Multi-Level Government and COVID-19: Lessons from India's experience

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What form does multi-level government take?

India is comprised of 28 States and 8 union territories (UT). India terms itself as a union of states, often referred to as "co-operative federalism." Under the Indian Constitution, public health and sanitation are state-level subjects or responsibilities identified on a list. The responsibilities of the Central Government listed in the Constitution includes railways, shipping and navigation, and airways, all of which affect economic activities including movement of people across State boundaries. For subjects such as education/training, both the Centre and states/UTs have authority to make laws; where conflicts occur, the law made by the Central Government would prevail. Central institutions like the National Center for Disease Control and the Indian Council of Medical Research also play important roles. Finally, legislation such as the colonial-era Epidemic Disease Act (1897) and the National Disaster Management Act (2005) strengthen the hand of the Centre in time of crises.

Most of the States and UT have elected legislatures. States manage public health and sanitation matters, including developing and implementing public health strategies such as containment (surveillance and contact tracing and quarantining) and mitigation efforts. In most States, as part of the administration, a Central Government employee, the Health Secretary, is responsible for coordinating anti-COVID-19 activities. Healthcare services are delivered through State hospitals and clinics. The private sector is also a key provider of healthcare nationwide, especially for the middle class and the well-to-do.

Additionally, based on Article 242 of the Constitution, elected municipal (or local) entities are authorized to conduct several functions in urban areas: one of these is public health, but the specific functions of local governments are determined by State-level legislation. So local government entities are an integral part of the effort to combat COVID-19, although the degree of autonomy they possess varies by State.

The Panchayati Raj (PR) functions as a Constitution-based local level system of governance in which gram panchayats, or village councils, are the basic units of local administration at the rural level, where 65% of the Indian population still reside. Currently, the elected PR exists in most states (Nagaland, Meghalaya, and Mizoram being exceptions), and in all UTs (except Delhi). The PR also have some public health and sanitation responsibilities.

Broadly, the Central Government deals with national statistics, guidelines, maintains oversight, conducts training and provides material and technical support. Strategies and policies for containment and mitigation are adapted at the State level from Central guidelines and the actual implementation and monitoring is often left to State and local governments. Given this approach, inter-State and inter-regional differences in outcomes are inevitable.

What were the main mechanisms used to handle the COVID 19 challenges, both health and economic, in your country? How well did they work for the purpose?

Based on the legal framework, institutional framework, administrative infrastructure and financial resources, governments at multiple levels played a key role in handling the COVID-19 challenges in India. Containment activities, such as screening, tracing contacts, and isolation of suspected cases, were among the mechanisms used to break the chain of transmission of the COVID-19 virus. Another major mechanism that the Central Government introduced as part of its pandemic containment efforts was initiating a ten-week nationwide lockdown in mid-March, 2020. While this primary mechanism worked for a time, the consequences of that step continue to impact all subsequent government-level actions.

To what extent were responses to the pandemic influenced by multi-level government in your country?

A couple of examples would serve to demonstrate the impact of multi-level government on the COVID-19 response. A nationwide lockdown, preceded by a day-long curfew, was hastily initiated by the Central Government on 24 March 2020, at a time when there were only a relatively small number of confirmed COVID-19 cases daily (see Table 1 below). This lockdown, with relatively minor adjustments, lasted ten weeks: it affected most economic activities and restricted the mobility of people at all levels, resulting in extreme hardship. With transportation systems initially shut down, millions of migrant or "guest" workers in large metropolitan areas had no travel options back to towns and villages in other States. As was well-publicized, many travelled thousands of kilometers literally on foot to reach home.

Table 1: Rolling average of new cases and deaths from April-September 2020		
2020 Month	**7-day av new cases /day**	**7-day av deaths/day**
April	684	27
May	3301	111
June	9256	252
July	20618	454
August	52346	758
September	81598	1003

Data Source: https://www.worldometers.info/coronvirus/

At short notice, in most instances, State/UT and local (both municipal and PRs) governments had to step in, aided by members of the public, to provide temporary relief measures like housing, food and other assistance to both local residents and migrant workers. After almost six weeks, the Central Government finally launched the Self-Reliant India program, which provided food and other forms of assistance. The Central Government subsequently organized special trains. These Shramik trains operated with limited stops from May through July to transport migrants back to their home States. The return of migrants was a concern for smaller and fragile health systems, especially in rural areas facing the possibility of new infections. Looking at the growth in new cases in Table 1, there is arguably a link between the rise in new cases and the return of the migrant workers during the May-July period. Notably, after the initial national lockdown, a number of States subsequently introduced smaller local lockdowns, as part of their containment efforts, restricting mobility within and inter-State, and requiring travel permits or passes.

As another example, in March, the Central Government provided guidelines for surveillance-related activities such as tracking, with compliance left to the States. The Central Government developed a smartphone-based app (Aarogya Setu), in April, to facilitate contact tracing efforts. Despite concerns about data privacy, among other issues, 150 million users have downloaded the app. But it remains unclear whether all States/UT and local governments have the capability to download the data and monitor individuals at high risk for infecting others.

Did emergency conditions change the normal arrangements for multi-level government?

Emergency conditions affected many areas. Three examples serve as illustrations. First, State Governments had to reallocate greater fiscal resources towards public health activities as well as relief efforts. These measures ranged from sourcing scarce personal protective equipment, ramping up testing, preparing hospitals and health facilities for a surge in patients, and allocating greater resources to surveillance and tracking efforts. The efforts have led to an increase in borrowing across the board: the Centre has authorized States/UT to raise their debt limits. The fact remains though, that given lower revenue collections due to the state of the economy, government-funded activities will be constrained for the foreseeable future. Local government is usually reliant on State funding for parts of their activities and will face similar constraints.

Second, the pandemic led to a situation where delays in routine preventive health steps are likely. Delays in treatment amidst the pandemic are also inevitable for infectious diseases other than COVID-19. Preliminary data indicates a drop in prenatal visits and vaccinations, both of which have adverse long-term health outcomes. AIDS, malaria, and tuberculosis kill an estimated half a million people annually in India. There is increasing concern that remedial plans have not been fashioned to return to normal operations.

Third, policing and law enforcement personnel have been redirected from regular activities to pandemic-related compliance activities. Reportedly, defiance of quarantine regulations has been an issue drawing significant law enforcement resources. In some instances, media reports indicate that local law enforcement used violence to enforce rules. In addition, protection had to be provided to hospitals as medical staff were occasionally attacked, threatened or harassed by family members of COVID-19 patients.

Were both/all levels of government involved in responding to the pandemic?

Government at all levels were involved in responding to the pandemic, with varying degrees of effort and organization. Based on preliminary assessments, two factors appear to have influenced responses at the state and local level. Firstly, the capacity of State/ UT, especially their public health infrastructure, is critical. States with relatively smaller populations were able to manage their resources effectively; Kerala, Karnataka, and Orissa were cited as early examples. A second factor in their success was their prior experience with virus outbreaks or natural disasters, such as the Nipah virus outbreak of 2018-2019 (in Kerala, Karnataka) or natural disaster preparedness (in Orissa, Kerala).

In urban areas, especially larger metropolitan areas, local government played a prominent role. For example, one of the severely affected areas was in Mumbai, particularly the densely populated locality of Dharavi. When cases started spiking, most of the successful intervention work in Dharavi was done by the BrihanMumbai Municipal Corporation (BMC) working closely with the State authorities, with strong support from civic society. The BMC in Mumbai is an outlier in the Indian context because it has complete control of public health functions in the metropolitan area, which likely accounted for

its success. It should be noted, going forward, that more research on pandemic-related responses across different States and local governmental entities need to be conducted.

Did governments work together, separately, or both?

By and large, there was cooperation at all levels of government. There are exceptions: a notable one is the announcement of the nationwide lockdown on 24 March 2020 with little advance consultation or notice. Many migrant workers in cities, facing loss of their livelihoods, left. State/UT and local governments were trying to contain the virus while simultaneously dealing with the economic consequences of the lockdown. The Central Government eventually stepped in after several weeks.

How effective was action by the centre? How effective was action by sub-state levels of government?

Effectiveness is usually defined as the degree to which something is successful in producing a desired result. One of the challenges of effectiveness is identifying appropriate measures. Based on numbers in mid-August 2020 (with the caveat that statistics are less than reliable in the midst of a crisis!), the Central Government points to the Case Fatality Rate (which roughly measures the proportion of deaths among confirmed cases), which declined from 3.3 (in June) to 1.9 (August). There has also been a decline in positivity rates for COVID-19 tests across the country: less than 8% of all tests performed currently are positive. The patient recovery rate of about 75% and a ramping up of testing (approximately 900,000/day) are also mentioned and interpreted as indicators that the public health and medical intervention programs have been effective. The Central Government identifies the logistical effort involved in returning 6.3 million internal migrants on 4500 Shramik trains to their home States and the repatriation of 1.1 million from overseas as signs of success. A fiscal stimulus amounting to 10% of the Gross Domestic Product, expansionist monetary policies that allow States to increase their debt levels, and relief measures taken to address the collapse of the economy are also listed as positive outcomes.

Contrast these outcome measures with the current caseload exceeding 80,000 new COVID-19 cases per day and about 1,000 daily deaths. Based on rolling seven-day averages calculated at the turn of each month, the nation-wide trends are heading in the wrong direction (see Table 1 above). Kerala State, which was at one time seen as the gold standard within India for its anti-COVID-19 efforts, is currently dealing with 20,000 active cases; an additional 180,000 people are quarantined.

Containment efforts in India have not stymied the spread of infection. Additionally, the low testing rates in many States have masked the true prevalence of infections. As long as the caseload keeps increasing, it is difficult to return to normal operations at all levels since the fight against COVID-19 is resource intensive. Clearly, the time is right to think of mid-course corrections and also think in terms of mitigating the negative impact of the pandemic.

On balance, was multi-level government a positive, negative, or neutral factor in responding to this emergency?

India is too diverse to adopt a one-sized approach to dealing with health and social matters. This diversity covers faiths, cultures, languages, caste, urban/rural as well as in terms of the capacity to deal with issues brought on by the pandemic. Given the constitutional framework, a multi-level government approach was/is a necessary factor and allows the Central Government to assume an even more significant role.

Data from India indicates that the COVID-19 infection curve has not flattened. So the broader question(s) becomes whether India is doing the right things consistently. In other words, the key issue is one of governance. Two issues come to mind:

- First, given the range of pandemic-related data that is now available, are policies and strategies being implemented based on evidence-based approaches to both containment and mitigation? Is enough known about disparities in infections and outcomes across social groups in order to develop targeted interventions?

- Second, is the issue of implementation. Are strategies being implemented appropriately and consistently? Are governmental entities conducting analyses of "gaps" and "barriers to implementation" in order to tweak their programs, based on initial outputs of interventions?

Do you expect the experience of dealing with this emergency to have a longer-term effect on multi-level government?

Given the wide disparities across States/UTs, investments in public health and medical infrastructure are essential. That said, based on the success in Mumbai, steps will need to be taken to empower local government to handle more responsibilities, even as devolving power requires attention to political, legislative and constitutional concerns. Additionally, the lockdowns, the situation of migrant workers and fiscal issues associated with the pandemic have called into question the meaning of "cooperative federalism." A constructive evaluation of these matters is needed but that, along with discussion of local empowerment models, is unlikely to occur in the midst of a pandemic. Devolution of power and empowerment models only work if there are clear lines of responsibility, accountability, a reliable stream of funding and capacity building.

What positive or negative insights can be gained from experience with multi-level government during this emergency in this case?

All levels of government must:

- Organize conditions for the economy to reboot;
- Be attentive to data standardization and reporting, which are essential for informed decision-making;
- Maintain regular, non-pandemic, health functions;
- Enforce emergency public health measures;
- Build capacities and empower local government.

Biography: *Ramdas Menon is currently an independent scholar who lives in India (part-time) and the United States (part-time), a lifestyle that has been upended by what may termed "La Vida Covida."*
He has a doctoral degree in sociology and a diploma in public health. Ramdas has over two decades of experience as a statistician, a public health practitioner and as a program evaluator. Additionally, he has taught courses in public health and conducted training on public sector effectiveness.