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ORIGINAL ARTICLE

Evaluation of the Argentine government's response to COVID-19

Evaluación de la respuesta del gobierno argentino a la COVID-19

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ABSTRACT This article describes the Argentine government's response to COVID-19 and the reaction of the national political environment in order to characterize the main prevention and immunization policies implemented from 2020 to 2022 and analyze their performance by comparing excess mortality with other South American countries. This descriptive-analytical study was based on secondary sources. The results suggest that, despite an extremely adverse oppositional political environment, the Argentine government produced consensus with diverse sectors, implemented early prevention measures, expanded critical health-care capacity, planned a satisfactory immunization strategy, and extended access to information. In regional comparisons, excess mortality placed the country among the relatively successful governmental responses in the subcontinent in the 2020–2022 period. The article concludes that interjurisdictional coordination is associated with favorable health outcomes, and offers evidence toward designing policies for future Public Health emergencies.

KEYWORDS COVID-19. Health policy. Excess mortality. Program evaluation. Vaccination.

RESUMEN *Este artículo describe la respuesta del gobierno argentino a la COVID-19 y la reacción del entorno político nacional, con el objetivo de caracterizar las principales políticas de prevención e inmunización implementadas entre 2020 y 2022 y analizar su desempeño mediante la comparación del exceso de mortalidad con otros países sudamericanos. Se realizó un estudio descriptivo-analítico basado en fuentes secundarias. Los resultados sugieren que el gobierno argentino, pese a un entorno político opositor sumamente adverso, generó consensos con sectores diversos, implementó tempranamente medidas de prevención, amplió la oferta sanitaria crítica, planificó una estrategia de inmunización satisfactoria y extendió el acceso a información. En la comparación regional, el exceso de mortalidad ubicó al país entre las respuestas gubernamentales relativamente más exitosas del subcontinente durante 2020-2022. El artículo concluye que la concertación interjurisdiccional se asocia con resultados sanitarios favorables, y ofrece evidencia para el diseño de políticas ante futuras emergencias sanitarias.*

PALABRAS CLAVE *COVID-19. Política de salud. Exceso de mortalidad. Evaluación de programas y proyectos de salud. Vacunación.*

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Introduction

This article examines the Argentine government's response to COVID-19 and the reaction of the national political environment in order to characterize the main prevention and immunization policies implemented from 2020 to 2022 and analyze their outcomes by comparing excess mortality with other South American countries. It does not seek, however, to attribute direct causality between policies and outcomes, but rather to provide input for an informed public debate on what was done, which debates occurred regarding possible alternatives, and which health outcomes Argentina recorded during that period.

Methodologically, this descriptive-analytical study was based on secondary sources. The regional comparison of excess mortality was developed from official publications issued by each country included in the analysis.

The prior context limited the Argentine government's capacity to respond to COVID-19. The administration that ended in December 2019 left the country facing unprecedented difficulties in domestic and external financing and a deep economic recession, compounded by decreased public spending that affected the State's institutional capacities, particularly in health policies. Thus, the consequences of the pandemic accrued to an already alarming socioeconomic situation.

These problems were compounded by the characteristics of a federal system of government and a highly fragmented health system marked by major inequities, as well as by the difficulties inherent in a strongly polarized political system, in which obstructive attitudes marked their presence in a significant sector of the opposition to the national government.

Nevertheless, Argentina's response was distinguished by the speed of its initial measures, sustained federal coordination, consultation with stakeholders in the health system and the scientific community, open publication of information, an unprecedented expansion of access to intensive care, and a mass immunization campaign with a diversity of vaccines and high coverage.

Materials and methods

This article summarizes the results of an observational, descriptive-analytical, cross-sectional study that integrates a historiographic reconstruction of national and federal policies; an analysis of installed capacity and the expansion of intensive care units; a characterization of the immunization campaign; and a regional comparison of annual excess mortality adjusted by population. This was complemented by triangulation of documentary sources from publications issued by the ministries of health or national statistics institutes of each country: Argentina (Directorate of Health Statistics and Information-DEIS)[1], Bolivia (National Institute of Statistics-INE)[2], Brazil (Mortality Information System of the Department of Informatics of the Unified Health System-SIM-DataSUS)[3], Chile (National Institute of Statistics-INE)[4], Colombia (National Administrative Department of Statistics-DANE)[5], Ecuador (National Institute of Statistics and Censuses-INEC)[6], Paraguay (National Institute of Statistics-INE)[7], Peru (National Institute of Statistics and Informatics-INEI)[8], and Uruguay (Department of Vital Statistics of the Ministry of Public Health-DEV-MSP)[9]. Venezuela has not yet published complete official data on the number of deaths during the period. For the purposes of estimating regional data as a whole, Venezuela's values were estimated on the basis of Datosmacro and Our World in Data (OWID).

The 2020-2022 period was used to compare mortality, during which differences in the number of deaths could be attributed mainly to the pandemic. The last year with available data was 2023 and was also added to the analysis to verify the validity of the criterion used to identify the study period. The calculations were performed by comparing, in each country, the percentage variation for each year against the number of deaths recorded in 2019. This criterion underestimates the slight upward trend in mortality that South American countries had been showing in the preceding years.

The indicator 'excess mortality' better reflects the effectiveness of the health system in confronting the pandemic than the more frequently used indicator, 'COVID-19 mortality', not only because of possible underreporting in the latter, but also because the former incorporates the indirect effects of the pandemic, such as the lack of care for other diseases or deaths from external causes.

Results and discussion

The pre-pandemic context

On December 10, 2019, Alberto Fernández took office as President of the Argentine Nation after defeating his predecessor, Mauricio Macri, in the elections. The economic and social crisis had deteriorated in the second half of 2019, which explains some of the main difficulties the government had to face in responding to the pandemic: the percentage of people living in poverty rose from 26% in the second half of 2017 to 36% two years later[10]; the year-on-year variation in the Consumer Price Index (CPI) increased from 25% to 52% between December 2017 and November 2019[11]; in particular, the year-on-year variation in the CPI Health component reached 72% in November 2019; the price of the ten most dispensed prescription-only medicines in Argentina increased between December 2015 and December 2019 by more than twice the average remuneration in the private sector[12]. In addition, while other governments managed to draw on preexisting countercyclical funds – such as Chile – or on domestic or external borrowing, the Macri administration had exhausted the national State's ability to take on debt, having increased total gross external debt in four years from US$149 billion to US$228 billion, and national government debt from US$70 billion to US$124 billion: a 78% increase[13].

In 2018, the National Ministry of Health (MSAL) had been downgraded to a 'Secretariat of State', and several of its main programs were severely underfunded, especially those aimed at the most vulnerable population[14]. MSAL's accrued expenditure as a share of total national State expenditure represented 2.4% in 2015; it fell to 2.0% in 2016 and 2017; it declined to 1.5% in 2018, partly because the program 'Medical Care for Beneficiaries of Noncontributory Pensions' was no longer hierarchically under MSAL; and in 2019 it fell to 0.8% of total national public expenditure[15]: a 75% decrease in four years.

The reduction in spending directed toward the lowest-income population was particularly relevant. For example, expenditure on 'Family and Community Health Strategies' fell from 6 per thousand to 1 per thousand of total public expenditure from 2015 to 2019; and the Remediar program, which guarantees free access to essential medicines for people without social security health coverage, recorded a 53% decrease from 2015 to 2019[16]. In September 2019, health ministers from 14 provinces signed a document demanding that the National Government assume "its responsibility" in the face of the "abandonment" of national programs; the lack of provision of "milk, vaccines, medicines, supplies, oncology drugs, reagents, antiretrovirals, among others"; coverage for people with disabilities; and the "explosive increase in medicine prices"[17].

Among other undesirable effects of this austerity policy, from 2015 to 2019, the Infant Mortality Rate decreased by only 5%, the worst performance since 1983. These were the conditions under which the new government had to confront the challenges of the pandemic.

Health policy priorities

Immediately after taking office, President Fernández restored the Ministry of Health to ministerial rank and established its priorities: stewardship of the health system, federalism, and social consensus-building (*table 1*); integration of health subsystems (*table 2*); expansion of rights; and health workforce planning (*table 3*).

Table 1. Policies governing the health system of the Argentine government

Reinstatement and expansion of programs dismantled by the previous administration, targeting the most vulnerable populations;
Reestablishment of the Federal Health Council (COFESA) as the governing body of the system;
Restoration of the operational and regulatory capacity of the National Administration of Laboratories and Health Institutes (ANLIS) and the National Administration of Drugs, Food and Medical Technology (ANMAT), which played a crucial role during the pandemic;
Strengthening of policies on gender and diversity, sexual and reproductive health, vector-borne diseases, non-communicable diseases, and mental health;
A significant increase in transfers to the provinces, which were allocated, among other things, to the strategic purchase of health services for the population with exclusive public coverage, which later included hospitalizations for COVID-19.

Source: Prepared by the authors.

Table 2. Actions of the Argentine government for the integration of health subsystems

Coordination of resources for testing, care, treatment, and hospitalization to strengthen equitable access for the entire population;
Addition of 4,026 Intensive Care Unit (ICU) beds in 2020, representing a 46% increase in the installed capacity of the entire healthcare system;
Centralization of the purchase of ventilators and a temporary ban on their export to ensure rational and equitable distribution;
Coordinated management of resources between the public, private, and social security sectors for monitoring critical hospitalization resources, allowing real-time access to the level and evolution of ICU bed occupancy in every healthcare facility in the country, identifying those operating at maximum capacity and those that could receive new patients;
Equipping all provinces with portable sequencers and thermocyclers, developing genomic sequencing capacity.

Source: Prepared by the authors.

Table 3. Human talent policies of the Argentine government during the pandemic

Rapid implementation of biosafety measures for healthcare facilities;
Provision of supplies and personal protective equipment to reduce the number of healthcare workers infected with COVID-19;
Comprehensive training for tens of thousands of nursing professionals;
Creation of continuing education opportunities with specific thematic and epidemiological focus in the workplace.

Source: Prepared by the authors.

Table 4. Actions of the Argentine government at the beginning of the pandemic

Ongoing consultation with the 23 provinces and the Government of the Autonomous City of Buenos Aires (CABA) for decision-making and technical cooperation;
Holding COFESA meetings at least weekly during the pandemic;
Numerous trips by national government authorities and professionals to all provinces;
Implementation of the vast majority of prevention and immunization measures with the full political and technical agreement of all jurisdictions and respecting the recommendations of the National Immunization Commission (CoNaIn);

Table 4. Actions of the Argentine government at the beginning of the pandemic

Collaborative work in intersectoral coordination groups that included national and provincial social security organizations, private health insurance companies, private healthcare provider associations, and representatives of key supply producers;
Frequent consultations with organizations and committees of specialists and representatives of scientific societies and patient associations;
Immediate publication of health information, prioritizing the use of open formats;
Extraordinary payments to 665,000 health workers in the public, private and social security sectors dedicated to managing cases related to the pandemic.

Source: Prepared by the authors.

With regard to the expanded rights, although it was not decisive for pandemic management, several initiatives stood out: support for the enactment of laws such as the Law on Access to Voluntary Termination of Pregnancy (IVE); the creation of the 'Thousand Days Plan' for the comprehensive protection of the health of pregnant persons and of children in the first three years of life; the increased provision of essential medicines; deinstitutionalized mental health; and the expansion of sexual health programs, which favored a sharp decline in adolescent fertility.

Pandemic management

The Argentine government rapidly adopted prevention measures aimed at mitigating the consequences of a fragmented and decentralized health system (*table 4*). MSAL coordinated critical resources and prepared the system for the prevention and care of COVID-19. To this end, priority was given to the public sector and to lower-resource regions to achieve unprecedented levels of quality and equity in access to care[18]. In the first months of 2020, the national government's actions focused on measures to prevent transmission, strengthen the health system, and mitigate the economic and social impact of the pandemic.

The MSAL organized several preparedness measures before the first positive cases of COVID-19 arrived in the country, such as restoring the capacity of ANLIS and the laboratory network, controls at traveler entry points, preparation of hospital emergency departments, and expansion of ICUs. ANLIS played a central role in SARS-CoV-2 diagnostics, training, decentralization, equipment, supplies, and validation of techniques, diagnostic kits, and biosafety cabinets.

It promoted scientific development and technology transfer to the public and private sectors. It also initiated a change in the organizational paradigm through relationships with provinces and municipalities, international organizations, and peer institutions in other countries; with the national and international science, technology, and innovation sector; and with universities and the private productive sector. More than 130 laboratories were incorporated into the National Respiratory Virus Network with sample-processing capacity.

From the start of the pandemic, ANLIS decentralized testing and trained all jurisdictions so that they could perform diagnostics, avoid overloading daily testing capacity, and guarantee coverage throughout the national territory. It also achieved whole-genome sequencing of the SARS-CoV-2 variants that circulated in Argentina, which ensured diagnosis, complemented epidemiological surveillance, and contributed to the development of a representative vaccine.

At ANMAT, the review of the regulatory framework helped prevent the health system from collapsing and avoided shortages of critical supplies. ANMAT also created multidisciplinary teams for the manufacture of products needed to confront the pandemic,

streamlining procedures and administrative processes. Argentina, together with Brazil, was selected by Pan American Health Organization (PAHO-WHO) to participate in the regional platform for the production of mRNA vaccines and other health technologies for COVID-19.

As in the rest of the world, the Argentine government, in agreement with all provinces and the Autonomous City of Buenos Aires (CABA), imposed restrictions on movement and interpersonal contact to mitigate the spread of COVID-19 and create the time needed to strengthen the health system. To guarantee the functioning of essential activities – such as access to food and medicines – several exceptional measures were issued and updated in each region or locality according to the epidemiological and health situation. These measures resulted from an unprecedented consensus among the different State levels, through collaborative work with all provinces and their municipalities. This is particularly noteworthy in a federal system of government in which subnational authorities come from different political parties, compounded by the particular situation of increasing hostility observed in Argentine party politics in recent decades.

The health policies implemented prevented ICU beds from becoming saturated through a dual strategy consisting of prevention measures and an increase in the number of beds. In previous winters, shortages of beds in public facilities had been repeatedly reported, and the mass media frequently published photographs of patients treated in hallways. Argentina went from 18.8 adult ICU beds per 100,000 inhabitants in 2019 to 27.5 in 2020, one of the highest values in the region, and the share corresponding to the public subsystem increased from 28% to 40%, thereby balancing its participation in the health system: according to the 2022 Census, 39% of the population had no social security health insurance or prepaid private coverage[19].

MSAL promoted the reconversion of the textile industry to produce personal protective equipment and encouraged the production of ventilators; moreover, it purchased and distributed ultrasound machines, infusion pumps, monitors, defibrillators, oximeters, supplies, and personal protective equipment. In 2020, 12 Modular Emergency Hospitals were built, adding 874 beds in densely populated areas, and 1,289 volunteer professionals in Internal Medicine, Cardiology, Pulmonology, Adult and Pediatric Intensive Care, Emergency Medicine, Pediatrics, and General or Family Medicine were sent to the most underserved provinces[18].

MSAL authorities negotiated with the different companies and countries developing COVID-19 vaccines. On December 29, 2020, health personnel at the highest exposure level began to be vaccinated. Logistical, equipment, and training preparations had begun months earlier: 150 professionals traveled to the 24 jurisdictions for this purpose. MSAL prepared a georeferenced registry of vaccination centers according to population concentration.

Given the gradual availability of vaccines, linked to global scale-up and production difficulties, priority criteria were agreed upon with all provinces. It was the largest immunization campaign in the country's history, organized with unprecedented speed. "By the last day of 2021, 90% of the population over 50 years of age had completed the vaccination schedule, and more than 5 million people had received their third dose"[20], far exceeding the target proposed by WHO.

Mass vaccination entailed the ongoing study of the safety of each vaccine and of the combination of different brands; the analysis of events attributable to vaccination; and the adaptation of information systems so that they could support the data load. For the first time, the entire vaccinated population was nominally registered, which made it possible to issue a national vaccination certificate that facilitated local and international mobility.

Finally, with the objective of coordinating the capacities of the scientific and technological system, national technological developments and innovations were promoted as

soon as the pandemic began. These included two serological kits and three molecular virus detection kits; a hyperimmune therapeutic serum; antiviral fabrics for face masks; and regulation of the use of plasma from recovered patients for therapeutic purposes.

The disinformation pandemic

The Argentine government's health decisions were strongly criticized by a sector of the political opposition and the mass media. In particular, a sector of the opposition with strong media presence proposed eliminating restrictions on movement and replacing them with 'active case-finding' and specific protection for 'risk groups'. These were not isolated attitudes held by minority groups. Among others, the public criticisms made by President Fernández's predecessor and successor – Macri and Javier Milei – stood out.

Supposedly, these alternative measures would have been more similar to those adopted in other countries of the region whose management was considered exemplary, although they were not grounded in comparative studies or in evidence validated through any scientific method. As will be shown below, they often assumed a false premise: that Argentina conducted fewer diagnostic tests than other countries in the region. Nor did these critical statements clearly explain how such specific protection could have been implemented in a country with Argentina's geographic and demographic characteristics, much less could they be justified by the health outcomes that one strategy or another would have produced.

These actions contributed to reducing adherence by part of the population to prevention policies, making it reasonable to assume that they may have been concurrent causes in a fraction of the deaths that occurred during the pandemic. This contrasts, for example, with Chile's experience, where the national government implemented similar restrictions and did not receive comparable criticism. In fact, some analysts argued that countries with strong political polarization "handle the pandemic worst"[21].

In Argentina, a large amount of false news circulated regarding the effectiveness of MSAL's management. Some was disseminated by the mass media, while other false news circulated through virtual social networks. Its broad dissemination coincided with an increase in the negative opinion of one sector of the population regarding the effectiveness of prevention measures, as well as with a decrease in adherence by that same sector to those health measures. The greatest noncompliance was observed among young people.

One example was the lobbying of some opposition leaders in favor of Pfizer, which included an unprecedented campaign to discredit vaccines from other laboratories whose only peculiarity was that they had supplied the Argentine State with vaccines that competed with Pfizer's, even though Pfizer itself publicly stated that it did not have the capacity to supply all the vaccines in the quantities and time frames required by the Argentine population.

False news operated in favor of interests associated with what PAHO has called an 'infodemic'[22]. In Argentina, health system management could not remain outside the field of political competition, which led the entire health system into a state of dependence and weakening because of the conjunctural dispute among partisan interests. Several false news stories were widely disseminated in the mass media. The purpose of this text is not to describe the extent to which these communications were erroneous or malicious: we have analyzed them in detail in other works[23], although political leaders and media outlets continue to repeat them even in 2026. We will refer only to those that may have had possible consequences for health outcomes.

For example, several media outlets and political leaders claimed that there were 'ideological affinities' in the purchase of the Sputnik V vaccine, which supposedly was not sufficiently safe or effective. If the Argentine

case is compared with that of two other governments in the region that reflected a different ideology, the website ourworldindata.org (OWID) shows Chile's preference for Sinovac (65%) and Brazil's preference for Pfizer (50%). No opposition leader accused Sebastián Piñera of having ideological affinity with the Chinese Communist Party. The same can be said of the United States and European countries: in most of them, more than 90% of the vaccines purchased were from one or two brands. As of December 31, 2022, according to OWID, 26% of the vaccines administered in Argentina corresponded to Sinopharm; 24% to Oxford/AstraZeneca; 18% to Sputnik V; 17% to Pfizer/BioNTech; 14% to Moderna; and 1% to CanSino. It would be imprudent to infer the existence of ideological bias from these percentages.

Another misinformative topic posits a supposed insufficiency in the number of diagnostic tests performed, for example, in comparison with Chile. The OWID website records that, during the pandemic, an average of 1.9 tests per person were performed in Chile, whereas this value was 0.8 per person in Argentina. However, it is challenging to estimate the actual number of tests performed because, for several months in Argentina, most negative test results were not entered into the system. This can be verified by comparing test positivity, which in Argentina was, on average, 2.5 times higher than in Chile. Given that both countries had relatively similar mortality and case-fatality rates, this difference in positivity is explained by the fact that the actual number of tests performed in Argentina was far higher than the number recorded in the databases.

It was also claimed that the Argentine government imposed 'the longest quarantine in the world', which conceals the fact that, 22 days after the first restrictions began, a gradual process of reopening started according to the epidemiological and health risk of each region, and provincial governments were authorized to establish exceptions. Thus, it is concealed that other countries taken as 'models to mimic' had, at several points, more stringent restrictions. Furthermore, reference is often made to a supposed greater harm caused by this 'quarantine' to productive activity in Argentina than in other countries, omitting the cumulative effects of the health and economic crisis in which the country had already been immersed since 2018, and failing to note that economic activity deteriorated even in countries where there was little or no national coordination in pandemic management.

The prevention measures adopted by the national government were dynamic, responding to the evolution of infections and to scientific input, and initially had a high level of social consensus and compliance, despite specific protests involving opposition leaders that were widely covered by the mass media. By late 2020, an increasing level of noncompliance with prevention measures was observed. It would be hard to determine the extent to which this was due to involuntary exhaustion among the population, economic difficulties, or hostility from opposition leaders and media outlets. From 2021 onward, as vaccines began to arrive, the health strategy combined decreasing restrictions on movement with an increasing scheme of mass immunization.

COVID-19 mortality

A final widely disseminated false news story is the claim that pandemic management in Argentina failed because it supposedly generated high mortality: there are political leaders who still mention the figure of 130,000 deaths as if it were sufficient proof of supposedly poor health management. A more reasonable way to evaluate it is to compare the mortality rate with other countries in the region, since this relates the figure to each country's number of inhabitants. According to OWID, by the end of 2022, Argentina's COVID-19 mortality rate was exceeded by more than 10% by that of the United States, Great Britain, Chile, or Brazil, countries that at different points during the pandemic were considered 'models' by opposition leaders.

However, it is possible to consider the argument that the pandemic generated not only direct deaths from COVID-19 but also indirect deaths, which should be considered for a more complete assessment of government responses. The journal 'The Lancet' published in 2024 an article with global estimates of COVID-19 mortality in 204 countries and territories and 811 subnational locations, using 22,223 data sources from civil registration, samples, surveys, censuses, and other sources[24].

Excess mortality was defined as all-cause mortality minus the mortality that would have been expected if the pandemic had not occurred, according to historical trends. This difference in deaths is attributed to the pandemic as a whole, both due to SARS-CoV-2 infection and to other factors. Whereas worldwide excess mortality in 2020 and 2021 was estimated at 104 per 100,000 inhabitants, in Argentina the value was lower: 85, equal to the figure for Western Europe as a whole and even exceeded by 'high-income' countries.

In Latin America and the Caribbean, there was an excess of 199 deaths per 100,000 inhabitants, more than twice the figure in Argentina. Although some high-income countries showed optimal results in this indicator, others exceeded Argentina in excess mortality: the United States (159), Italy (138), Portugal (105), Spain (103), Great Britain (102), Canada (95), and the Netherlands (92). In Latin America, the best results were observed in Uruguay (49), Costa Rica (74), and Panama (81). The following countries showed higher excess mortality than Argentina: Chile (103), Paraguay (111), Brazil (136), Colombia (170), Venezuela (222), Ecuador (258), Mexico (261), Cuba (265), Bolivia (419), and Peru (427).

The study concludes by emphasizing that mortality during the pandemic was not associated solely with each country's level of development, since 'vaccination efforts, public policies, and changes in individual behavior influenced the severity of the pandemic in all countries and territories'.

Finally, these estimates are consistent with official data from the governments of countries in the region, including 2022 and 2023, for which data are already available, except in Venezuela and Paraguay. According to the vital statistics of South American countries, the annual average excess mortality during the 2020-2022 period was 24% relative to 2019.

However, although the pandemic was already considered to have been overcome in 2023, that year, excess mortality in the region was 10% relative to the same base year, 2019, indicating that pre-pandemic health outcomes had not yet been recovered. The calculation was performed by comparing the average percentage variation for each year with the number of deaths recorded in 2019.

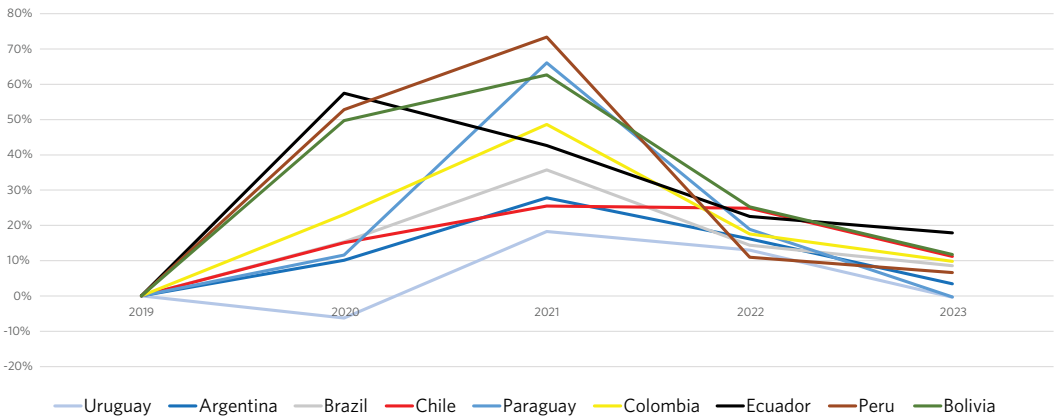
In 2019, 2.6 million people died in South America, and the annual average number of deaths between 2020 and 2022 was 3.2 million, representing an average difference of 630,000 deaths per year that could be attributable directly or indirectly to the pandemic, either because the cause was COVID-19 – identified or not – or because there was some other pandemic-related cause, such as lack of access to medical care for other diseases or accidents.

In this regard, the excess mortality indicator appears to better reflect the effectiveness of the health system in response to the pandemic than the COVID-19 mortality variable, not only because of possible underreporting, but also because of the indirect effects of the pandemic. In 2023, the last year for which official statistics are available in most countries of the region, the total number of deaths was estimated at 2,855,000, which would represent approximately 260,000 more deaths than in 2019. Population growth also affects this increase, but only to a limited extent.

In any case, excess mortality during the pandemic years showed strong variation across countries. As *graph 1* shows, if Venezuela is excluded because of lack of data, the South American country with the lowest excess mortality in the 2020-2022 period was Uruguay, with an annual average of only 8%, followed

by Argentina (18%), Chile and Brazil (22%), Colombia (30%), Paraguay (32%), Ecuador (41%), and Peru and Bolivia (46%). The order of results across countries hardly changes if the 2023 mortality data are included in this comparison, although there were relevant differences among some of them: still using 2019 as the base year, in 2023, the South American countries with the lowest excess mortality were Uruguay and Paraguay (0%), Argentina (3%), Peru (7%), Brazil (9%), Colombia (10%), Chile (11%), Bolivia (12%), and Ecuador (18%).

Graph 1. Excess mortality in South American countries, 2019-2023



Source: Prepared by the authors based on vital statistics from official sources of Argentina (DEIS)[1], Bolivia (INE)[2], Brazil (SIM-DataSUS)[3], Chile (INE)[4], Colombia (DANE)[5], Ecuador (INEC)[6], Paraguay (INE)[7], Peru (INEI)[8], and Uruguay (DEV-MSP)[9].

Conclusions

A review of the policies implemented by the Argentine government during the pandemic and of the health outcomes obtained will streamline the response of future governments to events of similar severity. In this regard, it is challenging to estimate the extent to which health outcomes may have been affected by the fact that the Argentine government's pandemic management began in the context of an economic and social crisis and was subsequently shaped by partisan disputes. It will be particularly cumbersome to determine the extent to which the harassment suffered by health authorities and the systematic questioning of their decisions led to greater noncompliance with prevention measures and, consequently, to a greater number of hospitalizations and deaths.

However, there is sufficient evidence to dismiss most of the criticisms formulated in this regard by leaders of the political and media opposition. Subjecting these criticisms to verification against validated and available data is relevant because they continue to be repeated even today without minimally reasonable corrections, more than five years after the start of the pandemic. This is not merely a historiographic review, since the lessons

learned from the COVID-19 pandemic will enable us to address future health crises more effectively, and it is hard to fully understand those lessons if misinformed or fallacious opinions continue to be repeated.

Author contributions

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