4. Recasting Welfare Politics in India at the Time of COVID-19

Christine Lutringer

Abstract

The COVID-19 pandemic has led to focus on practices and discourses of welfare across the world. It has pushed states to adopt a more proactive welfare approach to certain areas of human life, such as healthcare. On the other hand, a "societal" response based on the work of mutual-aid groups, voluntary networks and associations has also been an important aspect of how communities have attempted to survive. In countries like India, especially in metropolitan cities, the latter took the shape of slum-dwellers and the working poor inventing new strategies to cope and help their communities, preparing the ground for a "bio-politics" from below. This chapter explores the intersection of governance and welfare in order to understand the shifts that have been induced or revealed by the COVID-19 crisis. First, it maps the institutional responses driven by the central government in Delhi that were justified by the COVID-19 emergency. By doing so, it seeks to analyse the tensions that the pandemic has revealed or amplified regarding centre-state relationships. The second section sets out the redeployment of some core elements of India's social welfare during the pandemic, while situating these changes in their larger political and institutional context. The chapter concludes by discussing the importance of subnational responses to the COVID-19 crisis.

Keywords: Governance; Welfare; India; state-Society relations.

4.1. Introduction

As a global public health crisis, the COVID-19 pandemic has challenged democracies in unprecedented ways. All across the globe, the sudden move to close borders, including internal state borders as in the case of India, had wide-ranging effects on rights and livelihoods. This has both exposed and deepened pre-existing issues, such as inefficient governance, the erosion of trust in institutions, polarisation, fragility of freedoms of speech and information, and attacks on civic space. Acting as a shock to the world system, the pandemic has had significant consequences in domestic as well as international politics. As a multifaceted crisis, it has exposed and amplified some trends that may have been slowed down by institutional inertia or political resistance (Eggel et al. 2020).

This chapter posits that the COVID-19 crisis in India made more salient and visible a series of processes that have longer histories – and that are likely to have impact far beyond the pandemic (Prakash 2021). As in other parts of the world, the Indian state has intervened in various policy domains to limit the propagation of the virus and to provide for socio-economic measures. The analysis of "welfare" or "social policy" needs to be located within the transformations brought about by globalisation and the reconfiguration of state and society over the past few decades (Krisch 2020). Against this backdrop, this chapter asks the following questions: How has the COVID-19 pandemic influenced the politics of welfare in India? To what extent have the relationships between central and state institutions been redefined along the provision of emergency support to affected citizens? While exploring these questions and their articulation, the chapter will focus on the role of the state at its various levels of governance. My objective is twofold: on the one hand, I seek to examine the responses of India's central and state governments. On the other hand, I would like to highlight and discuss what these responses reveal about the nature of the state-society engagement in a context that I define as "welfare construction".

The chapter argues that the response to COVID-19 has revealed the nature and the limits of the construction of India's welfare policy. It builds on newspaper articles, reports published by international and national organisations, academic journals, and social media websites. It explores the intersection of governance and welfare in order to understand both state-society relations and the shifts that have been induced or revealed by the COVID-19 crisis. In fact, there have been puzzling

differences between India's states in their responses to and their experiences of the pandemic (Harriss, Luong 2022, p. 706). The first section of the chapter will map the institutional responses driven by the central government in Delhi that were justified by the COVID-19 emergency. It will analyse the tensions that the pandemic has revealed or amplified regarding centre-state relationships. The second section will set out the redeployment of some core elements of India's social welfare during the pandemic, while situating these changes in their larger political and institutional context. The chapter concludes by discussing the importance of subnational responses to the COVID-19 crisis. Overall, it seeks to contribute to the discussions about "welfare states" that have been brought about both by scientific disciplines and by social policy decision-makers (Kawiorska 2016, p. 188). These discussions, we argue here, need to be informed, and possibly revisited, in the light of the global experience of the COVID-19 pandemic. This piece suggests that not only the policy response but also the narratives and the discourses of the pandemic intrinsically relate to the ways in which "welfare" has been constructed in India.

4.2. Governing the Crisis: The Tensions Revealed by the Responses to COVID-19

> "On March 24, 2020, the Government of India ordered a nationwide lockdown for 21 days as a preventive measure against the spread of the coronavirus. The lockdown […] restricts 1.3 billion people from leaving their homes. Transport services are suspended, educational institutions are closed, and factories are shut down. This is in line with the measures imposed in most European countries and in the United states, but the sheer scale of the measure – as in the case of most policies in India – is intimidating. Add to this the grim truth of Indian occupational structure and poverty, and you would likely predict what we now see: unending streams of migrants trying to find their way home, the fear of loss of all income, deep privations, and even (in the space of days) hunger, starvation and death" (Debraj et al. 2020).

The pandemic was not only a medical emergency: it was at the same time a political, an economic and a social crisis, which implied new challenges for democratic institutions and practices, for citizenship rights and for human rights. This section explores the tensions

pervading the responses of the Indian state faced with the emergency. In fact, during health crises, lines between public health and national security have often been blurred, given the economic, human, and humanitarian impacts of such crises (Glušac, Kuduzovic 2021). Health emergencies can become security threats – and they are indeed often portrayed as such. Worldwide, the recurring question throughout the pandemic was how to respond effectively to this major public health crisis in full respect of human rights, democracy and the rule of law. In India, the pandemic has arguably represented "an inflection point, exposing the fragility of liberal democracy" (Prakash 2021). The first case of COVID-19 in India was reported on 30 January 2020, when a 21-year-old medical student travelling back from Wuhan tested positive for the virus. The country's first COVID-19 death was announced on 13 March 2020. A nationwide lockdown was declared on 24 March 2020 and was then extended until 31 May 2020. Although the lockdown contributed to contain the spread of the virus, it had a massive impact on the socio-economic condition of the population, in a country where 69% of the Indian population lives on less than $2 a day (Dhar et al. 2021). It prompted a livelihood crisis in a context where millions of migrants in India's cities were left without jobs (Nilsen 2022; Pellissery, Kaur 2022).

From the legal point of view, many governments across the globe declared a state of emergency, investing the executive branch with extraordinary powers and temporarily suspending civic and other fundamental rights. In India, the central government requested all state governments to invoke the *Epidemic Disease Act* (EDA) of 1897 to address the COVID-19 emergency. There have been voices among civil society claiming the unconstitutionality of the lockdown since it impacted the fundamental right of free movement enshrined in Article 19 (1)(d) and that of residing and settling in any part of the country 19 (1)(e) (Ghose 2020; Purushothaman, Moolakkattu 2021). By imposing an all-India lockdown, the central government created *de facto* a legal health emergency and made it a subject of federal intervention. As a matter of fact, there are no health emergency provisions in the Indian constitution (Gowd et al. 2021, p. 6). The lockdown was declared under the *Disaster Management Act* (DMA). The DMA was enacted in 2005 with the objective to provide for the effective management of disasters and for matters connected therewith. It provides for the establishment of dedicated institutions such as the National Disaster Management

Authority (NDMA), state Disaster Management Authorities (SDMAs), District Disaster Management Authorities (DDMAs). It also outlines a series of measures that may be taken by the government during the disaster, as well as sanctions for the violators (Gowd et al. 2021, p. 4). The NDMA was established in December 2005[1]. The Prime Minister is the *ex-officio* Chairperson along with nine other members (Government of India 2022). However, this created tensions as healthcare is a state subject under the Indian federal arrangement. It is important to note that some states took action to respond to the health emergency even before the central government: for example, fifteen states closed schools and colleges and cinema halls before 24 March 2020 (Harriss 2022, p. 721). From the formal point of view, before the COVID-19 pandemic, some state governments had their own public health acts or had amended the EDA to include certain provisions at the state level (Gowd et al. 2021, p. 4).

The pandemic revealed and exacerbated tensions that were not only legal, but also social and political: it highlighted that social inequalities not only conditioned individual or community initiatives but also the actions of the state. According to Tiwari and Singh Parmar (2022, p. 977) "minorities especially Muslims were at the receiving end of state's selective enforcement of lockdown laws in India". Amidst many other crises caused by the pandemic, the migrant exodus was unprecedented. Millions of migrant workers had come from the central and eastern states to Delhi, Maharashtra, Gujarat in order to work in construction, small industries and urban informal economy. Most of them were employed in small informal units which closed down. Encouraged by their contractors and employers, they decided to return to their villages as they were not able to pay the rent and buy food without earning (Agarwal 2022; Bandyopadhyay et al. 2021). Some ten million people left India's metropolitan cities and walked home after losing their livelihoods (Nilsen 2022, p. 470). This represented the largest human displacement in the Indian subcontinent since the India-Pakistan Partition in 1947 (Bansal 2021).

The extensive media coverage of the mass reverse migration has "ensured that the crisis was seen, heard, and felt" (Binoy, Mehendale 2022, p. 344). Exploring how the Indian media visually framed the migrant crisis during the COVID-19 lockdown, Binoy and Mehendale an-

[1] For an assessment of similar bodies in the rest of the world see Popovski (2021).

alysed two hundred photographs published by Indian media outlets covering the migrant crisis. They found that the predominant stylistic frames and visual patterns were "human interest frames, and that they highlighted human suffering, grief and misery" (Ibid.). The migrant workers were left with no livelihood. They were caught in a situation where they had nowhere to go, oftentimes stuck at stations or state borders. This has been presented as epitomising the lack of accountability of the state to the migrant workers in the neoliberal regime: "state's minimum accountability, lack of social safety net, and hostility to workers solidarity and resistance resulted in migrant worker as disposable, individualised, and powerless" (Bansal 2021, p. 55). Images of the migrant workers' exodus from big cities like Delhi, Mumbai and Ban revealed the "bare lives" (Agamben, Heller-Roazen 2020; Sylvester 2006) of working class and poor citizens of the country. As argued by Bhide (2020):

> "This desperation, the clamour to go home, however distant; is indicative of a deep distrust of the state and city society. The migrants' decision to tread these paths irrespective of challenges indicates that they understand that the city only has use for a productive body; it doesn't care for them or their lives. They have not protested, nor raised demands of their elected representatives, they have no demands of the state […] Here is a set of people who know that they are stateless at the core and so have to care for [themselves] and [their] families despite the state and its democratic rites and rituals. They only have their bodies that they can rely on and hence the departure from the city. It is in this silent act of departure that they exhibit not only their agency but also the falsity of development narratives and skin-level depth of the promises outlined in the Indian constitution committing itself to justice, liberty, equality and fraternity for all its citizens".

With its profound social and emotional repercussions, the pandemic's impact has tested citizens' trust in governance and their confidence in state and institutions. The health emergency also contained the risk of increased nationalist tendencies, discriminatory practices and discourses held during the crisis, targeting the weak, the marginal, the different. For example, on several instances, the virus has been blamed on Muslims in India (Ghosal et al. 2020). At the level of governance, there have been challenges for local authorities in context of increased centrality of the executive. Competences and financial resources have been

re-centralised (Desai et al. 2020a; 2020b). As in other contexts, central governments played a major role in policymaking while some of the national leaders appeared to personally take command of the whole "war against the pandemic" (Mohanty 2020). A first observation on the situation in India pertains to the number of executive orders: according to Prakash (2021, p. 107), "the sheer number and detail of these orders expand bureaucratic power and impunity and create excessive centralization in the hands of the Union government and the Prime Minister". Besides, the notion of political scrutiny of these decisions was conspicuous by its absence, with the parliament being prorogued, differently from many other countries (Ibid., p. 109). The overall impact of this mode of governance amounts to extreme centralization of both powers and finances towards the Union government and an accompanying *étatisation*. Alongside, there was some shift of responsibilities and functions to the state and sub-state levels without the necessary powers (as powers were circumscribed by the orders of the NDMA). This arguably further compromised the autonomy of states under the federal arrangement of the Indian constitution. Moreover, the unwillingness or the inability of the central government to transfer sufficient resources to the states complicated the situation (Prakash 2021, p. 109).

This state of affairs also laid the ground for a wide variation of the response to the emergency that states were able to provide. Comparing the numbers of excess deaths in the period of the pandemic with numbers of reported COVID-19 mortality, the ratio between the excess mortality rate and reported COVID-19 mortality ranged from 1.96 in Kerala to 26.08 in the case of Bihar (Harriss 2022, p. 724). Given the diversity of social and economic conditions across India, and the likelihood of variation in the incidence of COVID-19, Harriss argues that there would have been "a strong case for subsidiarity, with the Centre ensuring finance and taking on the role of coordination of state and local effort". But, according to him, "in practice the central government used the moment of the pandemic for extending its powers in relation to the states" (Ibid., p. 721). Later, during the second wave of the pandemic in 2021, the Centre, without any consultation, effectively handed the responsibility of vaccination to the states, after having first sought to blame them for delays in the vaccination programme (Ibid., p. 722). In this context, the difference among state responses – and that of the impact of COVID-19 across India – needs to be related to the ways in which healthcare and welfare systems have been set up.

4.3. Practices and Discourses of Welfare During COVID-19

India has the third highest death toll from COVID-19, which is estimated over 530,000[2]. Suffering during the summer of 2021 was described "a crime against humanity" (Roy 2021) while commentators described a breakdown of public health and welfare. The second wave of COVID-19 hit India even harder than the first wave. This arguably pointed to the consequences of underinvestment in the public health system. In comparative terms, expenditures in India's public health expenditure amount to only 1% of GDP per annum compared to 3% in China, 4% in Brazil or 4.5% in South Africa (Tillin, Venkateswaran 2022, p. 26). Private out-of-pocket expenditures represent 64% of total health expenditures, including by low income households and therefore exceed by far the public financial commitment to health expenditure (Ibid.). While healthcare financing in India is a mix of public and private schemes, an estimated 75% of the population has no kind of insurance cover (Goel et al. 2021, p. 152).

Besides the impact of the pandemic on public health, its socio-economic effects were massive: they resulted from the combined effect of the lockdown, the manifold restrictions, and of the economic slowdown that followed. The response provided by the central government was designed by the COVID-19 Economic Taskforce, which laid down a US$ 23 billion special economic stimulus programme called Pradhan Mantri Garib Kalyan Yojana (Prime Minister's Poor Welfare Scheme) in order to support poor households. This programme provided free essential food items, cooking gas, direct cash transfers to the poor, and insurance coverage to COVID-19 health workers. In addition, small and medium enterprises and households were granted tax relief and debt relief (CPIGH 2020; Kühner et al. 2021). The question of relief and welfare is central and deserves to be further explored. The COVID-19 pandemic has focused our attention on the discourses of welfare in different parts of the world. It has pushed nation-states to adopt a more proactive welfare state approach. On the other hand, a "societal" response based on the work of non-hierarchical mutual-aid groups, voluntary networks and associations has also been an important aspect of

[2] For further information please see: <https://covid19.who.int/region/searo/country/in> and <https://covid19.who.int/> (last accessed 26 June 2023).

how communities have attempted to survive. In countries like India, especially in metropolitan cities, the latter took the shape of slum-dwellers and the working poor inventing new strategies to cope and help their communities, preparing the ground for a "bio-politics from below" (Samaddar 2021, p. 51).

Many citizens' groups and civil society organisations engaged in relief activities. They mobilised swiftly and commendably, thereby mitigating some of the state's significant shortcomings, which were particularly evident when migrants had to walk back to their home villages. According to Prakash (2021, pp. 112-113) "[w]hile there was some degree of variation between states, in most places, the large numbers of walking migrants had no access to food, except for the charity of citizens and some civil society organizations". A survey of 11,159 migrant workers was carried out three weeks into the lockdown and revealed that about 50% of those who had left the cities they worked in had food rations left for less than a day. Mid-April, the Indian media reported growing hunger among migrant workers, who were not able to access food grains from India's Public Distribution System (PDS) as they were not in their home states (Nilsen 2022, pp. 470-471).

While the design, delivery and funding of welfare came to the fore in scholarly and public debates (Desai et al. 2020, Karanth 2022), the government used a narrative of "war" and "warriors": community health workers were portrayed as "forefront warriors", "foot soldiers of the battle", "frontline health soldiers", "first line of defence" and "unsung heroes" (Wichterich 2021). This rhetoric spread across the media and Prime Minister Modi asked citizens to clap, ring bells, or beat plates for healthcare workers "to boost their morale and salute their service". As pointed out by Shanmugham (2020), the work carried out by ASHAs[3] and other scheme workers was presented as heroic and self-sacrificing while in fact, they performed the riskiest healthcare labour and they were at the same time the least paid and most neglected health workers. The government assigned an outstanding role to accredited social health activists (ASHAs), who are "voluntary" (Wichterich 2021, p. 163). During the COVID-19 vaccination campaign, ASHAs were mobilised as a vaccination "army" because of their previous success in organising child immunisations throughout the country (Ibid., p. 179). Local women were recruited as "honorary" workers receiving only a

[3] *Asha* means "hope" in Hindi.

small honorarium or piece rate "incentives". According to Wichterich, ASHAs had to spearhead awareness – raising, identify infections, and organise vaccinations in rural areas, often without proper protective equipment and always without fair payment. Despite such care extractivism, these caregivers were celebrated by the middle classes as frontline fighters of the nation in the context of a masculinist discourse of "war", "warriors", "heroes" and "sacrifice". Wichterich interprets this as the "exploitation of care as a resource that shifts the burden of managing crises, including its costs and responsibilities, away from the state or the health industry" (Ibid., p. 164). "In an authoritarian move, one million ASHAs, who were responsible for mother and childcare, as well as immunisation, were transformed into 'frontline fighters' against the disease – often without proper protection or fair payment" (Ibid., p. 165). As in other countries, healthcare workers were celebrated as fearless "heroines" by the Indian middle classes, giving previously unseen visibility to this traditionally invisible, low-valued care work. But the solidarity with them did not appear as strong when they organised nationwide protests when, in July 2020, 600,000 ASHAs went on strike and demanded better payment and more recognition as well as appropriate social and physical protection. What AHSA's role reveals about the healthcare system (and welfare) system in India is that it rests to a large extent on community-based efforts, civil society and voluntary help. This should be related to the complex (and piecemeal) development of welfare in India.

The COVID-19 crisis represents a timely moment to look at welfare policies and also at welfare discourses globally. The emergency is an important additional element, across contexts. Although it is difficult to provide a common definition of "welfare", a few characteristics underlying the concept of the welfare state are commonly acknowledged. One of the main aspects of its definition is that it involves state responsibility for securing some basic, modest standard of living for its citizens. Some scholarship complements this definition by referring to certain domains of state activity and to relevant criteria of social justice (Kawiorska 2016). In contemporary welfare states, especially in Europe, the attention is drawn to the key role that the state plays in matters relating to social security, healthcare, education, housing and working conditions, as well as to the principles of equal opportunities and fair distribution of wealth. Research on welfare state development in the Global North has long struggled with the lack of consensus on

"how to conceptualise, operationalize and measure change within welfare states", resulting in disagreement over the nature of welfare state development (Clasen, Siegel 2007, p. 4). Scholarship in the 21st century often refers to the context of "crisis of the welfare state" in the Global North. However, Hirschman already noted in 1980: "That the welfare state is in trouble can hardly be contested". At the same time, since the beginning of the 21st century, many of the world's low- and middle-incomes countries have experienced welfare development. States throughout the Global South have expanded public social spending and introduced broader and more generous social programmes. This process of welfare state expansion laid the ground for the "emerging welfare states" (Dorlach 2020). These tend to rely more on social assistance rather than on social insurance. Moreover, this welfare state expansion can be seen as "wide but not deep" (Ibid., p. 769). An important aspect relates to the policy areas that are considered as welfare policy: oftentimes, meaningful social protection is provided only for the formally employed. Across the Global South, the rural and urban poor have instead often been protected by "social policy by other means" (Seelkopf, Starke, 2019 quot. in Dorlach 2021, p. 770), ranging from the tacit permission of squatter housing to agricultural subsidies and land reform.

Across time and space, welfare states have been trapped between contradictory social imperatives: for instance, between legitimation and accumulation, or between the demands of democratic politics and the imperatives of economic scarcity. In the case of India, what can be observed is not a comprehensive welfare policy per se, but rather a series of schemes and social assistance programmes:

> "Since the late 1990s, the Indian state has both expanded the ambit of social and economic rights for its citizens as well as launched major programmatic initiatives. Cumulatively these measures (weak as they may be) have woven safety nets for social protection and provide rudimentary underpinnings of a welfare state. Of the two principal components of social welfare policy—basic public goods (especially public services) and social protection—India has focused disproportionately on the latter in the last two decades, expanding existing social protection programs and creating new ones. By contrast, the country's basic public services, such as primary education, public health, and water and sanitation, have languished" (Kapur, Nangia 2015).

Although responsibility for social welfare policy is shared between the central and state governments in India, many of the major social protection programmes in the last decades have been initiated and funded by the central government. As a matter of fact, the central government has considerable – and growing – influence on the policy priorities of states, and this influence seems to have become stronger in recent years. In parallel, its expenditure on social protection has increased steadily over the last decade and it exceeds that on three core public services (Ibid.). This is noteworthy as in lower income countries public services generally represent a much larger part of state resources than social protection does. It is only after universal provision of basic public services such as primary education, public health, drinking water and sanitation that most other countries embarked on an ambitious expansion of the welfare state (Ibid.). The expansion of social protection programmes raises the question of how the state determines which groups to target for welfare. The state faces multiple claims of vulnerability and demands for support. As suggested by Chatterjee (2008, pp. 61-62): "The state, with its mechanisms of electoral democracy, becomes the field for the political negotiation of demands for the transfer of resources, through fiscal and other means, from the accumulation economy to programmes aimed at providing the livelihood needs of the poor and the marginalised".

By looking at official descriptions of India's welfare schemes[4], one sees that welfare is a very broad term. As far as healthcare is concerned, it is arguably fragmented and dependent on private providers, in a context where the Indian government expenditure on health as a share of GDP represents only about 1% (Harriss 2022, p. 715)[5]. In order to improve access to healthcare in rural areas, the central government launched the National Rural Health Mission (NRHM) in 2005, which now has over one million ASHAs. More recently, it extended these services to urban areas using *urban social health activists* (USHAs). The NRHM is a scheme, or a state-sponsored temporary programme, which must be renewed after a certain number of years (Wichterich

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4 See <https://accountabilityindia.in/blog/know-your-scheme/> (last accessed 21 June 2023).

5 Other Asian countries, for example Sri Lanka, China, and Thailand, spend three to four times more per capita. India's rural healthcare is impaired by a severe medical professional shortage, with only a quarter of Indian doctors working in the countryside (Wichterich 2021, p. 172).

2021, p. 166). As indicated above, during the COVID-19 pandemic the state mobilised community and solidarity resources, which included voluntary informal labour in India. This could be seen as the transfer of risks to community workers, thereby diminishing the state's own health and welfare responsibilities. At the same time, the central government keeps garnering political credit for initiating such schemes: as shown by Deshpande et al. (2019), voters tend to give credit for welfare schemes to the central government, rather opposed to state governments or local politicians. This centralization of the consent seems particularly evident for some of the Bharatiya Janata Party (BJP)'s new welfare programmes such as *Ujjwala* (Lighting) and the *Jan Dhan Yojana* (Public Finance Scheme). However, even earlier Congress-era schemes such as the Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGS) and the *Awas Yojana* (Dwelling Scheme) tend to be more associated with the central government. Earlier schemes such as the Public Distribution System (PDS) and the Old Age Pensions are still more likely to be associated with state governments. At the all-India level, the authors found some evidence that voters who received benefits under *Ujjwala, Jan Dhan Yojana* or *Awas Yojana* schemes were more likely to vote for the BJP, whereas recipients of pensions or MGNREGS were less likely to support the BJP.

A key aspect that emerges from the analysis of India's welfare programmes is the need of more coordination and cooperation between the levels of government. The Indian experience shows that this need of cooperation and effective communication between national and local levels aren't best achieved by centralization (Harriss 2022, p. 720). While the right to health is not explicitly mentioned in the Indian constitution, differently from the right to education (Gowd et al. 2021, p. 2), a Public Health Bill was introduced in 2009. However it was not passed because many states objected to it as health is a subject under the State List (Dhar et al. 2021, p. 5). In this context, recommendations have been twofold: on the one hand, to strengthen India's public health law by providing a comprehensive national public health law and reviewing various laws at the sub-national level. On the other hand, to focus on capacity-building measures in training human resources, expert workforces, healthcare workers, researchers, and data analysts to manage pandemics (Dhar et al. 2021). In this overall context and challenges, the role of subnational levels of governance is crucial.

4.4. Conclusion: The Importance of Subnational and Community Responses

The interconnectivity of a range of efforts in different spaces, and their transmission from the bottom up made up the effectiveness of local responses. Communities, civil society groups and a range of local organisations, played a key role, with many examples of "help and cooperation extended by private individuals, young and old, during this pandemic" (Bansal 2021, p. 65). For example, the Sikh community did an admirable work of supplying meals to the healthcare workers, migrant workers, and homeless people. This was part of their religious philanthropic practice of "langar" which refers to treating everyone in need of food, irrespective of their religion and community. Civil society organisations actively supplemented government's action to spread information about the disease and to set up isolation facilities. All their initiatives have been constitutive of the collective response to the pandemic. As suggested by Bansal (2021), there were successes worth of international recognition. One of these was the containment of COVID-19 in India's largest slum, Dharavi, in Mumbai. A heavily densely populated area, it quickly became a COVID-19 hotspot. But proactive testing and tracing initiative by the state government in liaison with local groups enabled to contain the spread of the disease.

Kerala, the first Indian state to register a COVID-19 case, has also been able to keep the number of cases down through quick and effective actions, largely relying on community engagement. Kudumbashree, an important women's network in Kerala, initiated about 190,000 WhatsApp groups with 2.2 million neighbourhood groups to educate on key safety measures as advocated by the government during lockdown. The Community Kitchen initiative of Kerala's Local Self Government Department was implemented with the support of Kudumbasree. It provided more than 8.6 million free meals to the labourers, people in isolation, and other needy persons (Ibid., p. 64).

According to Prakash (2021, p. 115), "the Indian state is thus simultaneously an overbearing but an absent state". The onus was largely on individual states to solve the crisis by relying on their multiple layers of subnational governance. As a matter of fact, the COVID-19 experience, with its successes and failures, illustrated the significance of decentralised, participatory self-rule at every level. Provinces, cities,

districts, and Panchayats had a critical role in devising responses to the pandemic and enforcing the treatment, lockdown conditions and economic support (Mohanty 2020).

This was also observed for many contexts in the world, beyond India. As stated by the Congress of Local and Regional Authorities of the Council of Europe[6], local and regional authorities have been at the forefront to contain the spread of the pandemic and to mitigate its impact. This raised the question of how to avoid the "lockdown" of territorial democracy and maintain the legitimacy of elected councils and elected representatives when political processes in councils could only be held electronically and when means of consultations with citizens were reduced, and elections postponed. It also pointed to the need of a public and democratic debate on how to strike the right balance between centralised and decentralised action. Finally, it raised the question of enabling the role of local and regional authorities within the context of broader national crisis management: this is about providing the competencies and financial resources adequate for them to respond to the crisis.

Kerala made for more effective responses to the COVID-19 pandemic, with significant participation from within society. Evans (1996) refers to the importance of the existence of coherent and dependable public institutions in making possible such a positive, synergistic relationship between government and social actors in the case of Kerala. This suggested that the conditions of the synergies with public institutions were not strong state, weak society, but strong state, strong civil society (Harriss, Luong 2022, p. 705). In this context, the pandemic can be seen as a driver to rethink the political foundations of healthcare and welfare in India.

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[6] For further information please see the following link: <https://www.coe.int/en/web/portal/-/covid-19-local-and-regional-authorities-on-the-frontline-> (last accessed 22 June 2023).

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