse of 1982 had left countries with little room for action to negotiate. According to Williamson (2008), the Washington Consensus project was promoted only as a set of economic reforms that would help heal the economy through fiscal discipline, redirection of public spending, economic liberalization, foreign investment and privatizations. However, as we know, in reality *"these policies were much more than an economic agenda"* (Stiglitz, 2008: 45) because they also ended up bringing new forms of subjectivity and a particular form of state management that recast social relations.

The spread and magnitude of the Washington Consensus policies' implications in the region could be summed up in three privatizations waves. The first wave of privatization was oriented to national companies and consumer products; the second wave was focused on infrastructure and telecommunications. The third wave meant the privatization of social sectors such as pensions, health and education. The social results associated with these privatizations were not great. As Lloyed-Sherlock (2009) documents, instead of reducing socioeconomic disparities in the region, many interventions in welfare systems such as reforms in education, health, and social protection ended up actively contributing to widening the gaps. CEPAL has reported in its Social Panorama over the years that the productive structure continues to present an uneven development of the productive forces and the social relations of production, which leads to differences in productivity levels, income distribution and access to consumption. All disparities have persistently tended to negatively affect the most vulnerable groups, such as women, youth, and people with low educational levels (CEPAL, 2010), rural areas, and the countries' most remote areas.

A second set of policies was established to generate legal reforms, regulatory institutions, flexibility in the labour market, and a battle focused on poverty (Green, 2003). However, the corrections of the model arrived at the wrong time. Various voices have begun to question the so-called social models of the Latin American market economy (Mayol, 2012). So far, the main criticisms have focused on two related issues: inequality of income and opportunities, and the privatization of social rights (Atria et al., 2013; Solimano, 2015). Both concerns appeal to the individual and social costs through which Latin American neoliberal models have built their achievements. The previous has served to generate a breeding ground for segregation, discrimination and individualistic behaviour in societies (Ruiz, 2013; Moulian, 1998) prior to the crisis caused by the Covid-19 pandemic.

Types of social harm in the pre and pandemic space

From a social harm perspective, the injuries caused by neoliberalism in the region could be grouped into three types of social harm: relational, autonomous, and physical/psychological harms. Relational harms are related to situations where people are partially or totally excluded from the social structure. For example, relational injuries can be linked to structural inequalities concerning income and available opportunities. However, this type of harms can also be considered when there are low levels of interpersonal trust or mistrust in society's institutions since mistrust favours antagonistic relationships between institutions and groups. Likewise, one could expect the formation and manifestation of social harms when individuals have low levels of integration in societies, which tends to act as a catalyst for different forms of discrimination and segregation. The autonomic harms account for situations in which individuals tend to lose control over their livelihoods to satisfy their needs. Individuals' self-realization is at risk when they do not have the possibility of making autonomous decisions and are somehow "trapped" by their life circumstances. Thus, harms to autonomy can take different forms, such as labour exclusion, stratification of educational achievements and differentiated access to the sphere of consumption and services.

Regarding physical and psychological harms, these are created in the social fabric when individuals cannot ensure the production and reproduction of their means of subsistence. That is when individuals cannot access food, shelter, or health systems in case of illness. The same rationale applies to the social harm of a psychological nature. The reproduction of human life also implies that individuals can sustain their mental capacities at healthy levels. And in doing so, high levels of stress, overcrowding or depression can lead to reduced possibilities for subsistence material reproduction, insofar as individuals' bodies cannot be used as vehicles to obtain their livelihoods.

Using this conceptual framework, one could identify at least three drivers that have contributed to intensifying the formation and exacerbation of physical, psychological, autonomic and relational harms in the region in the pre-pandemic space due to neoliberal reforms. First, even though there is an increase of social spending as part of the Washington Consensus recommendations' corrective actions, privatization/deregulation in social security systems has persisted in transferring collective responsibility to individual risk. The model keeps leaving many individuals exposed to different types of social injuries. Physical harms intensify to the extent that

not all individuals manage to access health, education and pension systems. The privatization of social risk management systems is necessarily associated with a monetary transaction in privatization schemes, which in turn is stratified by the labour market and access to credit mechanisms.

Covid-19 came to reinforce what the health literature has been warning about for a long time. Access opportunities for treating diseases are determined by the individuals' ability to pay. In this regard, CEPAL and OPS (2020: 14) indicate that "on average, households in the region must cover more than a third of the financing of health care with direct out-of-pocket payments (34 per cent)". Thus, differences stratified by income are exacerbated in a pandemic when the territorial distribution of the possibilities of testing, treatment and effective traceability of the population is analyzed.

Second, income concentration and its negative impacts on equity can be considered a second driver that facilitates social harm formation (especially relational harms). Latin America is still an unequal region, and this pattern has not been reversed. According to CEPAL (2019a: 21), "although between 2002 and 2014, income inequality decreased significantly, in 2015 that trend slowed down… the regional average measured by the Gini index was 0.465 in 2018". Income concentration is adverse to the sustained development of the countries. Inequality and lack of equity tend to generate fewer solidarity actions, and the loss of joint projects' construction. The above would explain, for example, that crime and victimization rates continue to rise, being one of the regions with the highest homicide rates in the world (Muggah and Aguirre, 2018).

Income concentration will not improve with the pandemic. International organizations anticipate the worsening of negative impacts on equity given the economic downturn, the persistence of high rates of informal employment in the region, as well as the fragility of the health and social protection systems. Situations of exclusion and marginality will persist, which would result in greater people´s vulnerability under Covid-19. The loss of employment, income and mobility restrictions given the quarantines, would leave even more unprotected the 54 per cent of people in the region who, according to statistics, carry out informal jobs. An increase in poverty incidence is projected in 7 points, raising the proportion of poor in the region to 37.3 per cent.

Third, dependence on credit in households in the region continues to increase (Ruiz-Tagle, 2017). In a low-income wage structure, the mechanism of people's indebtedness has turned out to be one of the strategies most used by households. The most indebted households in the region are Chi-

leans with a debt percentage of 45.4 per cent for 2018, followed by Brazil and Colombia with 28.2 and 27 per cent respectively (CEPAL 2019b: 43). In the Chilean case, the Central Bank has updated this figure (2019), indicating that household debt reached 75 per cent of family income. The concept of indebtedness and over-indebtedness is problematic from the point of view of social harm analysis. The logic of debt works with the idea that everyone can own "something" (such as cars and houses). Yet, this sense of ownership tends to predispose people to engage in discourses centred on meritocracy, sacrifice and resilience. Even when wages are insufficient to meet essential and nonessential needs, the indebtedness model helps consolidate behavioural explanations for social injury, because debt is always individual. In other words, it is presented as the result of a "personal choice" or as an individual opportunity to take advantage of the benefits of the neoliberal scheme. The debt circle reduces physical harm to the extent that it gives individuals access to a market share. However, debt also induces the purchase of non-essential goods, generating societies and consumer mentalities (Moulian, 1998). Over-indebtedness follows a similar pattern; it causes social damage to autonomy since options are mediated by payment schemes and physical harms due to non-payment of debts. Indebtedness is not a separate conversation from the trend of privatization of social security systems and risks. Given the region's social sectors' privatized schemes, the poorest deciles can access credit formula to navigate contingencies.

Given that in many Latin American countries, access to diagnosis and treatment of Covid-19 implies co-payments by individuals, a *"catastrophic and impoverishing effect is anticipated in the immediate future"* (CEPAL-OPS, 2020: 14). Suppose we add to the above the rise in credit and debit mechanisms as strategies to alleviate unemployment. In that case, the outlook becomes even more worrying in the short term. Households with low incomes or unemployed workers with high indebtedness rates would be added as important factors to the "perfect storm" that we will face during the Covid-19 pandemic and the post-pandemic.

The Covid-19 makes the physical, psychological, autonomic and relational social harms (that neoliberalism has left) more visible. First, Covid-19 is democratic in its form of contagion (we can all become infected). However, as social fabric dynamics present structural inequalities, they underpin how people perceive or experience the disease, quarantines, and treatment provision in health systems. Fragmented societies based on interpersonal and institutional mistrust do not help. There is a citizens' dis-

belief concerning the number of infected, tests carried out and possibilities of traceability cases. Also, there is mistrust of other people regarding the self-care measures and the chance of being infected or to infect others. These two interrelated factors pose significant challenges regarding health systems' response capacities to the crisis and question quarantine systems.

Second, the measures took around preventing Covid-19 and not the disease itself exacerbate autonomic harms. As we pointed out previously, the autonomic injuries are related to the lack of control of individuals over decisions that affect their lives. Under the Covid-19 pandemic, many individuals face overcrowding due to housing conditions under quarantines, the impossibility of teleworking (especially manual workers), and the gap in access to the internet and computers in poor Latin American households to receive online classes since the schools are closed.

Third, physical and psychological harms under Covid-19 pandemic are varied. These would range from mental health issues due to confinement such as stress, depression and anxiety to death where people could not recover from Covid-19.

The intersections between social harms, neoliberalism and the Covid-19 pandemic place the region in a delicate situation. We know that individuals are infected one by one, and have fairly well-established contagion rules[1]. However, no less uncertainty is produced by the fact that asymptomatic people can spread the virus. In any case, the ways to avoid getting infected and infecting others depend on personal behaviours. Nonetheless, given the same rules imposed by contagion, the only way to overcome the virus is collective. The Washington Consensus policies pose a method for understanding development, citizenship, consumption habits, freedom and individuality using market principles. It has been installed ideas that go counter wise of what the Covid-19 pandemic imposes on overcoming the illness. The individual over the collective as the formula for individual and social prosperity. Schemes of "governmentality", Michel Foucault (2002) would say, already underway in our bodies, practices, policies and institutions. All these drivers forged under neoliberalism in the region makes it difficult to articulate a collective response to Covid-19.

[1] According to the Center for Disease Control and Prevention, contagion occurs through close contact between people and by "respiratory droplets that are produced when a person coughs, sneezes or talks" (CDC, 2020), as well as people without symptoms can spread Covid-19. There is still discussion about the permanence of virus particles in the air and their duration on different surfaces.

The neoliberal harms to the health systems of Chile and Colombia

It is now time to investigate what harmful features underpin neoliberal harms in the region's health sector. For illustration purposes, the cases of Chile and Colombia will be used in the analyzes. In both countries, neoliberalism started during the eighties and nineties, respectively. Both health systems share a vision about health that is not based on public services but rather on health as a tradable good in the market. Under neoliberal schemes, Chile and Colombia experienced a reconfiguration of the state and the private sector's roles in providing health services. This approach to health systems is what the two countries find themselves in when the Covid-19 pandemic arrived. To a greater extent, this situation has been limiting the guidelines and effectiveness of the policies and actions that governments can take to address the Covid-19 crisis.

A very important aspect of the neoliberal harms production is its ability to transform and readjust its features for survival purposes. Implementing the model in Chile and Colombia's health systems clearly illustrates such adaptive capacity, expressed in the successive introduction of 'neoliberal amends'. The neoliberal model tried to soften the public perception of the model's negative impacts to facilitate its hegemony. In Chile, this adaptive capacity was demonstrated in the model's changes when moving from the military government to the democratic ones. In Colombia, based on the Chilean experience, the neoliberal model was adopted with certain adaptations, which gave it, at least in the discourse, a "human face to neoliberalism". These adaptations can also be observed in the health sector. For example, the drastic reduction in public spending on health and the closure of most service-providing institutions belonging to the public sector was justified by the widely disseminated discourse about improving spending efficiency. In reality, behind the scene, the model's injuries have not been mitigated. On the contrary, some of its recipes had been taken to the extreme.

Establishing neoliberalism in Chile and Colombia's health systems and the configuration of harms in its social protection aspect has several shared points. Firstly, it can be highlighted how both the National Political Constitution (NPC) adopted in Chile (1980), and Colombia (1991) legitimized and granted a constitutional floor to the application of neoliberal principles in health systems. The two NPC open the space for privatizing health services, a role that was essentially public until then. Under a constitutional fra-

mework, mandatory insurance was established, and a reduction of state intervention that limited coordination, evaluation, and control over the health system were imposed. Also, the constitutions gave users the possibility of choosing between healthcare providers (public or private). In the Colombian constitution, some adjustment to the neoliberal model was made, probably based on the ten years of operational experience from Chile's neoliberal system. Among them, a decentralized health system, space for the community's participation in health services (although null in practice) and state participation in promoting health practices and environmental sanitation (unprofitable activities). It is important to note that both constitutions contain contradictions between the principles they embrace. The constitutions talk about that health access to promotion, protection and recovery services are duties of the state. In Colombia's case, these issues are addressed in universality, gratuity, and compulsory basic care. As could be foreseen, and did indeed occur, such protection and guarantee could not be fulfilled in the segment of services that the private sector would manage.

Apart from the constitutional framework, the neoliberal reforms of Chile and Colombia's health systems were based on previous processes that affected the pre-existing health systems' institutionality and resources, leading them to a critical situation. This situation somehow provided legitimacy and public acceptance of the reforms that were to be enacted. In both countries, health spending had been systematically reduced over the decade before the reforms. In Chile, per capita spending on health fell by 64 per cent between 1974 and 1979, resulting in cuts in investment, infrastructure, and health workers' income, bringing the system to a breaking point in the late eighties (Taylor, 2006: 93). In Colombia, health spending as a percentage of GDP had systematically decreased during the 1980s. In 1990, it reached only 1.8 per cent of GDP, mainly affecting infrastructure investment. It was below the Latin American average of 2.4 per cent (Molina, 1994: 6-8). The health reforms had legal background changes and institutional restructuring aimed at the decentralization of roles and resource management[2]. They had the effect of cutting back the Ministries of Health's roles and other system institutions. The perception of a crisis and poor quality of services in the prevailing systems created an environment conducive to

[2] In Chile, Decree-Law (DL) 2763 of 1979 creates FONASA, which would be in charge of the administration of state health resources, establishes the decentralized function of the public health system and transfers (gradually) the role of primary care from central government to local councils. In Colombia, Law 10 of 1990 mandated the gradual transfer of health finances to local councils.

introducing system reforms, presenting privatization and other changes as the necessary and timely alternative.

Neoliberal approach to health care

The neoliberal health systems developed in Chile and Colombia present many similarities in their assumptions, structure and functioning. This section aims to explore the two health systems harms similarities and the mechanisms through which they act.

First, the Chilean and Colombian health systems' reforms are based on the same assumptions since they hold a similar neoliberal approach to social policy[3]. In both countries, the private sector's participation in the management and provision of health services is key. Both countries believe that private sector intervention would improve efficiency, effectiveness, and ensure greater health access protecting the right to health (Zamora, 2012: 1). Additionally, both countries believe that there is a lot of state inefficiency on health spending preferring subsides methods to supply (Santamaría, SF: 9).

The health systems created in the two countries are dual. In Chile, the system is composed of a private system called ISAPRE and a public system called FONASA. In Colombia, this dual system is represented by a Contributory Regime (CR) that covers the population with the ability to pay and the Subsidized Regime (SR) that covers the poor population.

Although Colombia has wanted to establish a unified system, there is a duality between the private sector that holds the management and administration of the Health Promoting Entities (EPS) and the system's financial operation, which is the state's responsibility through its territorial entities. In both countries, private services are organized under an insurance approach, managed by private companies that act as health insurance brokers, which outsource human resources and infrastructure when is needed (Taylor, 2006: 94).

Regarding the resources for the health system's operation, in both countries, the private system is financed exclusively by the workers' mandatory contributions.[4] In contrast, the public system (or the SR) is financed with

[3] In Chile, DFL No. 3 of 1981 created the Private Health System and the Pension Health Institutions (ISAPRE). In Colombia, Law 100 of 1993 created the General System of Social Security in Health (SGSS), defines the HPE (Health Provider Entities) as the main intermediary.

[4] In Colombia, the health contribution is a fixed percentage of the income level (12.5%). Dependent workers' contributions are covered by the worker (four%) and by the employer (8.5%). In the case of independents workers, they pay the full contribution (12.5%). They tend to have higher incomes than most salaried workers, they contribute to a base salary lower than the real one, resulting in their services being subsidized by salaried workers' contributions. In Chile, the

its members' mandatory contributions and with subsidies from the public treasury[5] (Ministerio Protección Social: 515). Another resource source is moderating fees and copayments created to avoid "moral hazard"[6]. Regarding services, all members receive a benefits package. In Colombia, this package, called the Obligatory Health Plan (POS)[7], was adopted from the beginning of the system's establishment[8]. In Chile, a similar plan called the Universal Access Explicit Guarantees Plan (AUGE) was part of the reforms introduced by democratic governments.[9]

Health systems' mechanisms based on the private insurance market's principles produce injuries to health and Latin American society. There are harms associated with the health systems' capitalist essence, including the abandonment of public health objectives with negative implications on the social fabric, equity, solidarity, and individuals' flourishing. These are injuries whose impact is difficult to assess and require in-depth analysis of the systems' operation. In the evaluations of the systems' internal operation given the requirements of free competition, the limitations that arise from the health "market imperfections" and the injuries that derive from them become evident. Among the most significant harms detected are the structural bias against the state system, territorial inequality of access, and discrimination against the poor population.

Dependence on public resources introduces structural biases against the state system (or subsidized system). The health system should cover the majority of the population, including the poorest segments. Chilean public system covered more than 75 per cent of the population with a third of the resources and the expenditure per beneficiary was four times less than the private sector in 2015. Consequently, healthcare quality in the private sector is much higher since they can pay higher salaries and hire more qualified personnel (Taylor, 2006). In Colombia, the financing and compensa-

health contribution is seven% of the workers' salary. There is no contribution from employers. This is expected to lead to a higher demand for quality of services.

[5] Besides, a copayment is charged for health care, linked to income level and the specific type of care.

[6] Moral hazard refers to the risk of overuse of services by users.

[7] There was a package of services for the CR (POS) and fewer services for the CR, called POS-S

[8] In the Colombian system, structured ten years after the Chilean system, improvements were made to the private insurance system's operation, including a single bag of procedures and medicines, and a single system where all public health providers (PHP), and private companies compete for POS contracts. A compensation system was also established between people with different risk profiles.

[9] There is an option of purchase supplementary care plans (SCP) and prepaid medicine plans that offer greater content than the POS and higher quality in Colombia. There is a prerequisite to belong to the Tax Regime and to an EPS to obtain these plans. An important part of the population goes to these plans to ensure minimally adequate care and completely dispenses using the POS, presenting a waste of resources and an increase in out-of-pocket expenses.

tion mechanisms between the resources source are extremely complex.[10] There are delays in transferring resources and diversion to other purposes, mainly affecting the SR and the territorial entities that undermine its performance capacity to provide health services.

Access and quality discrimination to health services happens in several ways. In Chile, the private system can charge extra for a health plan, and it has full freedom to raise its prices based on their analysis of individual risk, which considers age, gender and health status. As a result, the older population and women of reproductive age must pay more for their plans. It can be said that the system is dedicated only to young adults, with higher income and less likely to require healthcare services. In Colombia, although the financing of the system is based on a single amount (UPC) per beneficiary and a single package of services, the availability of services for the Subsidized Regime is very limited. Normally, there are only health centres of low complexity in most councils, which implies large trips and costs to access the main cities' services. According to the Ministry of Social protection, 49 per cent of first-level public IPSs did not have the requirements defined by the system to provide the lowest level of subsidized OHP (Ministerio de Proteccion Social, s/f: 536).

Although neoliberal health systems were built based on a free choice principle, switching between systems is highly restricted due to the asymmetry of information on supply and barriers to the health system affiliation and disaffiliation. In Chile, evaluations conclude that freedom of choice has not increased for the majority of the population due to risk discrimination and the high costs of ISAPREs. In Colombia, the payment system to EPS by Capitation Units according to the number of affiliates leads to the retention of affiliates delaying the issuance of the requirements for EPS change.

The health superintendencies were created in both countries[11] to carry out the monitoring, evaluation and control of the health systems. In practice, these agencies operate as corrective bodies for "market failures" and do not evaluate services' quality. Apart from this, in Colombia, the National Superintendency of Health has never had the sufficient resources or the

[10] In the RC financing, users make their payments while EPS and FOSYGA act as debt collectors. In the SR, there are different entities involved in the financial process: Resources of the Current Income of the Nation; resources transferred to the territorial entities (which differ according to the categorization of these entities); own resources of the territorial entities; the administrators of the subsidized regime (ASR), the FOSYGA and the Territorial Health Funds, which are the ones that ultimately turn the resources over to the ASR.

[11] In Colombia, the superintendency was created by Law 100. In Chile, the Ministry of Health carried out the superintendency role, but an adaptation was introduced to the system in 2005.

sanctioning power required to carry out true surveillance and control (Ministerio Protección Social, s/f: 516). At the level of territorial entities, the roles of inspection, surveillance and control are exercised in a decentralized manner, that is, surveillance falls on the territorial authorities, which are at the same time in charge of ensuring the flow of system resources and that they have no motivation to report failures for which they are responsible (Ministerio Protección Social, s/f: 526). This situation has encouraged favouritism in contracts, the diversion of resources and, in general, corrupt management of the system, which has seriously injured the quality of the provision of services.

The neoliberal harms to health systems and the impacts of the Covid-19 pandemic

The economic and social harms inflicted by neoliberalism relate to a high concentration of income, high level of poverty, households' vulnerability, and above all, the unprecedented growth of informal activities in the economy. In the two countries that we are analyzing, these are added the damage caused by neoliberal reforms to health systems. The following paragraphs will establish how the sum of harms enhances the pandemic's effects and limits governments' possibilities to confront it effectively and sustainably over time.

A review of Chile and Colombia's main health infrastructure indicators allows us to verify the precarious situation in which both countries were in when the Covid-19 pandemic hit. According to the OECD data for 2018[12] (OECD, 2020), Colombia and Chile had only 1.7 and 2.1 hospital beds per 1,000 inhabitants respectively, which placed them in positions 38 and 39 among 42 analyzed OECD countries; compared with Japan, Korea and Germany, which had 13, 12.4 and 8 hospital beds per 1,000 inhabitants respectively. In 2018, the world average of hospital beds was 3.1 per thousand inhabitants, and Colombia ranked 122 out of 181 countries. Bogotá only had 1.8 hospital beds per 1,000 inhabitants (DNP, 2018).[13] Regarding health spending, Colombia, with $ 960 per capita per year was ranked 43 out of 46 OECD countries and Chile, with $ 2,182 per capita, ranked 35, compared to the United States, Switzerland and Norway, which have the

[12] The 2020 report includes the most recent available data obtained from the countries. Some of the indicators correspond to 2019.

[13] There are no comparable data regarding the status of intensive care units. In Colombia, in March 2020, there were only 5,271 of these units in the entire country, and not all of them equipped with mechanical fans. Furthermore, intensive care units were concentrated in big cities. Several councils did not have a single critical care bed at that time (García, Francy *et al*., 2020)

highest expenses (in developed countries), with 10,586, 7,317 and 6,187 dollars per capita respectively. Relative to GDP, Chile spent 8.9 per cent on health and Colombia 7.2 per cent, compared to 16.9 per cent in the United States, 12.2 per cent in Switzerland and 11.2 per cent in Germany. In terms of health personnel, Colombia had only 2.2 doctors per thousand inhabitants, which placed it in 32nd place out of 36 OECD countries, and Chile, 2.6 doctors per thousand inhabitants, compared to Austria with 5.2 doctors per thousand inhabitants and Norway, with 4.9. Likewise, Colombia ranked second to last in the OECD, with only 1.3 nurses per thousand inhabitants.[14]

Other indicators, of which there are no systematized records, show unjustified shortages of infrastructure and equipment. In Colombia, at the beginning of the pandemic, there was only one public laboratory, with the certified capacity to process Covid-19 samples (the National Institute of Health). It took the government five months to enable a reasonable number of laboratories. Bureaucratic obstacles of all kinds were faced, affecting, for example, the importation of automated equipment to process the tests and import the necessary reagents.[15] At the beginning of August 2020, Colombia reached a capacity of 43,000 daily Covid-19 tests (Dinero, 2020), but only 37 tests per thousand inhabitants had been made in that month. Chile's situation was much better, 97 tests per 1,000 inhabitants but still far from other countries' experience: Luxembourg 707, United Arab Emirates, 505, Denmark, 297 and Iceland, 229 tests per thousand inhabitants respectively (El Tiempo, 2020).

All these numbers corroborate that the implementation in Colombia and Chile of neoliberal health systems based on the private insurance market led to the dismantling of the capacity to meet public health objectives such as those demanded by the pandemic. Hence, governments had to make large investments at a forced march to try to bring the capacity of the systems to the level required by the pandemic, which, in crucial aspects such as the ability to test and track infections, simply it was not possible. This explains why the government, at least in the case of Colombia, has finally given up completely from applying these strategies to fight the pandemic. Unsurprisingly, in Colombia's case, private health intermediaries who profited from

[14] The data for Chile regarding nurses per thousand inhabitants was not available.
[15] There are no reliable reports on the number of tests performed. According to press reports, at various point in times, there were thousands of test results damaged. The HPE private insurers did not provide an official response due to the delays in delivering the tests' results (RCN, 2020a). At the time, more than 30,000 samples were disabled by poor identification or lack of management protocols (Infobae, 2020).

the privatized system did not put a single penny for resolving this crisis. It was the state that made all the different type of investments.

The disruption produced by neoliberalism in health systems has reduced the capacity of states to guarantee the right to health, which is enshrined in national political constitutions. Contrary to the guarantee of the right to health, the system's operation has exacerbated inequality in access to services and large cities' different territorial divisions. In the few available balances on adequate access and quality of services, the indicators show that health neglect is high and uneven. In the case of Colombia, Guerrero *et al*. (2011: 150), point out that of the 1,219 IPS health providers registered in the system, only 19 (1.5 per cent) met high-quality assurance standards. García *et al*. (2020: 9) draw attention to the inequality in developing the infrastructure required for the care of the most seriously ill patients in the most remote regions of the country, where especially vulnerable population groups are concentrated. They detect serious shortages of biomedical equipment and little trained staff, which faces harmful and discontinuous hiring, late payments, while corrupt practices persist in managing resources destined for the care of the pandemic. Another indication of the lack of health care is what has been called the judicialization of health systems. In Chile and Colombia, many people must go to court to assert their right to receive health care.

In this context, and although there are still no in-depth studies in this regard, there are indications that the measures implemented by the pandemic are generating delays in the timely care of patients with conditions other than Covid-19 (García *et al*., 2020: 9). It is easy to foresee that other diseases' effects will be "devastating" as recorded in a PAHO document (AFP, 2020: 1). Based on a survey of 27 countries, this institution detected the suspension of routine vaccination campaigns, problems for the care of pregnancies and non-communicable ailments, such as hypertension and diabetes, and the shortage of drugs to treat HIV and tuberculosis. Several observers' concern also extends to the possible effects on mental health, suicide, gender-based violence, and malnutrition in children under five years of age. In Colombia, the main strategy against Covid-19, widely promoted by the government and by the EPS in the different media is "staying at home", a very convenient strategy for private insurers that save many resources in care, but that It will surely be to the detriment of the care of diseases other than Covid 19.

The social determinants of health and the impact of the Covid-19 pandemic

The social determinants of health are the circumstances present in people's life course, including the health system that covers them. These social determinants explain health inequities. In other words, the unfair and avoidable differences observed in countries' health situation (OMS, 2020). In Latin America, inequality, poverty and informality are the key determinants of inequities in health access. These drivers can greatly enhance pandemic's negative impacts (Acosta *et al*., 2020).

Through its long existence in the region, the neoliberal model has not allowed improvement in equity. In Colombia's case, the Gini index of per capita income only changed slightly, from 0.573 to 0.571 in the period 2002 to 2018. Although in Chile it was possible to reduce the index from 0.50 to 0.45 for the same period, these two countries rank as the second and third most unequal income distribution in the region, only behind Brazil (Universidad de los Andes, 2020a: 1-2; The New York Times, 2020: 1-8).

Likewise, and even though the statistics report a reduction in income poverty levels,[16] households' poverty rates continue to be very high, even in the most "developed" urban centres of the countries, as shown by the Multidimensional Poverty Index (MPI). According to the data from the CASEN Survey of 2017,[17] 17.6 per cent of the population was classified as multidimensional poor in the case of Santiago. In the case of Bogotá, according to the 2017 Multipurpose Survey (MPI) data,[18] the aggregate MPI affected 4.7 per cent of households[19]. This indicator may be underestimated[20] since the same survey records that 46.7 per cent of households in Bogotá belongs to strata 1 and 2, those with the greatest poverty. Even so, examining the regressions of the data from the same surveys, disaggregated at the level of the smaller territorial divisions in the two cities,[21] a clear positive relationship can be verified between the rates of infection and death from Covid 19 and the aggregate rates of multidimensional poverty (Figure 1). The decomposition of the MPI in its partial indicators shows a more pressing reality of poverty in the two cities: 28.2 and 21.9 per cent of

[16] In Colombia, monetary poverty fell from 49.7 per cent in 2002 to 27 per cent in 2018.
[17] CASEN databases were obtained from the Ministry of Social Development (2017) and processed by the authors.
[18] Bogotá Multipurpose Survey databases (EPM, 2017) were obtained from DANE (2018).
[19] The definitions of the Multidimensional Poverty Index (MPI) for the two countries differ in the dimensions included and in their weights, therefore are not strictly comparable.
[20] In Bogotá, households with at least 33 per cent of deprivations are reported as poor by MPI. If the households with at least 20 per cent of the deficiencies were counted, the index would be 28.4 per cent.
[21] 19 urban locations in Bogotá and 52 councils in Santiago.

households are affected by education deficiencies[22] in Santiago and Bogotá respectively; overcrowding affects 21.7 per cent of households in Bogotá, and the deficiencies in insurance or access to the health care system affect 15 per cent of households in Bogotá and 12.5 per cent in Santiago. Along with informality, it seems that these are the shortcomings most associated with the impacts of the Covid-19 pandemic.

The pandemic's advance has shown that the poor population is subject to higher rates of contagion and death by Covid-19, greater susceptibility that occurs based on their unfavourable situation regarding the social determinants of health. Among these determinants, due to their specific impact on the pandemic, employment informality, barriers to access to health services, lack of education and overcrowding, among others, stand out. The close relationship between the poor population's conditions in each of these factors and the pandemic's greater impacts will be shown in the following paragraphs.

The informality of employment is a recognized injury of the neoliberal model with great impact in Latin America. This injury contributes directly to the worsening of the pandemic and undermines the governments' capacity to govern effective strategies to combat it. According to official figures, in Colombia, the percentage of informal employment before the pandemic was 47.6 per cent[23] in the average of the country's 13 main cities (RCN, 2020b). However, according to the Labor Observatory of the Universidad del Rosario (2018: 1), informality was 60 per cent for the entire country. In any case, it is a very large mass of the population that carries out its activities on the street and relies on daily income to survive. In the case of Bogotá, the MPI for 2017 indicates that the most important dimension that explains poverty is informality, which affects 41 per cent of poor households in the city. In the Metropolitan Region of Santiago de Chile, the incidence of informality is slightly lower, but it also constitutes great harm as a legacy of neoliberalism: in the first quarter of 2020, informality affected 27.2 per cent of the employed population.[24]

To verify the relationship between the different dimensions of poverty and the impact of the Covid-19 pandemic on the poor population, data from the MPI 2017 of Bogotá and the CASEN 2017 survey of Santiago

[22] In Santiago, this deficiency refers to households where at least one of its members, over 18 years of age, has reached fewer years of schooling than those established by law according to their age (12 years). In Bogotá, this deficiency refers to household members over the age of 17 who have reached less than nine years of education.

[23] The DANE classifies workers not affiliated with Social Security as informal (DANE, 2020: 24).

[24] Data from the National Employment Survey, INE, Chile.

have been used (disaggregated by minor divisions, and their relationship with the data disaggregated at the same level of infections and deaths accumulated by the pandemic, from official statistics[25]). As noted, informality is a very important factor in explaining the pandemic's greater impact on the poor population. In Bogotá, a positive relationship is found between the percentages of poverty due to informality and the rates of contagion and deaths with correlations of 65 and 62 per cent respectively (Figure 2).[26] However, informality in the pandemic goes far beyond the increase in contagion and death rates. Informality becomes practically the main impediment for governments to implement effective policies to reduce the pandemic's progression. In Latin American countries, the main measure adopted by governments has been confinement, and it has been observed that in the periods in which strict quarantines have been established, the rate of reproduction of the virus has been reduced (EL PAIS, 2020). However, the high informality, together with the lack of pre-established emergency mechanisms or funds (such as the unemployment benefit that exists in developed countries), does not allow continuously maintain population mobility restrictions. In a situation of informality, individuals face the dilemma of protecting themselves against the pandemic or protecting themselves from hunger. In this circumstance, it is very difficult for a person to follow the confinement measures. Even more, when governments determine successive exceptions to the restrictions obeying not only the essential nature of some services but also different political and economic conveniences, stimulating all kinds of fraud. The information available in Bogotá about fine imposed by the police on the population that does not comply with sanitary restrictions indicates that informal workers are the ones who violate the restrictions the most and that, they repeat these behaviors. The effective days of quarantine in the case of informal workers end up being practically null. According to the El PAIS (2020), informality has nullified countries' ability to take effective measures in the fight against the Covid-19 pandemic and is one reason for which the confinement measures in Latin America are among the longest in the world. They have been ineffective, or at least they have not succeeded in suppressing the contagion at the levels that were achieved in Europe.

Given the demonstrated lack of sustainability of compulsory confinement strategies, these countries' governments should have strengthened epidemiological measures, diagnostic tests, and individualized isolations

[25] In the case of Bogotá, data from the National Institute of Health (INS,2020) was used while for the case of Santiago data from Covid-19 committee was pulled out.
[26] Informality statistics by councils were not available for the case of Santiago.

of suspected cases, strategies that were successful in Europe and Asia (El PAIS, 2020). However, as has been pointed out, when the pandemic arrived, the great difficulties in implementing this type of measures became evident due to the dismantling of health systems that had produced neoliberal reforms. Another great injury of neoliberalism is also evident, creating dual health systems that exert strong discrimination against the poor population in access to quality services.

Although the increase in insurance has been repeatedly highlighted as Chile's main achievement and Colombia's health reforms, the data indicate that important deficiencies persist on this matter. As has already been pointed out, in Bogotá, the lack of insurance or health care affects more than 15 per cent of households and 12.5 per cent of households in Santiago. Bogotá local data allow us to verify that insurance and health care deficiencies mainly affect the poor population. The deficiencies are directly related (correlations of 57 per cent and 59 per cent respectively) with the contagion rates and death caused by the pandemic (Figure 3). In the case of Santiago, the correlations are quite lower,[27] but they are also positive.

Lack of education is another characteristic of poor households related to the prevalence of the Covid-19 pandemic. As already mentioned, in Santiago, 28 per cent and Bogotá, 22 per cent of poor households have educational attainment deficiencies. In Bogotá, the correlation of this deficiency with the accumulated rates of contagion and death from the pandemic is high: 60 and 46 per cent respectively (Figure 4, panel a). In this city, all the MPI dimensions that have to do with deficiencies in education (illiteracy, non-attendance and school backwardness) are positively related to the accumulated rates of infections and deaths. Although it affects a small number of households, illiteracy shows high correlations, of 54 and 41 per cent, with infection and death rates respectively (Figure 4, panel b). What can be deduced is that the lack of access to information and the low capacity to understand messages is another of the mechanisms by which the pandemic preferably takes root in the poor population. The lack of education is another great harm of neoliberalism in these countries, where education is privatized and highly segmented. The panorama of educational deficiencies configures in poor households what has been called a "cognitive trap" (Universidad de los Andes, 2020b: 1-2) in which there is a scarce availability of information on quality, low expectations of people, perception of invulnerability and perception of non-compliance by "the others". All of

[27] Correlations of 24 and 22 per cent between the percentages of non-assignment to health services and the percentages of infections and deaths.

this occurs in an environment where the contradictory messages and disinformation campaigns make difficult to discern the appropriate behaviours to follow.

The overcrowding in which the poor population live is another factor that influences the impacts of the Covid-19 pandemic. In studies conducted by the Universidad Externado Colombia (Universidad Externado de Colombia, 2020: 1-2), social housing[28] has been observed that the probability of contagion has been eight times greater than that of other strata. Likewise, it has been verified that the higher population density where the poor live favours higher rates of contagion, as in fact happens in Bogotá in neighbourhoods where the population density is between 333 and 581 inhabitants per hectare[29] (Universidad Externado de Colombia, 2020: 2-3). According to the MPI data, 21 per cent of households in Bogotá can be considered overcrowded (3 and more people per room), and this situation of households is significantly correlated with infection and death rates with correlations of 50 and 34 per cent respectively (Figure 5). Although household overcrowding has a lower prevalence in Santiago than Bogotá,[30] the correlations of critical overcrowding with accumulated infection and death rates are the highest observed in Santiago, 51 and 55 per cent.[31]

Other dimensions of the poor population's environment and housing conditions are also positively correlated, although to a lesser extent with the impact of the Covid-19 pandemic. It is worth highlighting the lack of connection to sewerage due to its close relationship with the hygiene standards that must be adopted to protect against Covid-19. Such standards cannot be expected to be met in rural areas, marginal areas or poor neighbourhoods where there is no connection to sewerage. As is frequent, although there is a connection, the effective service is irregular, intermittent or null. According to the Universidad del Externado (2020: 1), many people do not have access to drinking water; Approximately 1.6 million people are estimated from council capitals and 6 million people from rural areas without access to sewerage. In Bogotá, a small number of households do not have sewerage (just under 2000 households according to the MPI 2017). However, statistics show that the lack of sewerage positively correlated with the rates of contagion and death from the pandemic. As has been

[28] Subsidized housing, usually small (about 50 m^2) and usually crammed with six or more people.
[29] Patio Bonito and Corabastos, El Rincón and Tibabuyes, Bosa Occidental and Diana Turbay, El Minuto de Dios, Alfonso López and San Francisco.
[30] In Bogotá, overcrowding deprivation is measured based on three or more people per room.
[31] For the Santiago data, a difference is made between medium overcrowding, 3.5 to 4.9 people per room, and critical overcrowding, five or more people per room.

said, the fact that a home has sewerage does not guarantee the continuity and quality of the service, so the real association with this factor may be much greater.

In sum, the available data shows a direct effect of inequity and poverty on the population due to the Covid-19 pandemic. The different dimensions of multidimensional poverty illustrate the mechanisms through which this relationship operates. The informality in employment is perhaps the most determining mechanism. Informality represents a recognized injury of neoliberalism to Latin America. It allows us to establish and track the relationships between the model's injuries and the region's vulnerability regarding Covid-19. Besides, informality can explain the inability of governments to adopt effective and sustainable policies. Evidence shows how the harms of neoliberalism, which acts through the increase in cost and segmentation of access to the education system, health, housing and essential services, has placed the population of Latin America in a position of maximum vulnerability to the pandemic.

Conclusions and recommendations

The Covid-19 pandemic reveals structural social harm in the region. The high correlations between infections and deaths that cause physical harm to the population show strong correlations with regional harms such as lack of education, exclusion from the labour market (informality), and relational harms of territorial inequality and inequity. This situation proves the systematicity of the injuries made by neoliberal societies. It also portrays that the obstacles imposed neoliberalism on human flourishing are not accidental or isolated. They respond to a cross-cutting nature of policies forged in the region under neoliberalism that would far exceed the individual responsibility.

Using spatially disaggregated data from Bogotá and Santiago, it has been possible to verify the great inequality of the population in terms of the social determinants of health and the close relationship of these determinants with the impacts of the pandemic. In these cities, the informality of activities is the most important determinant of the pandemic's differential impact. Moreover, informality partly explains the lack of sustainability of policies to fight the pandemic, such as restrictions on mobility, which had to be truncated early. There are also relevant relationships with access to health services, lack of education, overcrowding and access to drinking water. The need for comprehensive management of the measures directed at the poor population and informal workers emerges, including subsidies,

basic income, financial relief, and other sustained measures, without compliance with restrictive measures. On the contrary, additional risks of impoverishment and widening of social gaps are generated.

Education and access to timely and quality information have also fallen behind with Covid-19. The high correlations between deaths and infections by Covid-19 with educational levels show that reforms must move towards more collective and less territorially and socially segregated schemes.

Connections to be described are related, for example, to household health indebtedness rates and its consequences with informal employment. We know that where there is more poverty, the contagion rates and death from Covid-19 tend to be concentrated. Informal workers find themselves with the dichotomy of taking care of the disease or eating. The dichotomy seems to be overcome from the day-to-day survival strategy, which leaves the question of how they would face post-contagion health debts.

The indicators that were showing the decline of poverty in the region must be rethought. Informality in employment joined with the epidemic brought to light situations of marginality and social exclusion that were probably underestimated. In this sense, new methodologies and procedures should be evaluated to measure and scope informality's impacts in structuring social harms. The levels of informality exceed any reasonable planning of public policy. With current tools to focus on spending, it is impossible to establish subsidies and strategies with opportunity and equity, since this group of the population is excluded from the statistics.

The Covid-19 pandemic also leaves as a lesson at the Latin American level, the urgent need to profoundly and structurally reform our health systems. Here it will be key to retake public health objectives and reverse the transfer of collective responsibility to individual responsibility. Thus, it will be important to maintain the public infrastructure gained after Covid-19 (number of beds, equipment and medical supplies, personnel, among others) and have permanent emergency budgets capable of managing our health systems with higher levels of equity and solidarity.

All in all, a social harm reduction agenda is imperative to get out of this social and economic crisis in which we find ourselves. This agenda must emerge from the political and social will to reform how we approach and make public policies to achieve human flourishing. However, it is essential for the agenda's success that the citizen articulations that took place in Chile and Colombia in October and November 2019 be heard again. The reforms were paused after the arrival of the pandemic in Latin America, but perhaps, in view of the social harms left by Covid-19 (and those before

it), they could be pushed through democratic forms in the streets, at the desks of government officials and the polls.

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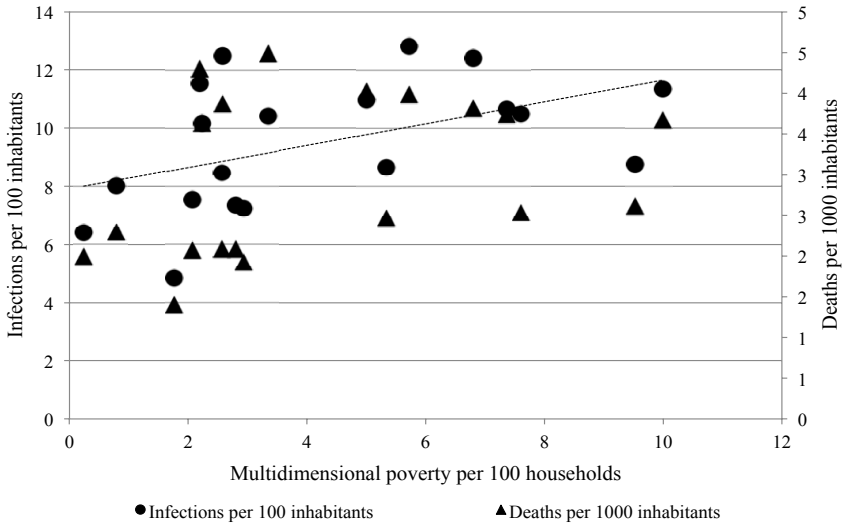
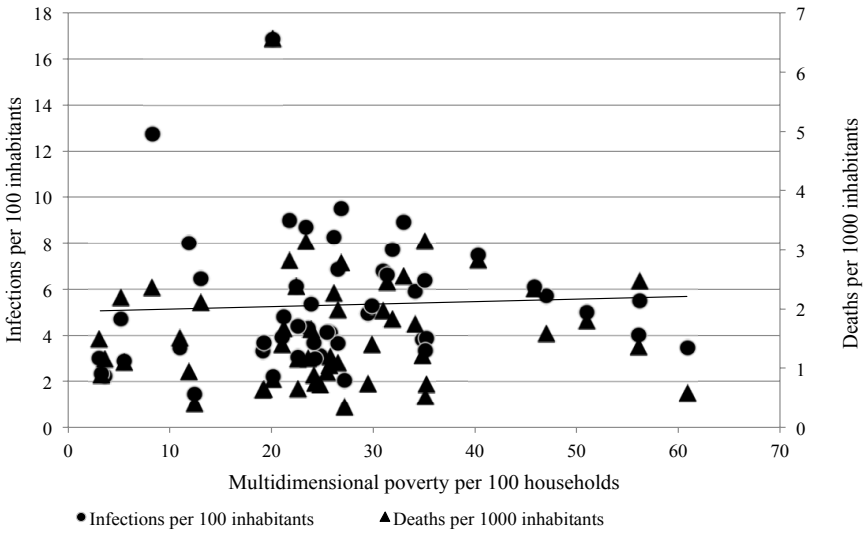
Figure 1: Association between multidimensional poverty and accumulated rates of infections and deaths by councils

Bogotá



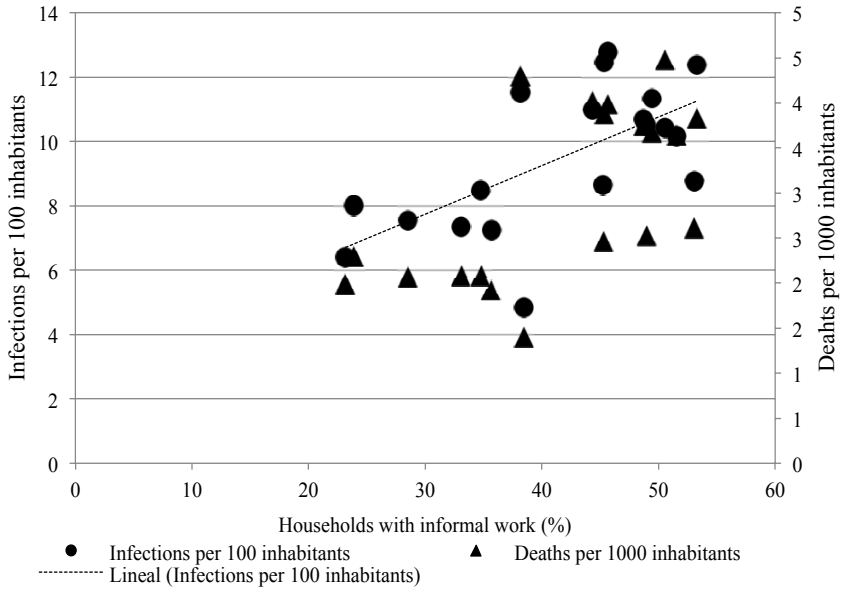
Source: DANE, Encuesta Multipropósito de Bogotá, 2017; INS, Estadísticas Covid-19.

Santiago de Chile



Source: Ministerio de Desarrollo Social. Encuesta CASEN 2017.

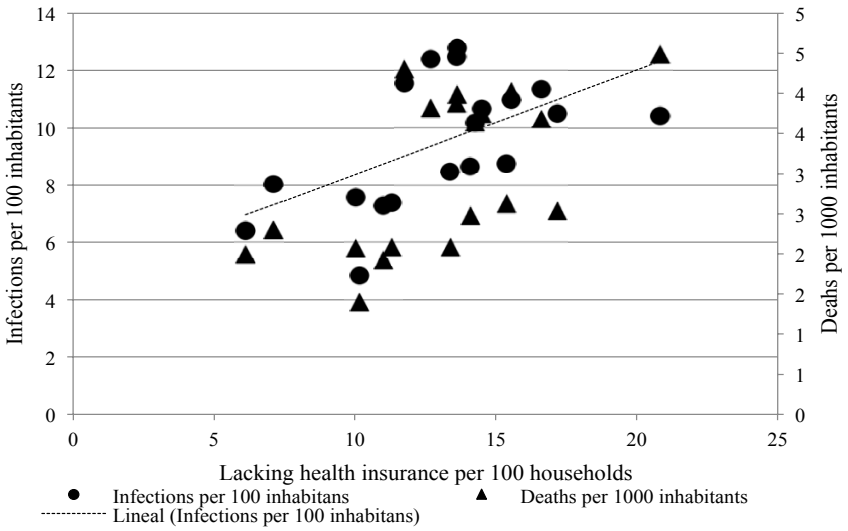
Figure 2: Association between informal work in households with accumulated rates of infections and deaths by councils (Bogotá)



Source: DANE, Encuesta Multipropósito de Bogotá, 2017; INS, Estadísticas Covid-19.

Figure 3: Association between health insurance with accumulated rates of infections and deaths by councils

Bogotá



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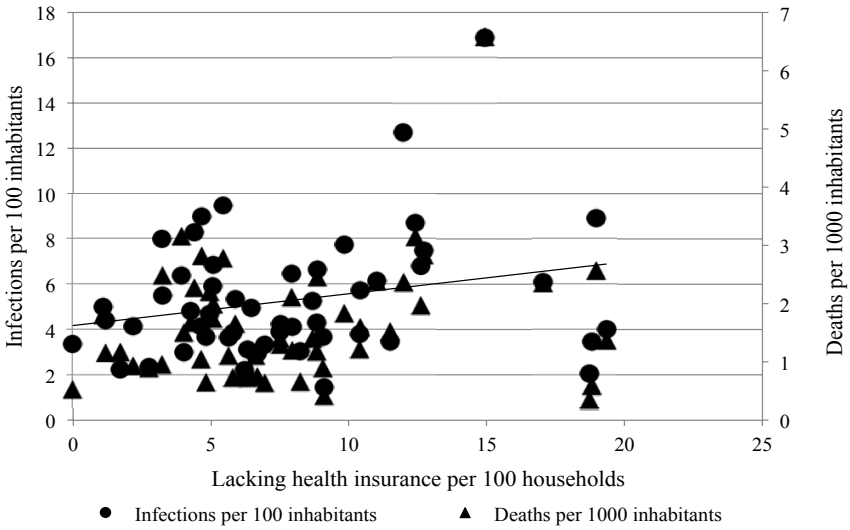
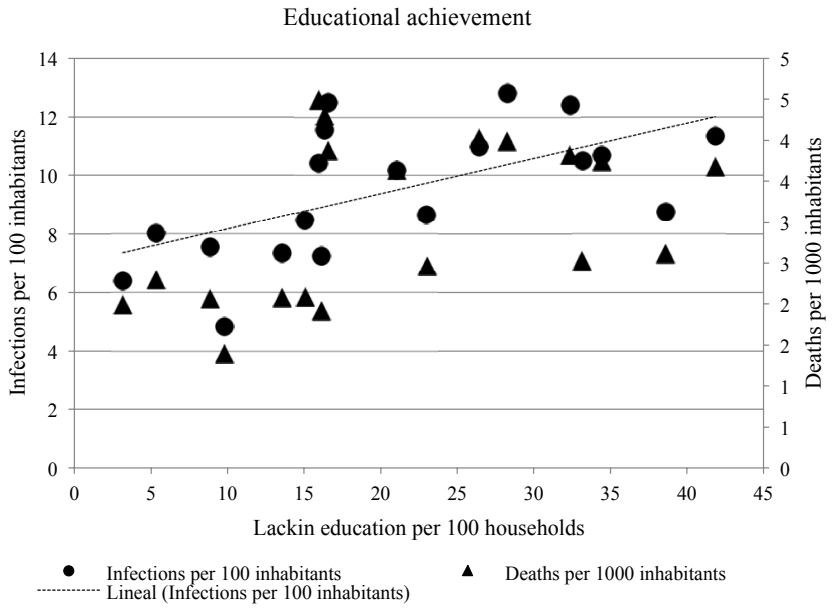
Santiago de Chile



Source: Ministerio de Desarrollo Social. Encuesta CASEN 2017.

Figure 4: Association between deficiencies in education with accumulated rates of infections and deaths by councils (Bogotá)



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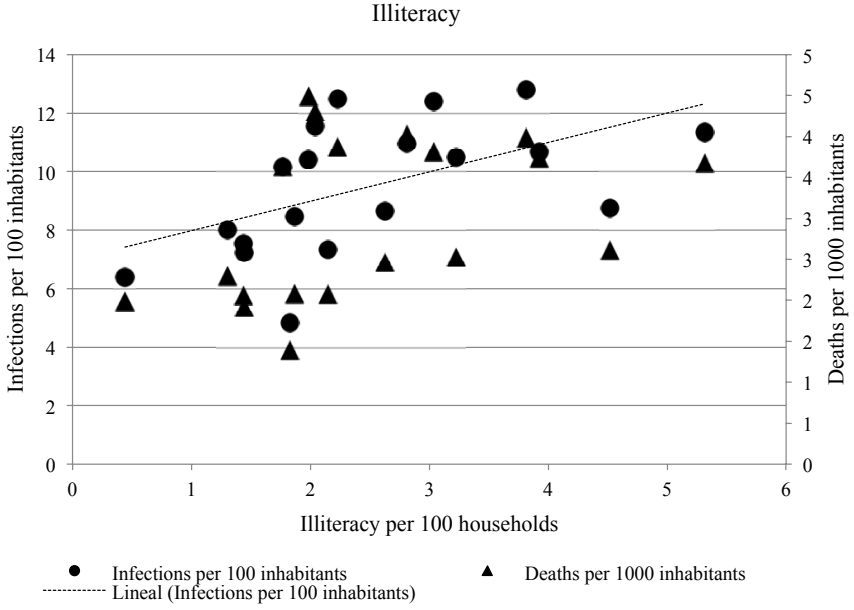
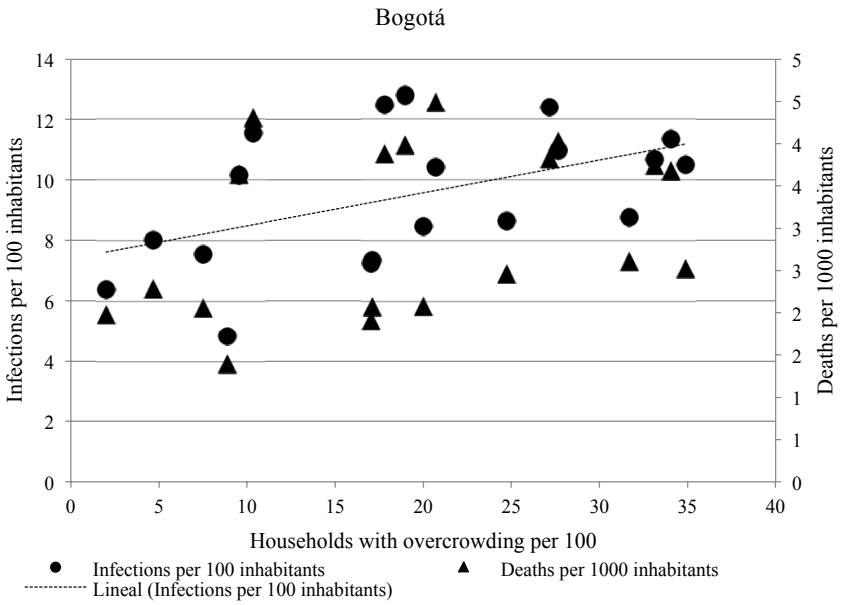
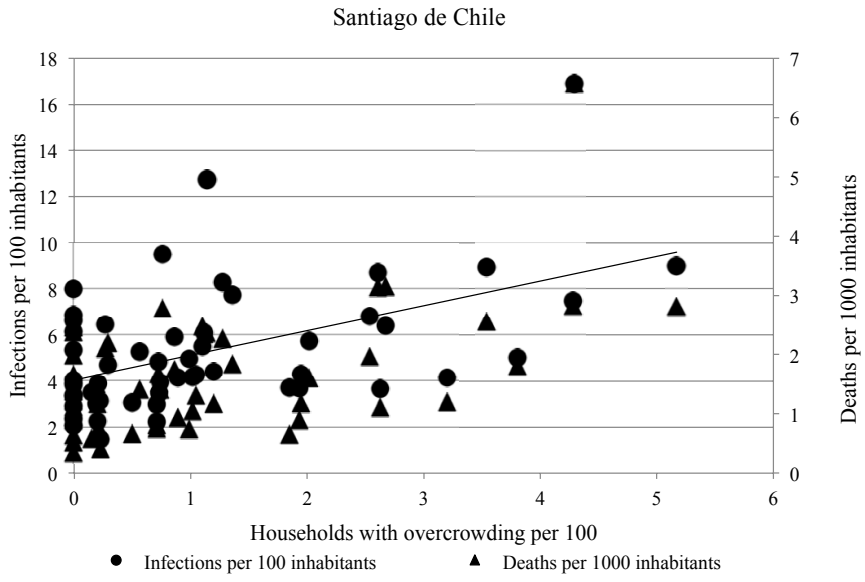


Source: DANE, Encuesta Multipropósito de Bogotá, 2017; INS, Estadísticas de Covid-19.

Figure 5: Association between household overcrowding with accumulated rates of infections and deaths by councils



Source: DANE, Encuesta Multipropósito de Bogotá, 2017; INS, Estadísticas de Covid-19.



Source: Ministerio de Desarrollo Social. Encuesta CASEN 2017.