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Weekly Editorial Analysis (WEA)

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Note -

- **The Newspaper clippings pasted in PDF are important from Mains point of view as it contains the fodder material for Mains Answer Writing.**
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Covers in DND

- Interpretations which impede a just social order
- A collage of laws that leaves the worker out in the cold
- Unwarranted arrest
- The Biden push-button to West Asia's diplomatic resets

1. Using all options

- Enabling other manufacturers to produce Covaxin is a necessary step

✓ It is now clear that universal and swift vaccination is the only way out to mitigate the effects of the pandemic.

✓ But with only 3% and 10.4% of the total population estimated to have taken the **second and a single dose,** respectively

Reason for low vaccination

- Supply constraints in delivering the only two vaccines available to Indians so far — Covishield and Covaxin — (the Russian-developed Sputnik V vaccine has just been deployed) are one of the reasons why the pace of vaccination has fallen.
- While the manufacturers have promised an augmentation in production capacity, the dependence on them till other vaccines, including those from abroad, are made available over the long term, will remain a constraint in the pace of vaccination and **expose much of the population to the possibility of infection.**
- India has rightly sought (along with South Africa) a temporary waiver of provisions in the TRIPS Agreement to facilitate universal access to COVID-19 vaccines. But the Centre has **done nothing to bring vaccines and medicines under a statutory regime** in India to allow for wider availability and a diversity of options.
- In fact, the Centre's submission to the Supreme Court that the "exercise of statutory powers... under the Patents Act, 1970... can only prove to be counter-productive at this stage", is clearly contradictory to its international position for a temporary waiver in the TRIPS Agreement.

Patent act 1970

- The Agreement allows exceptions to the rights of patent owners by grant of compulsory licences.
- **Section 100** of the Patents Act, 1970, allows the Centre to license specific companies to manufacture the vaccines **Section 92** of the Act allows the Centre to issue a compulsory licence in circumstances of a national or an extreme emergency.
- Considering the impact of the second wave, the daily toll and the high case load, the Centre **should revisit its rigid and contradictory stance on the issue of compulsory licensing** that would allow the manufacture of vaccines and important drugs without the consent of the patent holder.

- In the case of Bharat Biotech's Covaxin (developed in collaboration with the publicly funded **ICMR) , The ICMR can license other public sector vaccine manufacturers** to help augment its supply over the medium term.
- As of now, two central PSUs, Indian Immunologicals Ltd and BIBCOL, have already entered into a technology transfer agreement with Bharat Biotech, besides the Haffkine Bio- pharmaceutical Corporation based in Mumbai.
- Other manufacturers can also re-purpose their plants to produce the vaccine.

2. Counting the COVID toll in India (18)

- There are many challenges in estimating deaths due to COVID-19 in India.
- Since direct counting of COVID-deaths is problematic, the approach most commonly used is the **"excess" death approach** which attributes all deaths beyond what is considered "normal" for that area and time to COVID-19.
- It includes deaths directly caused by COVID-19 as well as deaths indirectly caused due to the impact on access to care for other diseases during the pandemic and the lockdown.

Global estimates released

- Based on the **World Mortality Dataset** — the largest international dataset of all-cause mortality encompassing 89 countries — researchers **estimated excess mortality** and reported that it **exceeded the number of reported COVID-19** deaths in these **countries by over 1.6 times.**
- It also said that this ratio is likely to be conservative as undercounting is likely to be much higher in countries which are not part of this dataset .
- The Institute for Health Metrics and Evaluation (IHME), a global leader in this area, recently **released its estimates** that put the global toll of COVID-19 deaths by **May 3, 2021 at 6.93 million,** a figure that is more than **two times higher than the reported number of deaths of 3.24 million.**
- India accounted for about 10% of them at 6,54,395 (only second to the United States with an estimated 0.9 million) which is about **three times higher than the reported official figure.**
- The lower number of reported deaths does not imply undercounting, deliberate or otherwise.
- Even **if there had been no underreporting of COVID** deaths in a country, this ratio **is likely to be above one as excess deaths include not only those that are directly** caused by COVID-19 and likely to be reported but also those where **deaths occurred due to other diseases,** either due to a lack of care or as a consequence of COVID-19. It is very difficult to tease out these proportions. We might have a better sense if we look at cause-specific deaths. But that kind of data is still more difficult to get.

WHO classification

- The World Health Organization classifies countries into three categories based on their data availability for COVID-19 excess death estimation.

  ✓First are those countries that have **good data available and excess death estimation** is possible (most countries in the above mortality dataset).

✓ Second is the group of countries whose **data, though not good, is acceptable** for use through some process of harmonisation or adjustment for incompleteness

✓ Third category of countries where the **data on deaths are not available or usable**

- India and China, which together constitute a third of the world population, are currently in **category three,** and unless we manage to provide some source of usable data, India will have to be content with an estimate generated by an external agency using an indirect approach.

Data for India

- Data from **Kerala,** which is among the States with a very good vital registration system, showed that there has been a decline in deaths in 2020 as compared to previous years . While it will need a closer look, under-registration of all deaths due to the pandemic is a possibility.
- Data released by the Municipal Corporation of Greater **Mumbai,** shows 22% excess deaths during 2020 in Mumbai region .
- An analysis of data from a panel of 2,32,000 households maintained by the Centre for Monitoring Indian Economy Pvt Ltd (CMIE) found that deaths from all causes between May and August 2020 numbered almost twice as many as compared with the same period in past years .
- Estimation of excess deaths needs a more sophisticated statistical approach which first defines a baseline, before estimating excess.
- The simplest approach for defining a baseline would be estimation of mean and standard error based on data for the last five years to provide a plausible range for a baseline.
- We could then see whether the registered deaths are beyond that range to estimate “excess” deaths.
- There are other statistical approaches which use different data distribution assumptions to define a baseline.
- This analysis should be done by age and sex on a weekly or monthly basis and correlated to the peaks of the epidemic.
- Combining data at higher levels is likely to lead to errors in estimation. A district-wise estimation is our best bet to arrive at a national estimate.
- An assessment of the quality of CRS data should enable us to identify districts with an acceptable quality of registration and generate estimates for them.
- For districts which lack an acceptable quality of registration, we could use alternative approaches.
- We are seeking access to the CRS dataset from the authorities and are hopeful of being able to generate national estimates in the next few months.

A continuing process

- Our experience with an estimation of deaths in past influenza pandemics shows that different agencies come up with different estimates which leads to confusion among policy makers and the public. The long-term way out for countries is to address the data limitations while academics work on refining their approaches.
- There will be more estimates of COVID deaths in the near future and the numbers will keep changing till some sort of a consensus emerges.

- However, putting up a number which is contested and debated is still good as it propels people to improve that estimate.
- The second wave has been deadlier, and undercounting is more likely to have occurred as the pandemic has spread to rural areas, and when access to testing has been adversely affected and many deaths are occurring outside hospitals. Refining our approaches using the first wave in 2020 would enable a much better estimation of the deaths in subsequent waves.

3. No learning from the Spanish flu (18)

- In the beginning of COVID-19 last year, thousands of people around the world shared an image on social media depicting the three waves of the 1918 influenza pandemic, commonly known as the Spanish flu.
- The image had the headline, 'Humanity should never allow a repeat of the same mistake made in 1918, in the time of COVID-19'. The image read, "The most severe pandemic in history was the Spanish Flu of 1918.
- It lasted for 2 years, in 3 waves, with 500 million people infected and 50 million deaths. Most of the fatalities happened in the 2nd wave.
- The people felt so bad about the quarantine and social distancing measures that when they were first lifted, the people rejoiced in the streets with abandon. In the coming weeks, the 2nd wave occurred, with tens of millions dead."

Lessons from the past

- This shows that we haven't been able to learn from history to prevent millions of infections and deaths worldwide.
- One would believe that knowledge makes one wiser. But in reality, knowledge doesn't change behaviour.
- Knowing about the Spanish flu is very different from having to live through a similar pandemic.
- Knowing about masks being protective doesn't make people wear them.
- Knowing about social distancing doesn't make people practise it.
- In most countries, people got **tired of lockdowns,** wearing masks, staying at home and not socialising last year. Human beings are social animals after all.
- Social ostracisation has been shown to cause pain in the brain similar to putting up with physical pain.
- So, as the number of cases began to fall by the end of the first COVID-19 wave, governments and people around the world started to let their guard down.
- Amongst many businesses that were allowed to resume, for example, **restaurants which were suspected to be one of the major centres** for the spread of COVID-19 were given permission to open.

Failure of governments

- Each one of us has to contribute to break the chain of COVID-19 infections.
- However, the ultimate responsibility of managing the pandemic cannot lie with the masses in today's modern societies; it is the job of governments.

- But governments of most countries failed to learn from the Spanish flu because they failed to understand and predict human behaviour.
- In India, the government allowed election rallies and religious gatherings.
- It hesitated in imposing a lockdown despite the emergence of new strains of the virus. Leaders were often seen addressing crowds and conducting meetings without masks.
- India had the opportunity to learn from the mistakes of other countries which opened up too soon after the first wave.
- While vaccines weren't available during the Spanish flu, we have the benefit of curbing COVID-19 by vaccinating people now.

4. Tracking the pandemic's rural march(19)

- When the first wave of the novel coronavirus pandemic hit the country, the central government imposed the strictest lockdown for almost two months. For most of the migrants stuck in urban areas without incomes, jobs and food to survive, the only escape was to walk back to the rural areas where they came from. **Migrants walked back thousands of kilometres to return to rural areas** not because the villages were best equipped to deal with the pandemic but primarily because it provided them protection from hunger and starvation.
- During the **second wave now,** it is the rural areas which are bearing the brunt of the pandemic with most cases being reported from rural areas. And, unlike last time, there is nowhere to go.

First Vs second wave

- However, unlike the last time when it was largely in urban areas, this time it has spread to villages.
- Also, in contrast to the previous episode, it has spread this time to the rural areas in Bihar, Uttar Pradesh, West Bengal, Jharkhand and Odisha — States which remained largely unaffected by the spread of the pandemic during the first wave.
- Most of these States are those with a low availability of health professionals and a lower level of health infrastructure.
- The result has been a much higher level of infections and deaths.

Neglect of primary care

- The scale of the misery inflicted by the pandemic was expected in most of these States, where the existing health infrastructure has been found lacking.
- But what made it worse was also complete apathy and a lack of governance in improving the health infrastructure despite knowledge of the second wave of the epidemic.
- As in the latest report of the Rural Health Statistics 2019-20 released by the Ministry of Health and Family Welfare (MOHFW), situation has worsened over the years.

Bihar

- Compared to 10,337 functioning subcentres in **rural Bihar** in 2005, only 9,112 subcentres were functioning in 2020.

- The number of community health centres declined during the same period from 101 in 2005 to only 57 in 2020.
- Despite population growth, during the same period, the number of **primary health care centres increased marginally** to 1,702 in 2020 compared to 1,648 in 2005.

Uttar Pradesh

- Number of primary health centres declining from 3,660 in 2005 to 2,880 in 2020.
- While the number of **community health centres increased** from 386 to 711 during the same period, **sub-centres increased only marginally**, from 20,521 in 2005 to 20,778 in 2020.

Health professionals

- only 29% of specialists were in place in the community health centres in Uttar Pradesh as against the requirement based on official norms.
- Bihar reported the highest shortfall in availability of subcentres, at 58%, followed by Jharkhand, at 44%, and Uttar Pradesh, at 41%, as on July 1, 2020.
- Similar numbers in the case of primary health care centres were 73% for Jharkhand, 58% for West Bengal, 53% for Bihar and 51% for Uttar Pradesh.
- The lack of governance in this case is not the state of health infrastructure that the State governments inherited but the failure to contain the spread of the pandemic despite the knowledge of the state of rural health infrastructure.

Avoidable events

- **West Bengal,** which has seen the fastest rise in cases, was witness to the longest period of electioneering this time, with no precautions such as social distancing in place.
- Similar adventurism in the case of Uttar Pradesh saw hundreds of polling officials getting infected and passing away due to the pandemic during the conduct of local body elections in the State.
- The **Maha Kumbh** organised in the middle of the pandemic, with millions of devotees participating, further added to the spread of the infection with devotees returning to rural areas in different States.
- All of these were eminently avoidable, with the resources used to augment and strengthen the rural health infrastructure.

Judiciary and the state

- In most cases, the judiciary at the level of High Courts has stepped in to fill the vacuum created by an absent state.
- The judicial intervention of the Allahabad High Court last month directing the State government to impose lockdowns in Uttar Pradesh was in turn challenged by the State government in the Supreme Court.

Testing and treatment

- Instead of expanding testing and contact tracing, attempts were made to restrict testing and report a lower number of infections, leading to a sense of complacency within the State administration.

- The reality in rural areas of most of these States is worse than what is being released to the public through official estimates. This is true for the number of deaths which by all measures appears to be much higher than official statistics.
- The **absence of testing and treatment infrastructure** has left the rural population at the mercy of private health providers; a large majority of the population has been left unable to avail the services of private health-care providers.
- The **slow pace of vaccinations** in rural areas despite the vulnerabilities has only contributed to the rise in infections and thousands of deaths which could have been easily prevented.

Aggravating rural distress

- Rural areas provided refuge to the majority of the migrant population which had lost jobs and incomes during the first phase.
- It also helped the economy revive given that rural areas were largely unaffected.
- However, this time round it is the rural areas which are facing the worst of the pandemic as well as economic distress.
- Rural wage data as well as data on rural non-farm income available from official and private surveys point to a dismal economic scenario.
- While many have lost their primary income earner, even for those who managed to recover, it has come at the cost of huge private health expenditure.
- Many are likely to fall into a debt trap with the usurious rate of interest from the private money lenders pushing them into chronic poverty.
- For the rest, the loss of jobs and income has come at the cost of depleted savings.
- Rural areas are not just staring at the worst of the pandemic but also at prolonged economic distress.
- While the pandemic with its uncertain nature is certainly responsible for it, the blame must equally lie with the government, both at the State as well as central levels, for its failure to anticipate and prevent the thousands of deaths.

5. Planning for future waves of the pandemic (19)

Surveillance strategy

- **First**, while it is easy to blame modellers for failing to predict waves, the reason why they are not able to do so is that **clear data are unavailable.**
- There is **unreliable testing and under-reporting** of cases and deaths even now.
- This does not instil confidence in any of the modellers to come up with realistic estimates. Under-reporting and manipulated data inputs can only provide faulty projections.
- The Central and State government should use real-time data by encouraging reliable reporting and initiating standardised definitions.
- This is the time to have a standardised definition of how many cases are expected per million population.

- Instead of admiring the efforts of administrations in the areas that have fewer cases, efforts should be made to detect the minimum number of cases, to instil confidence in people that the surveillance system works in the state.
- This can only be done through the syndromic approach of identifying suspect cases and through a reliable testing strategy which does not change when there is a surge in cases.
- The COVID-19 trajectory in other countries shows that there will be multiple waves in India.
- In Japan, the health system is crumbling during the fourth wave.
- A strong surveillance system reporting the minimum number of cases will thus provide reliable early markers of an impending wave.
- Review mechanisms should be strengthened to detect the outbreak in the initial stages and extinguish it before the pandemic spreads to other areas.
- Concurrent genomic sequencing in real-time in the fixed proportion of samples will give us an idea of the likelihood of the variants causing several outbreaks.
- If the outbreaks in **Kerala, Punjab, and Maharashtra** were noticed from the results of genomic sequencing, India could have advocated for local lockdowns in high-burden areas and imposed severe restrictions to stop the wide spread of the second wave.
- We can prevent the adversities of future waves by relying and acting on the inputs of a strong surveillance system.

Vaccinating the population

- India can emerge as the world's biggest exporter of vaccines in addition to helping citizens in the country.
- The Central government should proactively reach out to all the vaccine manufacturing firms in the west and invite them to collaborate with Indian firms under the 'Make in India' programme.
- India needs to **fast-track the manufacturing of all vaccines** which have been approved for use by various regulatory authorities through a single-window clearance.
- India can become a **soft superpower** if it facilitates faster manufacturing by helping the Indian industry. This is not an unrealistic ambition as the country has already proved how it can scale up testing facilities within a short period of time.
- At this stage, there needs to be greater impetus in stepping up manufacturing and coverage of vaccines.
- Not many countries in the world have the wherewithal to manufacture their own vaccines if India cannot cater to the vaccination needs of its own citizens and that of the world.
- With newer variants of concern emerging, it is important to update the vaccines depending on how the virus changes.
- This provides a clear case and a good business opportunity for setting up manufacturing facilities in both the public and private sectors.
- Vaccines might be the shot in the arm for our economy.

- Greater financial allocations, stepping up systems to expand vaccination, applied research, enhancing effective communication, and monitoring effectiveness will solidify India's role in the future for preventing and managing pandemics.
- Nearly 60% of known infectious diseases and up to 75% of new or emerging infectious diseases are zoonotic in origin.
- Respecting the boundaries of animals and preserving the ecosystem in its natural form is important in order to prevent future pandemics. Therefore, the country needs to adopt the **'One Health'** agenda in its entirety and ensure that environmental health and animal health are given similar priority as human

Robust public health workforce

- Doctors and nurses have to bear the burden mainly because of a depleted or absent public health workforce.
- It is an essential to **hire front-line workers** in public health who can engage in surveillance and contract-tracing, and mobilise people for primary healthcare services, including vaccination.
- The front-line public health workforce is particularly absent in urban areas, while critical care capacity (oxygenated beds, ICUs) is limited in rural areas.
- Irrespective of the urban-rural divide, the country **needs to reconfigure the health systems to ensure that one Accredited Social Health Activist (ASHA) worker is hired for every 1,000 people, an Auxiliary Nurse Midwife (ANM)** and nurse practitioner are hired for every 5,000 people and a hospital with at least 100 beds, including beds with emergency and critical care services, caters to a population of 30,000-50,000.
- It is time to have plans for pandemics. We need to improve the health system and public health and regularly review plans to ensure that we prevent future disasters.
- For now, it is important to have enhanced surveillance to detect and contain future waves, expand vaccination, and work towards building a robust pandemic preparedness plan.

6. The fault line of poor health infrastructure (20)

- As the second wave of the COVID-19 pandemic ravages India, many bitter home truths and fault lines have been starkly exposed. One of these is the abysmally poor state of the country's health infrastructure.

World Bank data

- It reveal that India had 85.7 physicians per 1,00,000 people in 2017 (in contrast to 98 in Pakistan, 58 in Bangladesh, 100 in Sri Lanka and 241 in Japan), 53 beds per 1,00,000 people (in contrast to 63 in Pakistan, 79.5 in Bangladesh, 415 in Sri Lanka and 1,298 in Japan), and 172.7 nurses and midwives per 1,00,000 people (in contrast to 220 in Sri Lanka, 40 in Bangladesh, 70 in Pakistan, and 1,220 in Japan).

Stagnant expenditure

- The latest data narrative from the Centre for Economic Data and Analysis (CEDA), Ashoka University, shows that this has been stagnant for years: 1% of GDP 2013-14 and 1.28% in 2017-18 (including expenditure by the Centre, all States and Union Territories) .

State vs Centre

- **Health is a State subject** in India and State spending constitutes 68.6% of all the government health expenditure.
- However, the Centre ends up being the key player in public health management because the main bodies with technical expertise are under central control. The States lack corresponding expert bodies such as the National Centre for Disease Control or the Indian Council of Medical Research.
- States also differ a great deal in terms of the fiscal space to deal with the novel coronavirus pandemic because of the wide variation in per capita health expenditure.

Inter-State variation

- In per capita health-care expenditure in 21 major States and how this has changed from 2010-11 to 2019-20 . **Kerala and Delhi have been close to the top in all the years.**
- **Bihar, Jharkhand and Uttar Pradesh, States that have been consistently towards the bottom** of the ranking in all years, are struggling to cope with the pandemic, as a result of a deadly combination of dismal health infrastructure as well as myopic policy disregarding scientific evidence and expert advice.
- **Odisha** is noteworthy as it had the same per capita health expenditure as **Uttar Pradesh** in 2010, but now has more than double that of Uttar Pradesh. This is reflected in its relatively good COVID-19 management.
- The **World Health Organization** estimates **that 62% of the total health expenditure in India is OOP,** among the highest in the world.
- **CEDA's** analysis shows that some of the **poorest States** (Uttar Pradesh, Bihar, Madhya Pradesh, Jharkhand and Odisha) have a **high ratio of OOP** expenditures in total health expenditure.

Government's role critical

- The inter-State variation in health expenditure highlights the **need for a coordinated national plan** at the central level to fight the pandemic.
- The **Centre already tightly controls major decisions**, including additional resources raised specifically for pandemic relief, e.g. the Prime Minister's Citizen Assistance and Relief in Emergency Situations (PM CARES) Fund.
- CEDA has shown that the first round of vaccinations, where the vaccines were procured by the Centre and distributed to the States, was marked by considerable inter-State variation, which was neither explained by the case load nor by the share of eligible (45+) population.
- Need of a coordinated strategy on essential supplies of oxygen and vaccines
- The **central government has shifted most of the responsibilities on to the States**, including that of procuring vaccines from the international market. This is inefficient, as the Centre can bargain for a good price from vaccine manufacturers in its capacity as a single large buyer (like the European Union did for its member states) and benefit from the economies of scale in transportation of vaccines into the country.
- Once the vaccines arrive in India, these could be distributed across States equitably in a needs-based and transparent manner.

- Another benefit of **central coordination** is that distribution of constrained resources (medical supplies, financial resources) can internalise the existing disparities in health infrastructure across States.
- A **decentralised management**, on the other hand, **exacerbates the existing inequities,** as better-off States can outcompete others in procuring resources. This is evident in the vaccine procurement with various States floating separate global tenders.

Recommendation

- In April 2020, CEDA came out with a policy brief, where among other measures
- It recommended the creation of a "**Pandemic Preparedness Unit" (PPU)** by the central government, which would **streamline disease surveillance** and reporting systems; coordinate public health management and policy responses across all levels of government; formulate policies to mitigate economic and social costs, and communicate effectively about the health crisis .
- The central government needs to deploy all available resources to support the health and livelihood expenses of COVID-19- ravaged families immediately.

7. The outdated nature of bureaucracy (20)

- Bureaucracy has emerged as a major concern for the ineffective response to the COVID-19 crisis. This inadequacy is the reflection of the outdated nature of public bureaucracy.

Issues

- In the 21st century, democratic countries are **still relying on traditional bureaucracies** to perform public policy formulation and implementation roles.
- These bureaucracies have outlived their relevance. Weberian bureaucracy still prefers a generalist over a specialist.
- A generalist officer (IAS and State civil service officials) is deemed an expert and as a result, superior, even if the officer works in one department or ministry today and in another tomorrow.
- Specialists in every government department have to remain subordinate to the generalist officers.
- The COVID-19 pandemic has exposed this weakness.
- Healthcare professionals who are specialists have been made to work under generalist officers and the policy options have been left to the generalists when they should be in the hands of the specialists.
- The justification is that the generalist provides a broader perspective compared to the specialist.

Weberian bureaucracy

- Traditional bureaucracy is still stuck with the leadership of position over leadership of function.
- **Leadership of function** is when a person has expert knowledge of a particular responsibility in a particular situation.
- The role of the leader is to explain the situation instead of issuing orders.
- Every official involved in a particular role responds to the situation rather than relying on some dictation from someone occupying a particular position.

- **Weberian bureaucracy prefers leadership based on position.** Bureaucracy has become an end in itself rather than a means to an end.
- Further, the rigid adherence to rules has resulted in the rejection of innovation. It isn't surprising to see COVID-19 aid getting stuck in cumbersome clearance processes even during the pandemic.
- The reform often suggested in India is new public management.
- This as a reform movement promotes privatisation and managerial techniques of the private sector as an effective tool to seek improvements in public service delivery and governance.
- But this isn't a viable solution, not the least in India where there is social inequality and regional variations in development.
- It renders the state a bystander among the multiple market players with accountability being constantly shifted, especially during a crisis.
- Further, COVID-19 has shown that the private sector has also failed in public service delivery.

New public governance

- The most appropriate administrative reform is the model of new public governance.
- This model is based on **collaborative governance** in which the public sector, private players and civil society, especially public service organisations (NGOs), work together for effective public service delivery.
- There is no domination of public bureaucracy as the sole agency in policy formulation and implementation.
- A network of social actors and private players would **take responsibility in various aspects of governance** with public bureaucracy steering the ship rather than rowing it.
- During the pandemic, we see civil society playing a major role in saving lives. As part of new public governance, this **role has to be institutionalised**.
- It needs a change in the behaviour of bureaucracy.
- It needs flexibility in hierarchy, a relook at the generalist versus specialist debate, and an openness to reforms such as lateral entry and collaboration with a network of social actors.
- All major revolutions with huge implications on public service delivery have come through the collaboration of public bureaucracy with so-called outsiders.
- These include the Green Revolution (M.S. Swaminathan), the White Revolution (Verghese Kurien), Aadhaar-enabled services (Nandan Nilekani) and the IT revolution (Sam Pitroda). New public governance is the future of governance, especially public service delivery.

8. Balancing act(20)

- At the open UN Security Council session on Sunday on the Gaza conflict, India, a non-permanent member, attempted a delicate balancing act by reaffirming its traditional support for the Palestine cause without abandoning its new friend Israel. T.S. Tirumurti, India's Permanent Representative at the UN, expressed concern over the violence in Jerusalem

- He also reiterated India's "strong support for the just Palestinian cause and its unwavering commitment to the two-state solution".
- But India was careful not to upset Israel's sensitivities.
- India also did not make any reference to the status of Jerusalem or the future borders of the two states, in line with a recent change in its policy.
- Until 2017, the Indian position was that it supported the creation of an independent, sovereign Palestine state based on the 1967 border and with East Jerusalem as its capital that lives alongside Israel.
- The balancing did not appear to have gone down well with the Israeli side. When Prime Minister Benjamin Netanyahu, who has a good rapport with Narendra Modi, thanked 25 countries that he said stood with Israel, there was no reference to India.
- For India, which voted against the creation of Israel in historic Palestine in 1947 in the UN General Assembly, ties with Israel have transformed since the early 1990s.
- In 2017, Mr. Modi became the first Indian PM to visit Israel and Mr. Netanyahu travelled to India in 2018.
- While Israel ties are on a strong footing, India cannot ignore the Palestinians for historic, moral, legal and realist reasons.
- Historically, India, which went through the horrors of 1947, opposed the partition of Palestine.
- Throughout the Cold War, it remained a strong supporter of Palestinian freedom, taking a moral and legal position against the Israeli occupation, in line with international laws and norms.
- It established full diplomatic relations with Israel in 1992, in the context of improving Israel-Palestine ties after the Madrid Conference and the changes in the global order following the disintegration of the Soviet Union, but never abandoned the Palestinians.

  ✓ India's Palestine policy had realist underpinnings too.

  ✓ India has been energy dependent on the Arab world.
- It cannot alienate the Arab voices or be isolated in the General Assembly, where most member-countries oppose the occupation.
- These factors should have driven India to take a more emphatic position against both the indiscriminate rocket attacks into Israel, in which 12 people were killed, and the disproportionate bombing of Gaza, which has claimed at least 230 lives, including over 60 children.

9. The czar of brinkmanship must seek peace (19)

- The recent stand-off between Russia and Ukraine has again captured headlines in the international news media.
- This geopolitical situation appears to be complex due to the indirect involvement of its multiple stakeholders, including the United States, Turkey and the North Atlantic Treaty Organization (NATO).
- Increased tensions between Ukraine and Russia can be viewed as a continuation of the unresolved conflict of 2014.

- Since then, the 'illegal annexation of Crimea' has become a buzzword in international politics, and Russia has been constantly painted as an aggressor and a hostile power.
- In addition to this, the country has been criticised for its involvement in the Donetsk and Luhansk regions in eastern Ukraine, where Russian-backed separatists have been fighting with Ukrainian troops.
- From the beginning of April 2021, Moscow has allegedly deployed thousands of troops as well as tanks and artillery near Ukraine's eastern border.
- It has also mobilised troops in the annexed Black Sea region of Crimea.
- This was enough to send a shock wave among the political elite in Ukraine, forcing them to appeal to the U.S. and NATO and ask for an intervention, if needed.

NATO, U.S. response

- On April 13, 2021, NATO Secretary General said, 'Russia's considerable military build-up is unjustified, unexplained, and deeply concerning and NATO would continue to provide significant political and practical support to Ukraine.
- The question though is how far the NATO alliance can go in its support, given that Ukraine has not yet obtained membership.
- In June 2020, NATO recognised Ukraine as an Enhanced Opportunities Partner, along with Australia, Finland, Georgia, Jordan, and Sweden.
- This partnership aims to maintain and deepen cooperation between countries that have made significant contributions to the NATO-led missions and operations.
- The recent visit of the U.S. Secretary of State, Antony J. Blinken, to Kiev indicates the U.S.'s foreign policy priorities. The underlying rhetoric of this visit was to support the 'independence, sovereignty, and territorial integrity of Ukraine'.

Support from Turkey

- On April 11, 2021, Mr. Zelensky visited Istanbul to mark the 10th anniversary of Ukraine's strategic partnership with Turkey.
- Both leaders discussed the security issues in the Black Sea region.
- The visit was a diplomatic success for Ukraine as it had obtained the necessary guarantees from Turkey should tensions with Russia escalate.

Russia's moves

So what is Russia's end goal?

- Arguably, the cornerstone of the Russia-Ukraine conflict is insufficient communication, especially on the part of Vladimir Putin's Russia. It is very difficult, if not impossible, to speculate on the overarching rationale behind Russia's tactical decisions towards Ukraine.
- There are more questions than answers regarding the strategic calculus of the Russian administration.
- A deficit of explicit messages from Moscow creates room for misinterpretations and exaggerations on the part of Ukraine and its western supporters.

- This misunderstanding can be best illustrated by the Russian explanation of its recent 'military build-up' in western Russia. According to the Russian Defence Minister, it was just a 'three- week drill' meant to test combat readiness to respond to NATO's threats.
- From the Russian perspective, the current 'military build-up' can be viewed as another round of muscle flexing and an attempt to perpetuate the narrative of a powerful and capable Russia.

For a peaceful resolution

- All the stakeholders in the ongoing crisis should focus on establishing a constructive dialogue
- The only way forward is to seek a peaceful resolution to the Russia- Ukraine conflict rather than exacerbating the reality and using quid pro quo tactics.
- Both countries do need support from the global community, but not in a military form.
- There is a need for a platform (similarly to the Minsk Agreements) that will facilitate negotiation, mutual consensus and possible compromises, as well as engagement with mediators.
- The long-term solution should be sought out in order to break the vicious cycle of animosity and misunderstanding.

10.Prioritising the right to life (18)

- The Supreme Court on May 13 directed the Centre and the State governments of Punjab, Haryana and Uttar Pradesh to **provide free rations without insisting on ID proof to all migrant wor**kers and to run kitchens providing free meals twice a day.
- The verdict was significant as this was the first time since the national lockdown last March that the apex court acknowledged a hunger crisis in the country that needed urgent state action.
- But it **fell short** of being path-breaking for three reasons:
  - ✓it did not extend the facility to the country as a whole
  - ✓it did not extend the facility to cover cash payments by the state besides meals and ration
  - ✓it made the facility a state largesse rather than a right. Had it recognised a universal right to livelihood as the basis for its verdict, deriving from the right to life, all three lacunae would have been overcome.

Right to life (Vaccination)

- The most brazen violation of the right to life by the state at present is its vaccine policy.
- The state must respect everyone's right to life, it must make the vaccine equally available to all irrespective of the recipient's capacity to pay.
- This can be accomplished only if vaccination is free.
- In many other countries, including the most privatised medical systems like the **U.S., vaccines are being distributed free to all the people**.
- India is making people (aged 18-45 years) pay to be administered these vaccines in private clinics — an obscene and counterproductive strategy to deal with a pandemic.

Failures of the Indian government

- It did not ensure adequate production through compulsory licensing of more producers
- It did not order enough vaccines; it reneged on its responsibility to provide these vaccines to State governments
- It introduced differential pricing, forcing State governments to compete with each other and with private clinics to buy vaccines
- It allowed price gouging by Bharat Biotech and Serum Institute of India.

Workers condition

- At least **90% of workers are informal**, with no legal or social protection, denied adequate compensation over the past year of lockdowns, restrictions and economic distress.
- But there is hardly any public outcry about the plight of the nearly one billion people whose lives depend on informal activities
- The consequences of inaction are going to be dire and long- lasting, not just for people experiencing untold suffering, but for the country and the future economic trajectory.

Hunger Watch Study

- by a large collective of social groups
- Found that even **two months after the lockdown** was lifted last year, **two-third families reported eating less than they did before the lockdown,** and a reduction in healthy food.
- For a quarter of the families surveyed, **incomes had fallen by half.**
- It also found that **hunger was higher in urban India** compared to rural. The recent knee-jerk lockdowns will stifle the attempts for revival.

A significant fiscal package

- India is one of the few countries in the world that has not come up with a significant fiscal package to counter the health and economic effects of the pandemic.
- It has remained fiscally conservative, and actual Central government spending over April 2020 to February 2021 shows a rise in non-interest expenditure only by 2.1% of GDP.
- This explains why India's economy has been performing so poorly compared to other countries that were more battered by the first wave of the pandemic, since most of them had significantly larger fiscal packages that were also directed towards providing income support to people.
- Free rations and meals, as mandated by the Supreme Court, though beneficial, have very little expansionary effect on the economy, since the bulk of the commodities required come from decumulation of existing stocks of foodgrains.
- Thus, both the need to provide relief and the imperative to revive the economy demand that a monthly cash transfer, of
  about ₹7,000 per family (the rough equivalent of minimum wages), be made to people, over and above the provision of free meals and rations.

Need to do

- Free immunisation to all

- Universal access to free foodgrains of 5 kg per month to all those who require it for the next six months
- Cash transfers of ₹7,000 per household for at least three months to those without regular formal employment
- Increased resources to the Integrated Child Development Services to enable revival and expansion of their programmes
- Making the MGNREGS purely demand-driven, with no ceilings on the number of days or the number of beneficiaries per household
- Covering urban India with a parallel scheme that would also cater to the educated unemployed.

Mobilisation of resources

- In an economy with substantial unemployment, unutilised capacity and **unused foodgrain stocks** (about 80 million tonnes at present), resource mobilisation does **not require curtailing anyone else's consumption**.
- Even enlarging the fiscal deficit would cause no harm, except that it would gratuitously widen wealth inequalities and frighten globally mobile finance capital.
- To prevent both, a simple measure would be to introduce wealth taxation (though larger profit taxation will also suffice).
- These measures together would not cost more than an additional 3.5% of GDP, of which about 1% would flow back as extra tax revenue to Central and State governments, requiring 2.5% of GDP as fresh additional tax revenue.
- A 1.5% wealth tax levied on only the top 1% of households will be adequate to raise this amount.

11.The basics of an effective vaccine policy(20)

- Unfortunately, the number of vaccine doses available is limited at present.
- Technicalities of vaccine production make it likely that indigenous manufacturers will require three to six months from now to increase capacity significantly.

The mRNA vaccine technology is new

- Though the Moderna vaccine does not have intellectual property constraints and Gennova is making its own mRNA vaccine based on science from HDT in the United States
- It is unrealistic to expect Indian manufacturers to be able to embrace this new technology without handholding through the process.

Difficult choices

- Import of vaccines in quantities that can make a difference will be possible perhaps from August, when wealthy nations would have made substantial progress in the immunisation of their populations.
- India is thus faced with the unpleasant reality of having to decide the priority in which it is going to vaccinate its population, i.e., the order in which the different groups should be vaccinated.

- However, it can take comfort in the fact that all countries were forced to make this decision, and nowhere in the world has it been possible to vaccinate the entire population at one go.

Vaccine Hesitancy

- The experience of vaccine hesitancy should not distract us from the goal of inoculating as many people as quickly as possible.
- The speed with which the vaccines were developed, the introduction of new technology, reports of a few serious adverse events, the decision of certain wealthy countries to halt using the AstraZeneca shot due to concerns over blood clots and because they had other vaccines, contributed to doubts about the safety of vaccines in India.
- But it is now clear that vaccines are highly effective and the risks are extremely low.
- Indeed, vaccines are the only way that we can stay ahead of the virus.
- It is, hence, important to draw in behavioural scientists to address vaccine hesitancy and ensure that the population is covered.

Careful planning

- Should we vaccinate the most vulnerable, i.e., those who are most likely to succumb to the disease if they get infected, or should we vaccinate the population which contributes the most to the economy?
- Should we first vaccinate the elderly who are at high risk of serious illness and death, or should we vaccinate the working population so that we can open workplaces and revive the economy?
- Wealthy countries with small populations went with the first option, but India must design a vaccine policy carefully because breaking the chain of transmission is not an option currently.
- Repeated lockdowns do not break the chain of transmission of the infection.
- They only slow the spread of the virus for a period, and when they are lifted, as they must be, the virus surfaces again.

Transparent decision-making

- The ethical and humane choice would be to vaccinate the most vulnerable first.
- If this is impractical, then the choice would be to vaccinate some combination of the elderly vulnerable and the working population in every tranche.
- This should be worked out using data and the basis of the decision should be made public.
- Opaque decision-making leads to a loss of trust in governance and social discord.

Access to all

- Leaving the vaccination policy to market forces is neither ethical nor practical.
- Allowing all adults to access the vaccine at the same time introduces ethical distortions, which no humane society should face.
- Those with the resources to get vaccinated early are the least vulnerable because they also have the ability to protect themselves.

- Attempts to make vaccination more accessible through technology, as is being done with the Co-WIN app, are failing at the moment.
- Many States have declared that they will bear the cost for all their citizens, but this is a decision that they should not have been forced to make
- The approach also does not address the dilemma of who will get the vaccine and in which order, given the very limited supply.
- Governments are elected to represent the will of the people. In a civilised society, when a life-saving resource is in short supply, the government must take it upon itself to both enhance the supply and formulate a policy to allocate the resource.
- Given our current circumstances, the State governments are struggling to find a way forward amid the scramble for vaccines. There are many options for distribution, and as a society, we ought to make decisions that are based on science and fairness. The logical basis of the decision should be explained.

12.It is getting from bad to worse for women workers

- The COVID-19 pandemic has destroyed millions of livelihoods and led to a sudden and large increase in poverty and a massive disruption of the labour market in India.
- Women workers, in particular, have borne a disproportionate burden.
- As the country meets the challenge of the second wave of the pandemic, it is crucial to learn lessons from the first wave to chart the policy path ahead.

A widening gap

- **Even prior to 2020**, the gender employment gap was large.
- Only 18% of working-age women were employed as compared to 75% of men.
- **Reasons include** a lack of good jobs, restrictive social norms, and the burden of household work.
- Our **recently released report**, 'State of Working India 2021: One Year of Covid-19' shows that the pandemic has worsened the situation.

Impact on women

- The nationwide lockdown **hit women much harder** than men.
- Data from the Centre for Monitoring Indian Economy Pvt. Ltd. show that **61% of male workers were unaffected** during the lockdown while only **19% of women experienced this kind of security**.
- Even by the end of the year, **47% of employed women** who had lost jobs during the lockdown, had not returned to work. The equivalent number for **men was only 7%.**
- Men who did lose work were able to regain it, even if it was at the cost of increased precarity or lower earnings, because they **had the option of moving into fallback employment arrangements**.
- Thus, **33% of formal salaried men moved into self employment** and 9% into daily wage work between late 2019 and late 2020.
- In contrast, **women had far fewer options** — only 4% and 3% of formal salaried women moved into self employment and daily wage work, respectively.

- Nearly half of the women workers, irrespective of whether they were salaried, casual, or self-employed, withdrew from the workforce, as compared to only 11% of men.

New entrants

- Even as new entrants to the workforce, women workers had poorer options compared to men.
- Women were more likely to enter as daily wage workers while men found avenues for self-employment.

Daily wage vs Self employment

- Daily wage work is typically far less remunerative than self employment as on average, between September to October 2020, a daily wage worker earned about ₹7,965 compared to a self-employed worker who earned nearly twice that at ₹12,955.
- So, not only did women enter into more precarious work, it was also likely to be at very low earnings compared to men.

Job loss

- Women tended to lose work disproportionately irrespective of the industry in which they were employed.
- For instance, the share of women in job losses in education was three times their share in that industry.
- So, while around 20 out of 100 workers in education were women, amongst those who lost work, about 70 out of 100 were women.
- Similarly, in the health sector, 40 out of 100 workers were women, while of the 100 in this sector who lost work, 80 were women.

Growing domestic work

- With schools closed and almost everyone limited to the confines of their homes, household responsibilities increased for women.
- Married women and women from larger households were less likely to return to work, suggesting that the burden of care may be a reason for poor employment recovery.
- But even for those women who managed to remain employed, this came alongside a massive increase in the burden of household work.
- The India Working Survey 2020 found that among employed men, the number of hours spent on paid work remained more or less unchanged after the pandemic.
- But for women, the number of hours spent in domestic work increased manifold.
- In February-March, about 10%-20% of women reported spending between two to four hours on domestic work.
- This share had increased to about 50% by September. This increase in hours came without any accompanying relief in the hours spent on paid work.

Need

- Expansion of the Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA) and the introduction of an urban employment guarantee targeted to women as soon as the most severe forms of mobility restrictions are lifted.
- States to facilitate employment of women while also addressing immediate needs through the setting up of community kitchens, prioritising the opening of schools and anganwadi centres, and engagement with self-help groups for the production of personal protective equipment kits.
- Further, a COVID-19 hardship allowance of at least ₹5,000 per month for six months should be announced for 2.5 million accredited social health activists and Anganwadi workers, most of whom are women.
- The **National Employment Policy**, currently in the works, should systematically address the constraints around the participation of the women's workforce, both with respect to the availability of work and household responsibilities.
- The time is right to imagine a bold **universal basic services programme** that not only fills existing vacancies in the social sector but also expands public investments in health, education, child and elderly care, and so on, to be prepared for future shocks.
- This can help bring women into the workforce not only by directly creating employment for them but also by alleviating some of their domestic work burdens, while also overcoming nutritional and educational deficits that we are likely to be confronted with as we emerge from this crisis.