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The pandemic and the state

Interrogating capacity and response to COVID-19 in West Bengal

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Abstract: COVID-19 has brought to the fore the issue of state preparedness in mitigating health emergencies. This paper problematizes the received wisdom of greater state capacity in mitigating the severity of the pandemic. Based on a case study of West Bengal, a subnational state of India, it shows that measures of state capacity do not map onto the pandemic response and outcomes very clearly. The three components of state capacity, namely authority, capacity, and legitimacy, show significant variation during the pandemic response. While the state was constrained by fiscal and infrastructural limitations in testing and vaccination, policy response also varied from harsh implementation of lockdown during the initial phase to limp containment due to populist pressures. These limitations notwithstanding, the state managed to avert the worst consequences in terms of COVID-19 deaths when compared to similarly positioned subnational states of India.

Key words: pandemic, state capacity, policy response, lockdown, COVID-19

JEL classification: H11, H12, H75, I18

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1 Introduction

In the context of COVID-19, available evidence shows that state effectiveness or capacity is relevant for mitigating the severity of the pandemic (Gisselquist and Vaccaro 2021; Serikbayeva et al. 2021). Large cross-country studies show that incidences of COVID-19 infections and deaths have been inversely related to the indicators of state effectiveness. Intuitively, states with better capacity are more likely to respond to and mitigate the adversities associated with the pandemic.

The relationship between state capacity and the outcome of the pandemic, however, appears rather fuzzy when examined closely. State effectiveness has been found to be quite uneven in COVID-19 responses and outcomes. Many countries that were high on the list of global health preparedness measures failed to prevent infections (Greer et al. 2021). Further, states with supposedly similar capacity varied in terms of policy measures and implementation (Puyvallée and Banik 2020). Conceptually, state capacity confronts us with varied and multiple indicators that are characterized by low dimensionality (Vaccaro 2020) and the choice of indicators often affects the relationship between state capacity and COVID-19 outcomes.

We contend that state capacity is dynamic and that any evaluation should focus on particular policy domains within specific contexts. Towards that end this paper looks at the connections between state capacity and COVID-19 responses and outcomes through a case study of the state of West Bengal in India. We argue and show that conventional measures of state capacity and preparedness do not map onto the pandemic response and outcomes very clearly. If state effectiveness is categorized into the component parts of authority, capacity, and legitimacy, the West Bengal case shows varying government effectiveness in testing and containment due to policy interventions and infrastructural limitations, and increased state legitimacy during the initial phase of the pandemic which is subsequently undermined by populist pressures and limited fiscal and institutional capacity that interacts with centralized decision processes. Yet, the state managed to avert the worst consequences when compared to similarly positioned subnational states of India. According to Government of India data on COVID-19, West Bengal was fifth in terms of the number of people affected, but twenty-first in terms of the death ratio among the 28 states and nine Union Territories in India.

The ambiguous relationship between state effectiveness and COVID-19 response and outcome maps onto the peculiarities of West Bengal as a lower-middle-income state with high population density but above-average indicators of health. In terms of fiscal capacity and performance, West Bengal lagged behind the average of all the major states in the past decades. The gap has somewhat narrowed in the recent pre-pandemic years largely due to the e-management of expenditure tracking and increased revenue collection, but concerns remain about bureaucratic quality, the impartiality of public administration, and the situation of law and order. Interestingly, fiscal capacity, service delivery, bureaucratic quality, and public administration are all considered to be indicators of state capacity.

The specific case study of state capacity in managing COVID-19 therefore instructs us about the complicated relationship between state capacity and outcomes across policy domains. Specifically, it informs the relationship and modalities of interaction between different dimensions of state capacity and health. The paper is based on secondary and tertiary data supplemented by interviews with a few key individuals. In Section 2 we interrogate the notion of state capacity and present our approach. In Section 3 we discuss the subnational context of state capacity and present select aspects of the state of West Bengal, such as the economic and the political, which are relevant to

our discussion. Section 4 discusses in detail the state's response to the COVID-19 outbreak. While most of the steps the state has taken are in accordance with the Government of India advisories, a few innovative state-level measures have also been undertaken. The narrative presented in this section suggests that the bases of most such measures may not be well-founded as it is hard to make them evidence-based. Section 5 concludes.

2 State capacity

The primary response to a natural disaster like COVID-19 is generated by the health care sector. The health sector in developing economies faces issues of infrastructure, service delivery, and economic sustainability, all of which require adequate state capacity. During a pandemic, the importance of state capacity is magnified due to the imposition of social restrictions and alleviating welfare measures for citizens, in addition to the need for health care.

In the literature, state capacity has been understood as the institutional capability of the state to carry out policies (Savoia and Sen 2015; Vaccaro 2020). It is closely related to governance and exerts considerable influence on outcomes such as economic growth, human development, civil conflict, public goods, and so on (Akbar and Ostermann 2015; Cingolani 2013; Hanson and Sigman 2021; Vaccaro 2020).

Beyond the theoretical notion, the concept is problematic with regard to operationalization and measurement. State capacity can be measured by what the state produces (its outputs and outcomes) as well as how governments function (i.e., administrative and bureaucratic procedures, capacity, and autonomy) (Savoia and Sen 2015). It has been narrowly viewed in terms of the traditional role of the state to ensure protection from external threats, maintain internal order, and provide basic infrastructure for economic activity and extraction of revenue (Akbar and Ostermann 2015). It has also been viewed more broadly in terms of capacity to ensure social and economic development with accountability, goods and service provision, developmental expenditure, legislative performance, bureaucratic culture, and corruption as indicators of state capacity (Akbar and Ostermann 2015; Khemani 2019).

Intuitively, conceptualizations of state effectiveness in terms of specific measures and outcomes have to consider historical and contextual specificities of states. In this regard, the framework suggested by Savoia and Sen (2015) and Gisselquist and Vaccaro (2021) of state capacity comprising authority, capacity, and legitimacy is rather useful as it allows flexibility to capture outcomes, institutional capacity, and quality of political institutions. Our evaluation of state capacity flows from such an understanding and focuses on infrastructure, delivery of public goods, tax capacity, decision processes, political leadership, and political competition. Such an approach is most apposite to contextualize the dynamic nature of state capacity during a pandemic as the literature shows changing policy interventions with spread of infection, with the executive–bureaucracy linkages (Khemani 2019), the structures of decision-making (Capano 2020), and intra-institutional and regional conflicts (Capano 2020; Javid et al. 2020) being important for state responses to the COVID-19 pandemic. Further, this approach is most suitable for a subnational study as it provides the flexibility to consider the distinct dimensions within the framework of state capacity, such as the relationship between the federal state and a subnational entity and regional socio-political dynamics.

2.1 State capacity and health

Health has featured as an important outcome in the literature on state capacity (Savoia and Sen 2015). The literature provides interesting findings on the relationship between institutional and fiscal indicators and health outcomes. Dawson (2010), in a study on child mortality rates, finds that rule of law and not fiscal capacity is associated with lower child mortality, while Rajkumar and Swaroop (2008) find that public spending has no significant effect on health and education in countries with worse bureaucracies and corruption (Savoia and Sen 2015). Evidently, the legal system, administration and bureaucracy, rule of law, and corruption—as components of state capacity—are as important as infrastructural and public goods delivery in shaping health outcomes. In the context of the COVID-19 pandemic, Gisselquist and Vaccaro (2021) find that authority (coercive power) and capacity (delivery of public goods) are important in shaping pandemic response and outcome. Saha and Kasi (2020) also find that capacity and the coordination between formal state structures and society (coercive power) is crucial for mitigating pandemic effects.

3 Subnational state capacity and the pandemic: the Indian context

Any discussion on subnational state capacity must begin with a contextualization of the federal institutional structure. The capacity of a subnational state must be analysed against the background of the centre–state relationship that is usually redefined during a disaster or crisis. For instance, state capacity has a fiscal dimension at its core affecting institutional development and public goods delivery. In India, a major part of the fiscal capacity of a subnational state is the consequence of central government policies, which grant little autonomy to the states in deciding on taxation and revenue generation. By design, the states in India generate very low shares of their total revenues from direct taxes.

The central government has overriding power in the quasi-federal framework, which has implications for COVID-19 management. Even though health is a state subject, the central government can directly exercise supervision/control over it through central agencies such as the Indian Council of Medical Research (ICMR). The central government imposed stringent lockdown measures on 24 March 2020, with a few hours' notice. The subnational states had to abide by these strict measures imposed by the centre, with little scope for adjustment leaving them unprepared to negotiate with the economic and social turmoil (Ghosh 2020). Thus, the alleged lack of subnational state effectiveness was not always self-induced.

The central government chose not to declare a national emergency, but resorted to using the Epidemics Act, 1897 (EA) and the Disaster Management Act, 2005 (DMA) that determined the legal constitutional contours of the state response and allowed the subnational states to manage COVID-19 in coordination with the central government (Datta and Grover 2021). The DMA lays down policies, plans, and guidelines for management and coordination of disasters (Ram Mohan and Alex 2020). It was passed only recently in 2005 with the formalization of the idea of integrated disaster management. The tenth Five Year Plan (2002–07) prescribed a number of policy guidelines for incorporating disaster management practices into development plans for prevention and mitigation of disasters. The Integrated Disease Surveillance Project was formulated in 2004 to address epidemic response (Sahoo et al. 2020).

The DMA provides for the National Disaster Management Authority (NDMA) as the nodal central body coordinating disaster management, with the prime minister as its chairperson. Similar bodies are created at the state, district, and local levels under the DMA. Naturally, the pandemic

response was marked by coordination as well as incongruities between the dictates of the central government and the execution by the state governments. The centre was responsible for the overall medico-technical aspects, vaccination policy, and distribution of relief, while the states were responsible for implementation. The differences in state capacity between the centre and the states and between the states meant that management of COVID-19 and vaccination were challenging, time-consuming, and often inefficient, especially when there was centre–state political-administrative tension, as was the case in West Bengal (Kar et al. 2021).

Finally, state capacity to manage COVID-19 is embedded in broader governance, as imposition of lockdown and the effectiveness of the government response—or lack of it—led to mismanagement and collapse of the economy. While the containment measures slowed the spread, they were not absolutely preventive, and the resultant economic crisis, coercive police brutality, and migrant workers crisis caused a significant number of deaths and immeasurable hardship. Infrastructural inadequacy of medical and health care facilities and socio-economic discrepancies of caste/gender acted as impediments in the application of containment measures and resource/relief allocation (Ghosh 2020).

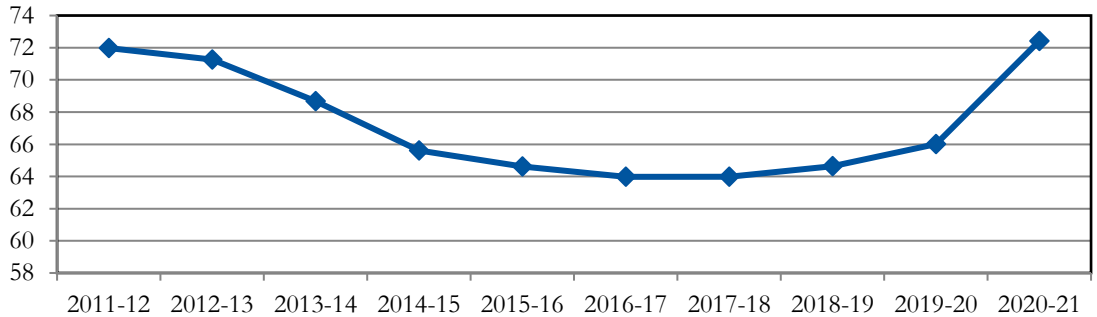
3.1 West Bengal in perspective

As elaborated in the preceding section, state effectiveness conceptualized as authority, capacity, and legitimacy is conspicuous through infrastructure, public goods, bureaucratic activism, fiscal capacity, decision-making, and so on. As such, it is imperative to have an overview of the economy, politics, and governance dynamics in the state.

Economy

West Bengal is the fourth largest state in India in term of population, and its per capita gross state domestic product (GSDP) is roughly three-quarters of the average across all Indian states. Once a highly industrialized state, West Bengal's steadily declining share in the total industrial output of the country has been a matter of great concern. In terms of fiscal capacity, the situation of the state has been rather precarious over the years, with a large debt-to-GSDP ratio. Although revenue mobilization and expenditure management have improved in the past decade, overall the state is still marked by poor revenue mobilization in comparison to other states. As a result, development and social expenditure, though improved, continue to be low in per capita terms. Figure 1 shows the recent trend in the per capita net state domestic product (NSDP) of West Bengal as a percentage of per capita GDP of India at constant (2011–12) prices.

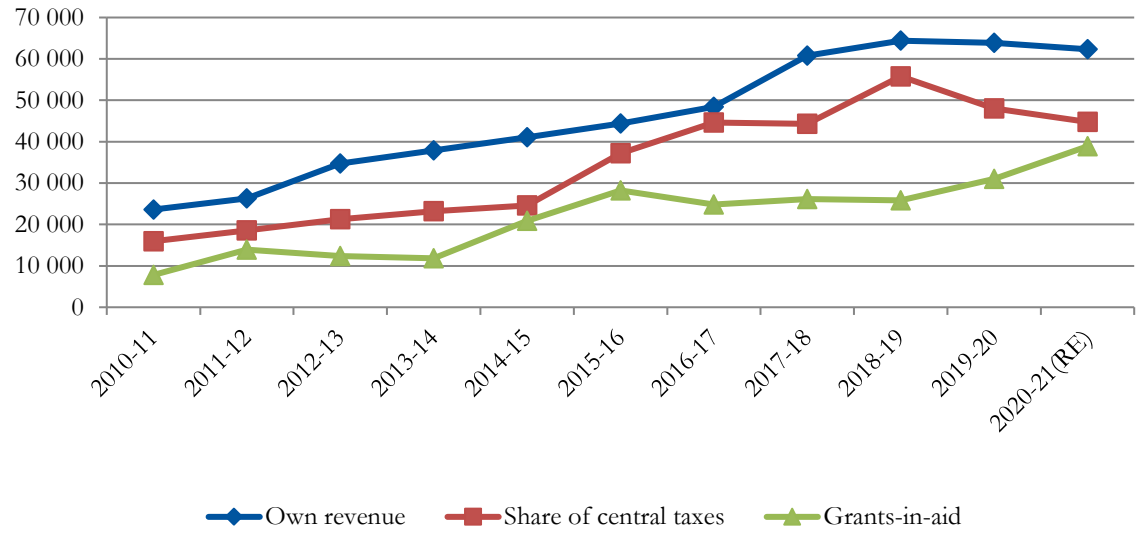
Figure 1: Per capita NSDP of West Bengal as a percentage of per capita GDP of India (2011–12 prices)



Source: authors' compilation based on data from the Reserve Bank of India.

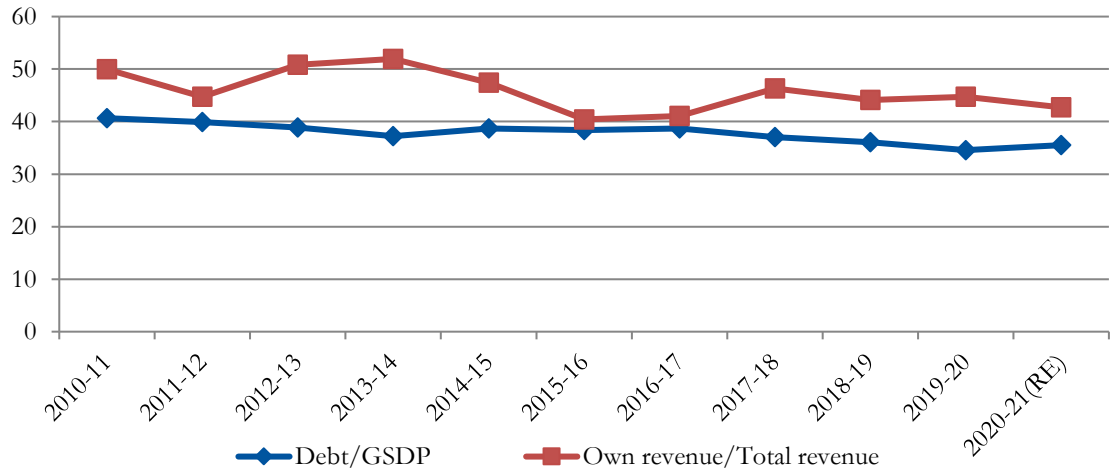
What is to be noted is that in the first year after the onset of COVID-19 (i.e., 2020–21), while the Indian economy shrank by 6.6 per cent, the NSDP of West Bengal posted a positive growth and, as a result, the latter's per capita NSDP vis-à-vis India's per capita GDP sharply improved in the 2020–21 financial year. These improvements notwithstanding, the state's own source revenue (i.e., its own tax and non-tax revenues together) plateaued, ostensibly due to the implementation of goods and services tax (GST) in 2017. More importantly, the state's share in central taxes also fell in 2019–20 for the first time since 2010–11, even though the grants-in-aid component increased, which included the grant portion of GST compensation. Figures 2 and 3 show the trends in different components of West Bengal's revenue since 2010–11.

Figure 2: Recent trends in different revenue components (rupees)



Source: authors' compilation based on data from the Reserve Bank of India.

Figure 3: Trends in own revenue as a percentage of total revenue and debt–GSDP ratio



Source: authors' compilation based on data from the Reserve Bank of India.

Since the state's own source revenue has increased at a lower rate than that of central transfers over these past years, the state's own source revenue as a percentage of its total revenue has declined since 2013–14 (Figure 3). The other fiscal indicator of concern is the debt–GSDP ratio.

Even though it has been steadily declining since 2010–11, when the state passed the Fiscal Responsibility and Budget Management (FRBM) Act, it is still much above the all-state average. The decline in the debt–GSDP ratio in the past decade has been due to the state's effort in bringing down the fiscal deficit from 4.24 per cent of GSDP in 2010–11 to 2.94 per cent in 2019–20.

Politics and governance

The state has been governed by the Trinamool Congress (TMC) since 2011, with the spirited Mamata Banerjee at the helm. The regime pursues welfare-oriented populist politics alongside patronage and cultural expression. The nature of governance under the TMC has witnessed a shift compared to the previous 34 years under the Left Front. Without deliberating on the distinctions, one can broadly point out certain characteristics of governance in the state.

First is the supremacy of the leader, Mamata Banerjee, which translates into distinct centralization of decision-making. Mamata Banerjee embodies the discursive mode of political asceticism (hawaichoti), nativist rhetoric (ma, mati, manush), gendered populist self (didi), and religious iconography in her leadership (Ray Chaudhury 2021). Such a narrative is appropriately disposed for populist politics that identifies the leader as the protector of the people, the upholder of a certain morality, and the embodiment of sovereignty (Chatterjee 2020).

The regime has initiated a certain style of governance distinct from the party-dominant structure of the Left Front. As compared to the party society practised under the Left (Bhattacharyya 2016), the TMC regime has sought to combine party dominance and patronage with a slew of social welfare policies (Kanyashree, KhadyaSathi, SwasthaSathi) that cater to the rural and urban poor. Distinctly, these policies are devised and designed by bureaucrats, and are quite top-down and technocratic in implementation.

The regime has also shifted the responsibility of delivering public services from elected public officials to the bureaucrats responsible to the chief minister (Ray and Dutta 2018). Consequently, the role of local government bodies like panchayats and municipalities in delivering social services has been restricted (Das and Chattopadhyay 2020). Notably, the government introduced 'Duare Sarkar' or government-at-the-doorstep camps across the state to deliver services through local bureaucrats and not through local government institutions, ostensibly to control corruption at the local level (Sengupta 2021).

Another feature of governance is an increasing reliance on social and cultural identity for political mobilization, even though the regime does not have any explicit agenda around social justice. This is reflected in the programmes, especially development councils, framed around caste and regional identity, such as the development boards for Lepchas, Bhutias, and Santhals, as well as funding to neighbourhood clubs for cultural and sports activities.

Context of the pandemic

Aside from the economic and political dynamics that mark the state, there were some extraneous events/developments during the period March 2020 to June 2021 that had consequences for the management of the pandemic. The second wave of COVID-19 coincided with state elections during April–May 2021. The electoral competition was contentious, with political parties mobilizing resources and labour with utter disregard for COVID-19 protocols (Mahmood 2022). The political context had been set during the parliamentary elections of 2019 when the Bhartiya Janata Party (BJP) made political inroads, winning 18 out of 42 parliamentary seats in the state. The contestation between BJP and TMC degenerated into a conflict between the centre and the

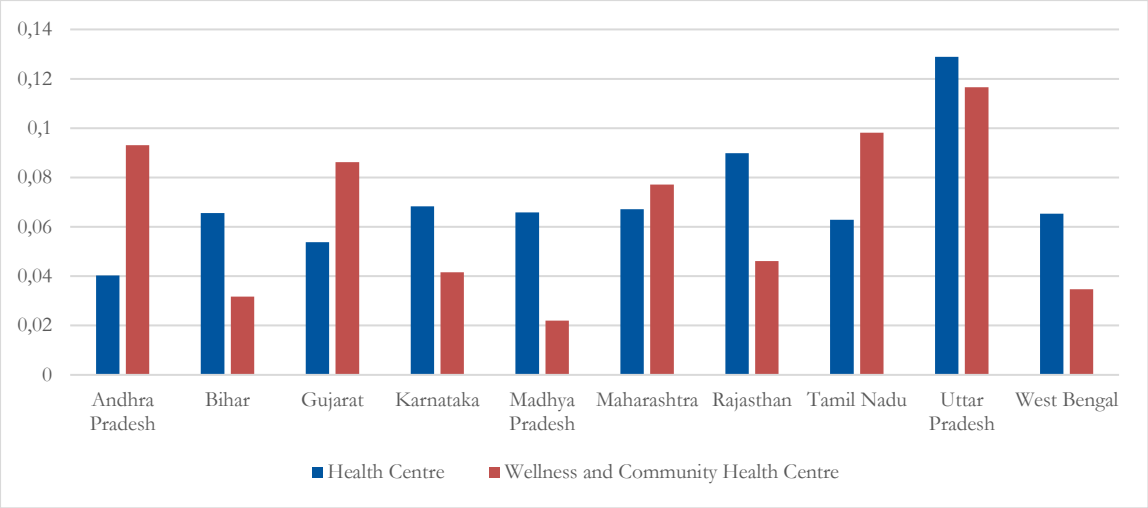
state government that affected the response to COVID-19. The eight-phase election from 27 March to 29 April, with campaigning lasting for 66 days, was unprecedented and contributed to the second wave of the pandemic. On 20 March, a week before the first phase of polling, West Bengal reported 3,380 active COVID-19 cases, which increased to 94,949 active cases by the time the state voted in the seventh phase (Mahmood 2022). It is also worth mentioning that the state was affected by the natural calamities supercyclones Amphan and Yaas during this period, which posed challenges for relief and rehabilitation and constrained COVID-19 mitigation efforts. Incidentally, Amphan-affected areas, particularly Kolkata and the neighbouring districts of South and North 24 Parganas, Howrah, and Hooghly are also the most affected by COVID-19.

3.2 West Bengal in perspective: the anomaly of health infrastructure and outcome

Before engaging in an in-depth discussion of state capacity and COVID-19 response, it is imperative to highlight an apparent anomaly in West Bengal, where an indifferent health infrastructure and above-average indicators of health outcomes coexist. For a long time per capita health expenditure in West Bengal has been on the low side. Yet, if we take the infant mortality rate (IMR) as an indicator of health outcome, we observe that West Bengal, with an IMR of 22, had been in fourth position (in increasing order) for a long time, with Kerala, Tamil Nadu, and Maharashtra above it. Very recently, Punjab and Himachal Pradesh have surpassed West Bengal. The maternal mortality ratio (MMR), which is 98 per 100,000 live births, is below the all-India average (113) but much higher than that for Maharashtra (46), Gujarat (75), and the southern states' average (67).[1]

The above-average health outcomes are not supported by data on the health infrastructure. Rural West Bengal contains 7.46 per cent of the population of rural India, but 6.56 per cent of the functional sub-centres, 4.44 per cent of primary health centres, and 3.9 per cent of district and subdivision hospitals. As Figure 4 shows, the all-India share of health centres in West Bengal is 6.5 per cent, while the share of the population is 7.79 per cent.

Figure 4: Share of health centres in selected states of India



Source: authors' compilation based on data from the Rural Health Statistics, Government of India.

[1] As per the Sample Registration System (SRS) reports by the Registrar General of India.

In other words, in terms of population per million the numbers of different categories of public health care institutions in rural West Bengal are below the all-India averages. On top of that, health centres are often unable to meet demand, especially in rural areas, and the quality of health care is severely impacted by poor services, lack of workforce, and lack of drugs and essential equipment. In 2013–14, only 909 primary health centres (PHCs) were functioning out of 2,166 required as per population, and only 248 PHCs had beds in accordance with the Indian Public Health Standards (Dey and Chattopadhyay 2018). The case of doctors at PHCs is similar, with the state's share of the country's total at only 3.85 per cent, which has deteriorated from 6.5 per cent in 2005. The situation becomes evident if one looks at the vacancies for doctors at the district and subdistrict hospitals in the state (Table 1).

Table 1: Percentage of vacant positions for doctors at district and subdistrict level hospital

State	District hospital	Subdistrict hospital
West Bengal	31%	62%
All India	14%	40%

Source: authors' compilation based on data from the Rural Health Statistics, Government of India (2020).

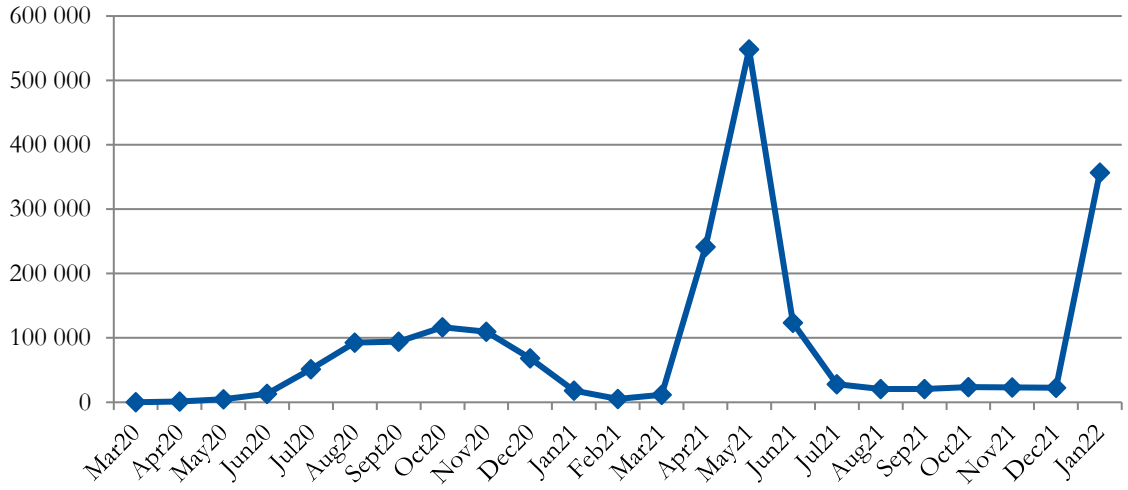
One interesting feature of the health care-seeking behaviour of the people of West Bengal is that a very high percentage of people go to government hospitals for in-patient care. In rural West Bengal the share of government hospitals in hospitalization cases is 74.1 per cent, which is the third highest after Assam (76.7) and Odisha (75.1), while the all-India average is 45.7. In urban West Bengal, 58.9 per cent goes to government hospitals for in-patient care, which is the highest among all the major states and much above the all-India average (35.3) (Government of India 2019). This high dependence of the people of the state on the government health care system keeps the government on its toes, and therefore responsiveness of the system to people's needs is of critical importance.

4 COVID-19 in West Bengal: infection, death, and vaccination

The first positive case of COVID-19 in the state was identified on 17 March 2020, when a student travelled from the United Kingdom to Kolkata. On 31 January 2022, the cumulative number of positive cases was 1,995,516, and the cumulative number of deaths was 20,619. Three-quarters of the total deaths occurred in Kolkata Metropolitan Area and four nearby highly urbanized districts—North and South 24 Parganas, Howrah, and Hooghly. Except for a few small episodes of increase in the post-festival days, daily deaths decreased quite significantly overall following the spike of May–July 2021. This period coincided with the state assembly elections. In January 2022 it again shot up, presumably because of the large movements and gatherings of pilgrims on their way to the Gangasagar Mela, a religious festival.

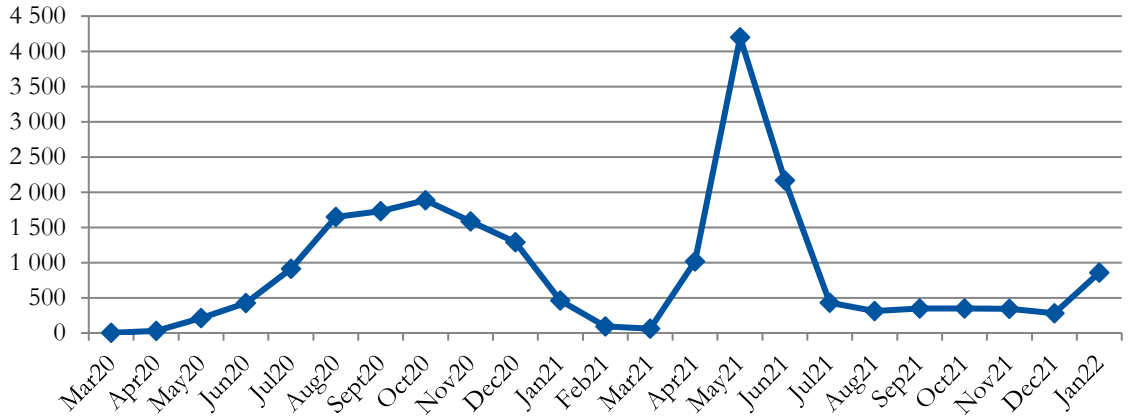
Figures 5–7 present month-wise numbers of positive cases, deaths due to COVID-19, and tests performed, respectively, for the period between March 2020 and January 2022 in West Bengal.

Figure 5: Month-wise COVID-19 positive cases (March 2020 to January 2022)



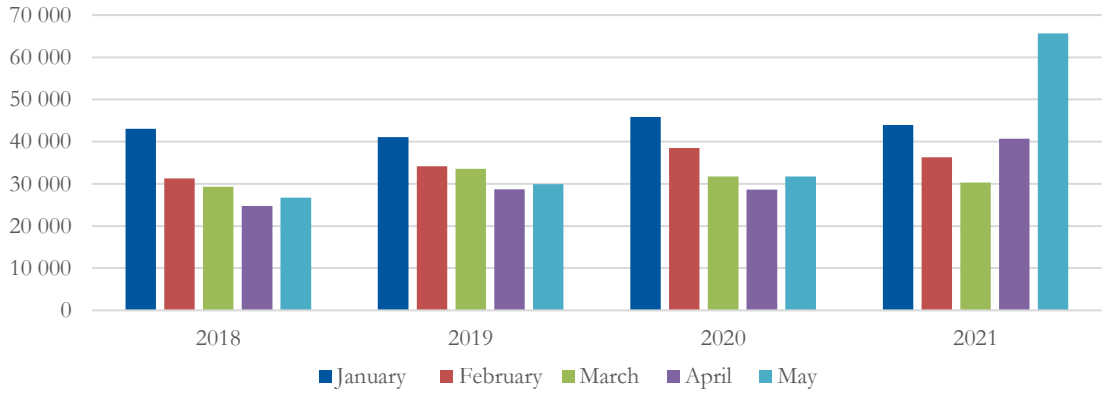
Source: authors' compilation based on data from the Department of Health and Family Welfare, Government of West Bengal.

Figure 6: Month-wise number of COVID-19 deaths (March 2020 to June 2022)



Source: authors' compilation based on data from the Department of Health and Family Welfare, Government of West Bengal

Figure 7: Registered deaths in West Bengal according to month and year



Source: authors' compilation based on data from Ramani (2021).

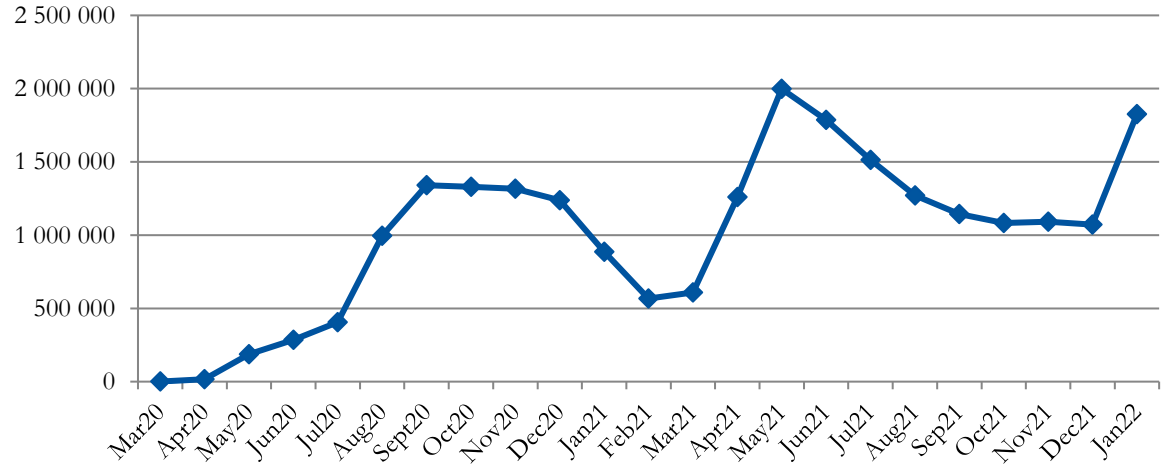
In terms of reported deaths due to COVID-19 there were charges of concealing or underreporting, even though, as it turned out, this was not unique to the state. This was supported to some extent by the National Sero-survey conducted by the ICMR sometime in June–July 2021 in 70 districts of India. Nearly 75 per cent of the sample tested showed COVID-19 antibodies, and in West Bengal this was found to be 61 per cent (Mint 2021). There could be other reasons beyond the deliberate suppression of numbers. For example, since there was no official follow-up of COVID-19 patients who developed complications later, deaths due to post-COVID-19 complications are usually not counted among deaths due to COVID-19.

The charges of underreporting were due to the formation of an 'audit committee' by the state government that ascertained the cause of death. Official figures were published only after the approval of this committee, which separated comorbidities from COVID-19 deaths. Some attempts to estimate the 'excess deaths' from COVID-19 by examining past trends in death rates suggest that the number of actual deaths due to COVID-19 could be as high as 11 times the official count (Ramani 2021).

As Figure 7 shows, the number of registered deaths in states show a marked increase in absolute values that correspond to periods of spikes in COVID-19 infections. While the precise estimates of the 'excess' can be questioned, there are clear indications that the actual numbers of deaths are likely to be several times higher than have been reported.

The record of the state in terms of testing and vaccination show a gradual but slightly uneven increase over the period. Curiously, the number of tests follows a pattern similar to the movement of the number of positive cases and the number of deaths (Figure 8).

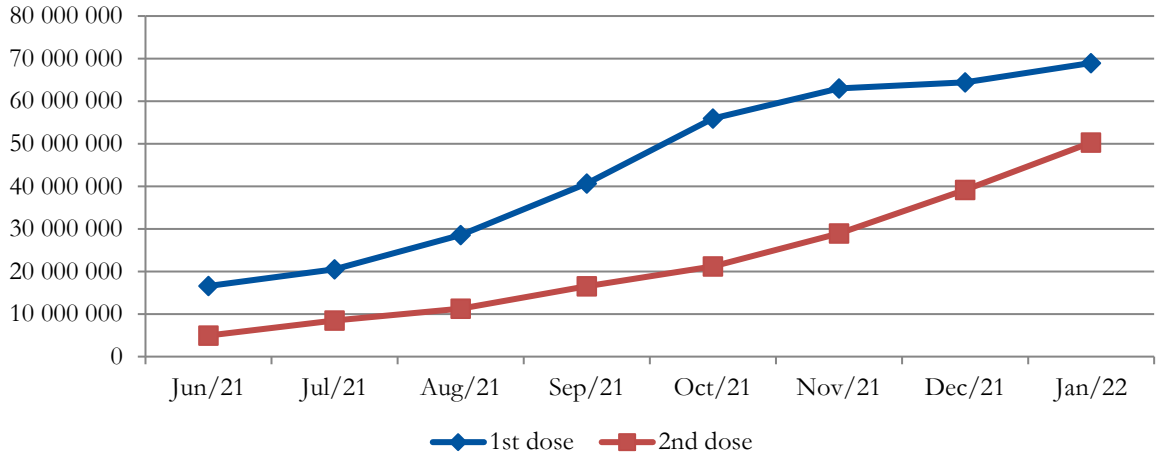
Figure 8: Month-wise COVID-19 tests performed (March 2020 to January 2022)



Source: authors' compilation based on data from the Department of Health and Family Welfare, Government of West Bengal.

On 30 June 2021, the accumulated number of vaccinated persons stood at 21,547,619, of which 4,955,392 had received two doses. On that day itself, 281,683 persons were vaccinated. As of the end of January 2022, close to 50 per cent of the people in West Bengal had received COVID-19 vaccines. Figure 9 shows the progress of vaccination in West Bengal.

Figure 9: Progress of vaccination (accumulative) as of 31 January 2022



Source: authors' compilation based on data from the Department of Health and Family Welfare, Government of West Bengal.

Importantly, the macro data on COVID-19 infection, death, and vaccination reveal that despite limitations in infrastructural capacity, the state managed to contain COVID-19, barring certain periods. The great disparity in official figures regarding deaths and the number of registered deaths in the state requires attention. In terms of vaccination and testing, the progress, although slow in the beginning, later improved significantly. However, one cannot miss the periods of surges in COVID-19 infections and evident waning in testing. In the next section we present a narrative on the policy response, which was conditioned by the prevailing economic situation, health infrastructure, political dynamics, and governance design and practice. The detailed policy measures are collated from the daily bulletins published on the website of the Department of Health and Family Welfare, Government of West Bengal.

4.1 COVID-19 policy response in West Bengal

Notably, right from the onset of the infection, there was no denial (e.g., 'not happening', 'exaggerated') of the seriousness of the situation, unlike in the countries of the developed West. This could be attributed to the chief minister and senior bureaucrats of the government. The government started its efforts to spread awareness and inform citizens on the recommended measures of hygiene, social distancing, restrictions, and home quarantine by early February 2020 (Saha 2020; Sinha 2020). The advisory received from the WHO and the central government and daily bulletins were uploaded on the Department of Health and Family Welfare website from 4 February 2020. A 24/7 control room was set up with two helpline numbers and two government hospitals, one in Kolkata and the other in Siliguri, were designated as isolation facilities.

On 28 February 2020 the state government published a directive for arranging awareness programmes about the spread and prevention of COVID-19, and on 16 March 2020 declared the formal suspension of all schools and colleges. It also issued guidelines for hospitals and medical colleges for identification and management of COVID-19 patients under sections 2–4 of the Epidemic Disease Act (Sinha 2020). District administrations were empowered to take the necessary steps for the prevention and containment of the disease. By the third week of March, all anganwadi (child care) centres and hostels were shut down and all services were restricted except for health care and essential commodities.

The promptness of the centralized administration functioned in foregrounding awareness of and response to COVID-19 in the state. Such efforts were, however, constrained by institutional shortcomings as the limited number of testing laboratories meant only a small number of tests were conducted. On 17 March, the day of the first positive case in the state, only 70 samples were sent to the two testing facilities—the National Institute of Virology, Pune, and the National Institute of Cholera and Enteric Diseases, Kolkata.

Following the central government decision for a nationwide lockdown, the state government published an advisory notification on 31 March 2020 detailing pandemic management and quarantine measures. District surveillance teams were created to compile reports (Saha 2020) and a three-tier health management system was created. The rural- and block-level health care units were demarcated as primary, district hospitals, and subdivisional health care as secondary units and state-owned government hospitals as tertiary units, along with a few private hospitals for COVID-19 (Saha and Kasi 2020). By the end of March, more than 1,000 beds were earmarked for isolation across 87 government and private hospitals (Saha 2020) and 200 safe homes with 11,500 beds for COVID-19 isolation were set up (Kar 2021). The government created the 'West Bengal State Emergency Relief Fund' along with a Rs.200 crore corona fund (Saha 2020).

During the initial phase, the chief minister—as the face of the government—held regular press briefings instructing the public on the importance of prevention and taking stock of administrative measures. She went out in public distributing masks and demonstrating the practice of social distancing, which had significant public purchase. The leader-centric action and bureaucratic response in terms of policy communication and management was effective in raising awareness.

The efforts of the government were, however, impeded by existing infrastructural–fiscal limitations and governance issues. News reports disclosed serious concerns around the inadequacy of PPE kits and masks (Nandi 2020), hospital beds, trained health professionals, and testing centres. Critics argued that centralized procurement and distribution of health items was responsible for the scarcity.[2] Concerns were also raised about the substandard quality of the purchase of COVID-19-related health items purchased by a committee formed by the government, instead of the usual West Bengal Medical Services Corporation Limited (HT Correspondent 2020a). The government, for its part, complained about inadequate support from central government in ensuring availability of kits and providing testing centres.[3]

In order to manage the ramification of health and economic dislocations for vulnerable populations, the state initiated a number of social welfare measures. Health workers and all other government staff on the frontlines of the crisis were promised additional health insurance worth Rs.5 lakhs. The 'Pracheshta' scheme announced on 10 April 2020 provided a one-time ex-gratia financial relief of INR1,000 to daily wage earners. The scheme remained effective from 15 April 2020 to 15 May 2020, and INR22.35 crore (223.5 million) was spent on 223,500 beneficiaries (Sonkar et al. 2021). The state also promised financial assistance of INR1,000 to stranded migrant labourers who were residents of the state under the 'Snehar Paras' (20 April 2020 to 3 May 2020). Subsidized rations for almost 9 crore beneficiaries and free rations for the population below the poverty line was promised for six months. Old-age pensions were released two months in advance

[2] D. Ghosh, interview with the authors 2021.

[3] D. Ghosh, interview with the authors 2021.

and 27 night-shelters were set up in Kolkata and Howrah to accommodate homeless people (Saha 2020).

The policy measures, while laudable, had glaring exclusions such as no aid to the families of vulnerable migrants, and insufficient allocation for the Snehar Paras scheme. The social security net for the vulnerable population was limited to allocation of rations, which was marred by allegations of hoarding by ruling party members. The ruling TMC faced allegations regarding relief distribution to Amphan-affected people in 2020 and food grains during the lockdown. The All India Fair Price Shop Dealers' Federation complained that ruling party councillors, panchayat members, and supporters were pressuring ration dealers to regularly purchase rice and wheat from their shops on the pretext of relief. The ration scam became a political feud between the governor and the state government (HT Correspondent 2020b). The chief minister announced the removal of the secretary of the Food and Supplies Department amid allegations (Nath 2020).

The more immediate weakness, however, pertained to containment, testing, and tracing of COVID-19. By April, five additional testing centres were approved by the centre, but the number of tests remained abysmally low—around 2,500 samples daily in April, which increased to 5,000 samples daily in mid-May and 9,000 samples daily in June (Saha 2020). The low number of tests, and consequently low numbers of cases and high mortality rates, exposed the institutional lacunae and caused controversy over the government's handling of the pandemic.

By July 2020 the rising number of cases led to the imposition of stricter containment measures in towns like Kolkata, Jalpaiguri, Malda, and Siliguri, and statewide lockdowns on 23, 27, and 29 July and 5, 8, 16, 17, 23, 24, and 31 August to break the cycle of transmission. This was necessitated due to the government's relaxation of lockdown rules outside containment zones in May 2020 that led to a spike in infections. The Health and Family Welfare Department demarcated the state into red, orange, and green zones, with relaxation and restriction simultaneously in clean and buffer zones. The government had allowed intra-district bus services with 50 per cent seating capacity, mining and industrial activities, operation of standalone shops, the tea industry, micro, medium, and large industries, government and private offices, shopping malls, and hotels. Interestingly, even though the government allowed business activities and offices, local trains—which constitute the transport lifeline of suburban West Bengal—remained shut, leading to insufficient transport facilities and crowding in other modes of transport.

In an effort to bolster the response to COVID-19, the West Bengal government formed a 'Global Advisory Board for Covid Response Policy in West Bengal', headed by Nobel Laureate Dr Abhijit Binayak Banerjee, along with other noted experts. The committee was much publicized after the government received flak for low numbers of tests and the massive increase in COVID-positive results. Arguably, global expertise constituted an important dimension of the state response to COVID-19 (Nag 2020).

Evidently the state response to the pandemic was undermined by concerns about the economy and populist politics manifested through relaxations in lockdown during religious festivals. The government changed the dates of partial lockdown in August 2020 because some of the dates clashed with festivals; a new list of dates of partial lockdown was published on 3 August, which excluded religious festivals. Although lockdown measures were extended in the state till 30 November 2020 and educational institutes remained closed, markets, theatres outside containment zones, and congregations in open spaces were allowed.

The state assembly elections in April–May 2021, with heightened political competition, shaped the pandemic response in a not insignificant manner. In December 2020 the state government initiated

its flagship 'Duare Sarker' (government at your doorstep) and 'Paray Samadhan' (solution in the neighbourhood) programmes. The objective of these programmes was to incorporate several flagship schemes and provide public services in panchayat and municipality areas by setting up outreach camps, under the supervision of block development officer and sub-divisional officers. The much-publicized scheme attracted enormous crowds, disregarding the COVID-19 protocols. The 750 camps in the first three days of the programme attracted more than one million people (Chakraborty 2020). In the month of August 2021, government records show 1.3 crore people turned up in the Duare Sarkar camps to receive the benefits, even though COVID-19 protocols regarding physical distancing were in place (TNN 2021).

The political pressure to alleviate economic hardships meant reopening establishments, markets, commercial workplaces, and recreational and extracurricular spaces. The government emphasized COVID-19 protocols such as sanitization, physical distancing, and provisions for thermal scanning, but the lack of coordination between the state's imposition from above and the society's incapacity to oblige meant that the second wave of the pandemic was more devastating than the first (Saha and Kasi 2020). The political mobilization and campaigns during the assembly elections disregarded COVID-19 protocols and made the bad situation worse.

Although the Election Commission put into place protocols and administrations were empowered under the DMA and EA, the ability of the state to impose its will was quite restricted as major political parties and prominent leaders (including the prime minister of India and the chief minister of West Bengal) were engaged in massive rallies and campaigns. The eight-phase election from 27 March to 29 April prolonged the electoral campaign and facilitated the spread of the pandemic. The elections saw massive rallies in violation of the COVID-19 code of conduct, utter disregard for social distancing precautions, and violation of norms (Mahmood 2020). By the end of April, when the election process was at its peak, the positivity rate (the number of daily cases) increased by 35 per cent and the daily accumulative active cases surpassed 100,000.

The elections also turned the pandemic and its management into a politically contested issue, with central and state governments trading claims and counter-claims. The TMC accused the central government of denying financial and infrastructural support in the fight against COVID-19. The state government claimed to have spent INR4,000 crore on COVID-19 management and INR6,500 crore in providing relief and rebuilding infrastructure. The central government denied the accusation that it had not yet paid INR50,000 crore dues to West Bengal for co-funded schemes and GST compensation (Press Trust of India 2020).

Post-election, the rising number of cases forced the government to reimpose partial lockdown. The notification published on 1 May 2021 restricted public gatherings for marriages and social events to the minimum. Retail and standalone shops were to operate from 7 a.m. to 10 a.m. and 5 p.m. to 7 p.m. The suburban local trains remained shut and an RT-PCR negative test result was made mandatory for entering the state. Lockdown restrictions were extended up to 15 July 2021 with exceptions for health care services and in-house workers in industries, mills, and tea-garden estates.

The intense political debate over COVID-19 management distracted attention from persistent infrastructural problems such as lack of trained workers and interdepartmental coordination that affected COVID-19 management. A study by Bhattacharyya et al. (2020) found a lack of effective coordination among multiple departments in the state, including data-sharing in the health sector. Decision-making at the district level was found to have no structured processes, discussions about infrastructure and supplies were often not supported by data, and planning targets were not linked to health outcomes. Interviews with doctors and health activists corroborated the ad-hoc decision-

making and lack of interdepartmental coordination as barriers to effective COVID-19 management.[4] Doctors' organizations in the state suggested that the delayed lockdown (only after election results were declared) despite the rising number of cases, lack of COVID beds, inadequate testing, and shortage of vaccines and trained health care staff were characteristic of hasty planning and aggravated the crisis (Kar 2021). They also alleged that the announced INR5 lakh (0.5 million) insurance for frontline and medical workers or INR10 lakh (one million) compensation for bereaved health care workers' families were not disbursed for a large number of health care workers who contracted or died of COVID-19. Management of COVID-19 also reached the Law Court as private hospitals that were enlisted under the state health scheme to provide COVID-19 treatment approached the court for non-payment of bills by the state (Maiti 2021).

Responding to the increasing criticism of COVID-19 management, the government became more reactive. In May 2021 the government decided to field roughly 300,000 untrained health workers and medical interns in the fight against the pandemic (Express News Service 2021). It also allowed all public and private hospitals to increase bed capacities by 40 per cent to meet the demand for hospital beds. These policies of the state government, while comprehensible in the light of the pandemic, reflect short-termism. The bureaucratic and centralized management of COVID-19 also received criticism from doctors' organizations and civil society, who called for decentralization of monitoring and management (Kar 2021). It is noteworthy that civil society organizations and clubs had come forward to support the overwhelmed public health system during the second wave of the pandemic by organizing/arranging isolation facilities, oxygen, and even medical support. Organizations such as the Red Volunteers acquired prominence by facilitating tertiary support to COVID patients through organizing oxygen cylinders and arranging hospitalization of patients (Chakraborty 2021). The government, however, continued with its reliance on centralized bureaucracy, and in July 2021 appointed 10 senior bureaucrats to be in charge of 10 districts that were witnessing high numbers of COVID-19 cases (Roy 2021).

5 Conclusion

The West Bengal government's response to the COVID pandemic was prompt and followed the expected line even though there was hardly any blueprint for this. The response at times was reactive to rising infections and public criticism and constrained by infrastructural limitations, a characteristic of many developing economies (Yen et al. 2022). In terms of the fiscal parameters and standard indicators of health care infrastructure, the state falls short of the average of all the major Indian states. Yet, the state managed to avert the worst consequences. To what extent this can be attributed to 'state capacity' remains unclear. One explanation of poor performance of government institutions generally in a country like India is that low effort goes unpunished, which is close to what is generally known as the principal–agent problem in information economics. In normal times it is a challenge to the bureaucracy to maintain its efficiency in service delivery. However, when the system is faced with a disaster, the institutions are likely to respond differently, defying the narrow self-interest-based explanation in the form of the principal–agent problem. Nor does the leader-centric explanation based on asymmetry of power between the leader and the followers in the bureaucracy seem appropriate. During the pandemic, a sense of social responsibility was clearly visible among the doctors, nurses, health workers, police, and various other officials. This makes the outcome of state action rather unpredictable. If one of the features of state capacity is considered to be strong institutions, the over-centralization of decision

[4] D. Ghosh, interview with the authors 2021.

processes gets in the way of strengthening state institutions. Although in the immediate response to the outbreak of a pandemic it may not be terribly important, as the West Bengal case shows, for long-run sustainability of the responsiveness of the health system to people's needs, strong and robust institutions seem necessary.

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