

THE INEQUALITY VIRUS

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to end
discrimination

Acknowledgments

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“THE COVID-19 PANDEMIC HAS PLAYED AN IMPORTANT ROLE IN HIGHLIGHTING GROWING INEQUALITIES. IT EXPOSED THE MYTH THAT EVERYONE IS IN THE SAME BOAT. WHILE WE ARE ALL FLOATING ON THE SAME SEA, IT’S CLEAR THAT SOME ARE IN SUPERYACHTS, WHILE OTHERS ARE CLINGING TO THE DRIFTING DEBRIS.”

- António Guterres, United Nations Secretary-General



The Coronavirus pandemic has been the world's worst public health crisis in a hundred years. It has triggered an economic crisis which is comparable in its scale only with the Great Depression of the 1930s. The contraction of GDP globally because of the pandemic is estimated by the World Bank to be 5.2 percent in 2020;¹ the number of countries registering per capita contractions is the largest the world has seen since 1870. The stock market collapse in March 2020 destroyed billions worth of financial assets. It seemed that everyone was in this crisis together.

However, with the passage of time, it has become evident that the existing socio-economic inequalities has led to an unequal health and economic impact among the various population sub-groups and has defined their coping abilities in recovering from the current crisis. The increasing inequality and the unequal impact on the haves and the have-nots have prompted many to refer to the health crisis as the "pandemic of inequality".² As António Guterres, the United Nations Secretary-General had said:³

"The COVID-19 pandemic has played an important role in highlighting growing inequalities. It exposed the myth that everyone is in the same boat. While we are all floating on the same sea, it's clear that some are in superyachts, while others are clinging to the drifting debris."

India introduced one of the earliest and most stringent lockdowns in the face of the pandemic,⁴ the enforcement of which brought its economy to a standstill triggering unemployment, hunger, distress migration and untold hardship. The rich could escape the pandemic's worst impact, and white-collar workers have easily isolated themselves and have been working from home. However, most of India has faced loss of livelihoods. During the pandemic, on the day when Indian billionaire, Mukesh Ambani, rose to become the fourth richest man in the world, a farmer, Rajesh Rajak, and his three daughters died by suicide as a result of his job loss.⁵ The rising inequality in the country is poignant: It would take an unskilled worker 10,000 years to make what Ambani made in an hour during the pandemic and 3 years to make what Ambani made in a second.⁶ The pandemic has also widened the existing social, economic and gender-based inequalities.



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1. COVID-19 AND WEALTH INEQUALITY

1.1 GLOBAL SCENARIO

During the pandemic, many billionaires saw a rise in their wealth. Jeff Bezos, the world's richest man saw a rise to USD 185.5 billion and the wealth of Elon Musk increased to USD 179.2 billion, as of 18 January, 2021.⁷ Other tech giants like Google founders Sergey Brin and Larry Page and former Microsoft CEO Steve Ballmer saw their wealth surge by USD15 billion since March 2020. Eric Yuan, founder and CEO of Zoom, too saw a sharp rise in his wealth, which is reportedly worth USD 2.58 billion.⁸

The global billionaires' wealth rose by 19 percent during this time.⁹ The world's 500 richest people gained USD 809 billion this year, a 14 percent increase since January 2020¹⁰ while 100 million people were pushed into poverty.¹¹ The pandemic also risked the income of the world's poorest population which might potentially get reduced to USD 50 million a day in developing countries where millions of people live just above the poverty line.¹²

1.2 INDIAN BILLIONAIRES ARE GETTING RICH

THE WEALTH OF INDIAN BILLIONAIRES INCREASED BY 35 PERCENT DURING THE LOCKDOWN and by 90 percent since 2009 to USD 422.9 billion ranking India sixth in the world after US, China, Germany, Russia and France.¹³



INDIA'S 100 BILLIONAIRES HAVE SEEN THEIR FORTUNES INCREASE BY INDIA-RUPEE 12,97,822 CRORES SINCE MARCH, ENOUGH TO GIVE EVERY ONE OF THE 138 MILLION POOREST INDIAN PEOPLE A CHEQUE FOR INDIA-RUPEES 94,045 EACH.¹⁴

This is despite the fact that most of India has faced loss of livelihoods and its economy has dipped into recession for the first time after a quarter of a century.¹⁵ The increase in wealth of even the the top 11 billionaires during the pandemic can easily sustain the MGNREGS scheme or the health ministry of India for the coming 10 years.¹⁶

Mukesh Ambani, emerged as the fourth richest man in the world and the richest in India and Asiaⁱ with his wealth rising to INR 5837 billion¹⁷-a rise of 72 percent in his wealth.

MUKESH AMBANI WAS MAKING INR 90 CRORE PER HOUR DURING THE PANDEMIC WHEN AROUND 24 PERCENT OF THE PEOPLE IN THE COUNTRY WERE EARNING UNDER INR 3000 PER MONTH¹⁸ DURING THE LOCKDOWN.

India's wealthiest people escaped the worst impact of the pandemic while majority of India suffered. This gross asymmetry of power and resources is not just a moral argument, but a practical question. As per International Labour Organization(ILO), with a share of almost 90 per cent of people working in the informal economy, about 40 crore of these workers are at a risk of falling deeper into poverty during the crisis¹⁹. The increase in the wealth of the richest person in India during pandemic could keep these 40 crore informal workers out of poverty for at least 5 months.²⁰

i China's Zhong Shanshan is the richest person of Asia while Mukesh Ambani is in the second position as of 18th January 2020.

The government was reluctant to spend on public welfare but the corporate sector and India's elites were actively subsidized by the government. Media reports have highlighted how the fourth tranche of the Government's COVID-19 relief package has benefitted a range of corporates like Adani, Reliance Group and Vedanta, among others.²¹ The provision of interest-free loans to Medium and Small Enterprises alone is calculated to have been worth INR 3 lakh crore, almost ten times the quantum of funds directly given to the poor (including Jan Dhan, PM Kisan Yojana and transfers to old persons, widows, disabled and construction workers).²²



THE INCREASE IN THE WEALTH OF THE RICHEST PERSON IN INDIA DURING PANDEMIC COULD KEEP 40 CRORE INFORMAL WORKERS OUT OF POVERTY FOR AT LEAST 5 MONTHS.



170,000 PEOPLE LOST THEIR JOBS EVERY HOUR IN THE MONTH OF APRIL 2020.

A survey done by Credit Vidya reported that the loss of income among those earning more than INR 60,000 a month was 10 percent compared to their pre-pandemic income whereas the income of those earning less than INR 20,000 a month reduced to 37 percent of their pre-pandemic income.²³

Eighty-four percent of the households suffered a loss in income in April 2020;²⁴ 170,000 people lost their jobs every hour in the month of April 2020;²⁵ and approximately 167 people killed themselves due to starvation and financial distress from job loss and reduction in income between March to July 2020.²⁶

1.3 POLICY ON TAXATION

India's real GDP was on a downward slope much before the COVID-19 pandemic hit the country. Growth moderated from 7 percent in 2017-18 to 6.1 percent in 2018-19, and further to 4.2 percent in 2019-20.²⁷ This was largely due to demonetization and the implementation of the Goods and Services Tax (GST) that paralyzed the cash-dominated informal sector and small businesses.²⁸ COVID-19 has worsened this situation by further declining the growth rate of GDP which in turn is affecting the revenue receipts of the country. It is projected that nominal GDP in 2020-21 will remain the same as 2019-20.²⁹ This will have a negative impact on the financing requirements that have risen due to the pandemic. An estimated 73 percent of the country's revenue comes through taxes³⁰ while the share of indirect taxes (custom duty and GST) has increased from 44 percent in 2014-15 (A) to 47 percent in 2018-19 (BE). For 2019-20 (BE), it is projected to be 46 percent,³¹ which indicates that there is still a heavy reliance on indirect taxes.

India has achieved only 42.1 percent of the total tax revenue target of INR 16.35 lakh crore for the fiscal year 2020-21 as per data from Controller General of Accounts (Budget Estimate). Only two-fifth of the total receipt has been achieved till November 2020 while 62.7 percent of the budgeted expenditure has been made.³² Any attempt to increase the tax-GDP ratio through GST would lead to higher inequality in a country because GST is an indirect tax and it is levied at the same rate on the poor and the rich.³³ This can be rectified through differential rates of GST on rich and poor, or removal of GST rates from essential commodities altogether.³⁴ In addition, there is a need to put more emphasis on direct taxes such as income and corporate tax rates, which are more direct forms of taxation and aim to collect revenue from the wealthiest of the country.

The recommendations as part of a policy paper titled 'Fiscal Options & Response to Covid-19 Epidemic (FORCE)', which the IRS Association presented to the

Prime Minister's Office (PMO) also suggested raising the income tax rate to 40 percent for those who earn over INR 1 crore per year, re-introducing wealth tax and effecting a one-time Covid-19 cess of 4 per cent on taxable income of over INR 10 lakh to help the economy recover from the lockdown.³⁵ Imposing such taxes would reduce reliance on regressive taxes on consumption such as the GST, which hurts the poor and the marginalised disproportionately. Indeed, one estimate suggests that a 4 percent wealth tax on the nation's 954 richest families could raise the equivalent of 1 percent of India's GDP.³⁶ At the same time, the direct fiscal impact of the Atma Nirbhar package announced by the Government of India for COVID-19 recovery comes to a little more than INR 2



A 4 PERCENT WEALTH TAX ON THE NATION'S 954 RICHEST FAMILIES COULD RAISE THE EQUIVALENT OF 1 PERCENT OF INDIA'S GDP

lakh crore or a mere 1 per cent of GDP.³⁷ While this is grossly inadequate to address the scale and extent of the impact of the pandemic; it is also clear that instead of raising tax from the middle class who were adversely affected by the pandemic economically, the government could have easily levied a COVID-19 surcharge on the richest in the country and financed its welfare packages.

Best Practice: Higher taxes on the rich

Many countries have introduced higher taxes on the richest individuals during the pandemic. Peru has proposed a temporary solidarity tax on the wealthy and super-rich Peruvians.³⁸ Argentina's senate has passed a one-off wealth tax that affects its richest 10,000 citizens and which aims to raise USD 3 billion for social spending for those impacted by the pandemic.³⁹ Levies on the rich has been made in countries like Spain⁴⁰ and Russia⁴¹.

2. IMPACT OF COVID-19 ON INTERSECTING INEQUALITIES

The experiences of the marginalized communities during this pandemic have been informed by the intersecting axes of identities as caste, class, gender, religion and region exposing the fractures in the social and economic systems. As such, its impact on health, livelihood and access to education has been uneven, hitting India's women, poor and the marginalized groups the most.

2.1 ACCESS TO EDUCATION

Governments globally have temporarily shut down educational campuses in an effort to curb the spread of the pandemic. At the peak of school closure, 1.6 billion students were impacted across 190 countries with 24 million children and youth at risk of dropping out threatening the future of an entire generation.⁴²

The central government of India announced a country-wide lockdown of all educational institutions on March 16, 2020.⁴³ Till the end of October, the number of students affected by the closure of educational institutions stands at over 32 crores.⁴⁴ Of those, 84 percent reside in rural areas and 70 percent attend government schools.⁴⁵ The closure of schools



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and the shift to online education classes has had serious consequences for children particularly those belonging to the poorer households and marginalized social groups. It also runs the risk of exacerbating inequalities between the genders and the rich and the poor in an already unequal educational system.⁴⁶

2.1.1. Unequal risk of drop-out

Short-term disruption in education risks permanent drop-out. While the children of India's elites have been sheltered from the worst impacts of the pandemic, many children from poor and marginalized families will never return to school. Oxfam India's survey across five states reports that close to 40 percent of teachers in government schools fear that the prolonged school closure might lead to a third of the students not returning once schools reopen.⁴⁷

The true proportion of dropout will only be apparent when schools re-open. Experts estimate that out-of-school rates will double in a year.⁴⁸ Moreover, the likelihood of dropout increases with the decreasing wealth quintile.⁴⁹ It is also often the socially marginalized that are the poorest. As such, it is likely that a higher rate of drop-out will be witnessed among Dalits, Adivasis and Muslims. Many of them will become victims of child labour and child marriage. Indeed the ILO has urged India's government to safeguard children from falling into child labour.⁵⁰

Girls are more vulnerable as they are exposed to additional risks including early and forced marriage, violence and early pregnancies. Fifty-two percent of adolescent girls surveyed by Praxis (75 percent of whom were from SC/ST categories) reported that

their time spent on studies significantly decreased due to lack of technical facilities, fights at home and domestic violence.⁵¹

2.1.2. Shrinking state schemes for the poor

Schools have not just been the major providers of education but the site of delivery of a range of social welfare schemes as well. The closure of schools has disrupted access to schemes for the poor in India's welfare system. Over 60 lakh SC and ST students enrolled in higher secondary education who get 100 percent and 75 percent centrally funded scholarships, respectively, have not received it. States have either discontinued the scheme or are running it at a limited scale.⁵²

The closure of government schools has disrupted the mid day meal scheme (MDM) which covers 120 million children in 1.26 million schools.⁵³ Around 77.8 percent of ST and 69.4 percent of SC children are in government institutions many of whom depend on MDM for their nutritional intake. This risks exacerbating malnutrition among vulnerable populations, mainly Dalits and Adivasis. Oxfam India's survey has found that despite being asked by the Supreme Court to continue the scheme, 35 percent children did not receive their mid day meals. Of the remaining 65 percent, only 8 percent received cooked meals, 53 percent received dry rations and 4 percent received money in lieu of the MDM.⁵⁴



THE CLOSURE OF GOVERNMENT SCHOOLS HAS DISRUPTED THE MID DAY MEAL SCHEME (MDM) WHICH COVERS 120 MILLION CHILDREN IN 1.26 MILLION SCHOOLS. AROUND 77.8 PERCENT OF ST AND 69.4 PERCENT OF SC CHILDREN ARE IN GOVERNMENT INSTITUTIONS MANY OF WHOM DEPEND ON MDM FOR THEIR NUTRITIONAL INTAKE.

2.1.3. Widening the digital divide

India, like many countries in the world, closed its schools and introduced a range of emergency

education measures particularly a shift to online or distance education modes. The government supported the transition of learning to the virtual space through online portals as Diksha, National Repository of Open Educational Resources, Swayam and e-Pathshala and through distance modes as television and radio.



OUT OF THE POOREST 20 PERCENT HOUSEHOLDS IN INDIA, ONLY 2.7 PERCENT HAVE ACCESS TO A COMPUTER AND 8.9 PERCENT TO INTERNET FACILITIES. 96 PERCENT OF ST AND 96.2 PERCENT OF SC HOUSEHOLDS WHOSE CHILDREN ARE IN SCHOOL LACK ACCESS TO A COMPUTER.

These initiatives are in good faith but have ignored the pressing digital divideⁱⁱ plaguing India. Entering the pandemic, only 4 percent of rural households had a computer and less than 15 percent rural households had an internet connection.⁵⁵ Much of the government's distance learning modes of instruction were undertaken through DTH (Direct To Home) TV despite only 5.25 percent of the households having a DTH subscription.⁵⁶ Low and no-tech modes of delivery have been ignored amidst the push to move all instruction online or into the digital space.

The gap is even wider if one digs deeper and looks at access for those who have historically been deprived of a good education. Out of the poorest 20 percent households in India, only 2.7 percent have access to a computer and 8.9 percent to internet facilities. Ninety-six percent of STs and 96.2 percent of SC households whose children are in school lack access to a computer.⁵⁷ Only 15.5 percent rural females can either use a computer or the internet.⁵⁸ These patterns may have changed during the lockdown, but the trends remain. According to ASER 2020, 11 percent of parents bought a phone during the lockdown to prevent an interruption in their child's learning. However, this is

woefully inadequate given that only about one-third of the surveyed children had access to online learning. The challenges that India's poor faced were not only with respect to accessing technology, but also with essential space and privacy. The average household size in India is 4.45⁵⁹ and 59.6 percent of India's population lives in a room or less.⁶⁰ Therefore, home environments are not conducive to effective learning.

The move online also has its risks. Thirty-seven percent of Indian parents in 2018 reported that their children experienced cyber bullying.⁶¹ The India Child Protection Fund (ICPF) recorded a 95 percent surge in child pornography traffic after the announcement of the COVID-19 lockdown.⁶² Neo-literate families have been least equipped to deal with these new threats.

The great divide between the rich and the poor

Cases of students missing classes due to lack of smartphones or an internet connection have been pouring in from across the country. One such instance is of two girls from the same class at a small private school in Punjab that highlights the glaring difference between the experiences of the rich and the poor.⁶³ While one of the girls, residing in a posh area had Wi-Fi at her home and found classes from home to be "awesome", the other girl could barely attend 10-12 classes in one and a half months' time. She had to rely on her smartphone's 4G signal, strongest in her terrace due to which she would often study there in the heat of the summer. Even then, she could not always log in to her classes. Watching videos online was a problem and so was downloading. Electricity was available only for a few hours and keeping her phone charged added to the stress. In another instance, a teenager in Kerala killed herself due to her family's inability to buy a smartphone or a television. Her father was a daily wage earner.⁶⁴

ii A digital divide is any uneven distribution in the access to, use of, or impact of information and communications technologies (ICT) between any number of distinct groups, which can be defined based on social, geographical, or geopolitical criteria, or otherwise. (www.ntia.doc.gov)

2.1.4. The burden of individualizing instruction

As government schools closed, the burden of ensuring that children continue their education fell squarely on individual households with those financially better off and educated benefitting. In the ASER 2020 survey, children in families with parents educated up to 10th standard were almost twice as likely to have access to a smartphone for instruction during the pandemic and almost twice as likely to receive family support for learning. Children from poor families and without access to technology were left without access to effective modes of education delivery.

The support extended to children has often come at a price in terms of increasing the burden on working women, attempting to juggle childcare responsibilities with work in the wake of closed crèches, schools and preschools. On-site nurseries in workplaces have also often been closed in many locations, further putting families in a quandary.⁶⁵

In contrast, India's elites have embraced the move online. This has also been fed by the exponential growth of private providers. Online learning apps such as BYJU's and Unacademy have gained prominence. BYJU's is currently valued at USD 10.8 billion whereas Unacademy is valued at USD 1.45 billion.⁶⁶ However, these apps are exclusive in nature with a customer base that is urban with access to technology and are purely geared towards profit.

Best practice: Tech-free education

While the situation appeared bleak, local, tech-free and more equitable innovations successfully helped children access education during the prolonged school closure, and offer cause for hope.

Chhattisgarh began Mohalla (neighborhood) classes in areas with low infection rates. Mini classrooms, with small groups of students, have been set up in community spaces. The teacher spends a couple of hours in each

room, engaging with all students at least twice a week. The use of Mohalla classes has been listed as a best practice by India's Ministry of Education⁶⁷ in its report on education during COVID-19. Chhattisgarh has also been successful in delivering mid-day meals to children's homes; an Oxfam study⁶⁸ showed that over 90 percent of children received their due entitlement under the MDM scheme in Chhattisgarh.

While states have reopened schools for older children, there is a need to prioritize reopening for early grades to ensure that the most marginalized children, especially those who cannot learn independently, get access to learning through in-person classes as well as due entitlements such as Mid-day meals, uniforms and textbooks. Indeed, many countries like France, UK, Germany, Ireland and Italy have prioritized taking necessary steps to keep schools open while they have imposed restrictions on other aspects of everyday life.⁶⁹

2.1.5. The private schools

An Oxfam India survey⁷⁰ showed that close to half the parents spent over 20 percent of their income on education during the lockdown. Thirty-nine percent parents reported being charged hiked fees despite the physical closure of schools and state guidelines restricting fee hikes. Fifteen percent parents were charged fees for uniforms despite schools being closed. India saw a shift from private to government schools between 2018-2020, in all grades and among both boys and girls in the face of financial distress in households and shutdown among private schools.⁷¹



AN OXFAM INDIA SURVEY SHOWED THAT CLOSE TO HALF THE PARENTS SPENT OVER 20 PERCENT OF THEIR INCOME ON EDUCATION DURING THE LOCKDOWN.

Best practice: Regulation of private schools

While private schools exploited parents by arbitrarily hiking their fees during the pandemic, a few good practices have emerged that offer hope for better regulation of private schools. Various states issued circulars preventing private schools from hiking their fees. Assam government⁷² asked all private schools to waive off their fees by 25 percent to offer relief to parents and Chhattisgarh⁷³ passed a fee regulation law as a long-term measure to regulate private schools. This lays down a precedent for a comprehensive regulatory body for private schools that includes and goes beyond fee regulation to prevent overcharging, exploitation and exclusion of children.

2.2 INEQUALITIES IN HEALTH

India currently has the world's second largest cumulative number of COVID-19 positive cases. Globally, the poor, marginalized and vulnerable communities have higher rates of COVID-19 prevalence. India, however, does not report case data disaggregated by socio-economic or social categories making it difficult to gauge the distribution of the disease amongst various communities.

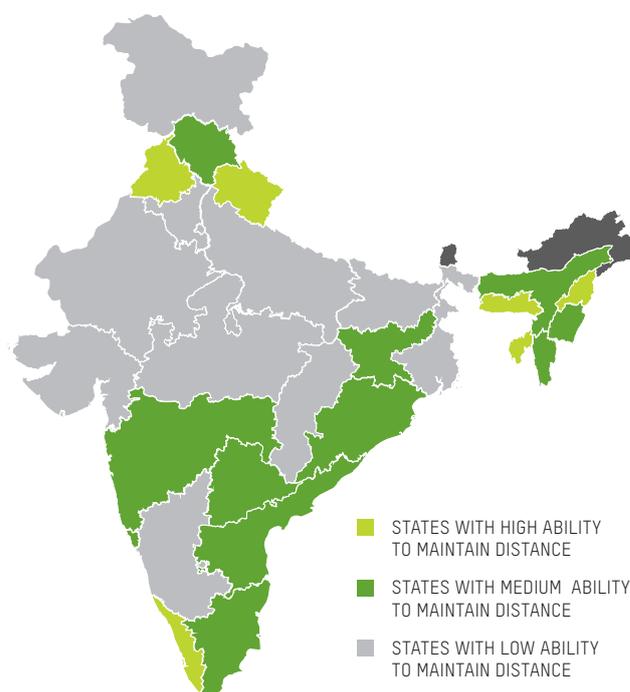
Nevertheless, the spread of disease was swift among poor communities, often living in cramped areas with poor sanitation and using shared common facilities such as toilets and water points. Similarly, the quick spread of disease across dense suburban slums of Mumbai highlighted greater vulnerability of those in more marginalized communities. Incidence of COVID-19 positive cases have been highest in slums of Mumbai.⁷⁴ In addition, it is often those employed in informal employment—migrants looking for opportunities in a city—who wind up in informal settlements as slums. Evidence from Chennai also highlights that areas with highest deprivation have experienced greater COVID-19 positivity rates.⁷⁵ Choudhury and Rao P. writes, "Slums...are situated on floodplains, garbage dumpsites and other hazardous environments... water facilities are grossly inadequate and sometimes more than 10 people share a tiny room and 10 to 100 people share a toilet. Social distancing, handwashing and sanitation prescriptions are a luxury".⁷⁶ In urban India, 32 percent and 30 percent of the households live in one room and two room houses, respectively.⁷⁷



ONLY 6 PERCENT OF THE POOREST 20 PERCENT HAS ACCESS TO NON-SHARED SOURCES OF IMPROVED SANITATION, COMPARED TO 93.4 PERCENT OF THE TOP 20 PERCENT. 37.2 PERCENT OF SC HOUSEHOLDS AND 25.9 PERCENT OF ST HOUSEHOLDS HAVE ACCESS TO NON-SHARED SANITATION FACILITIES, COMPARED TO 65.7 PERCENT FOR THE GENERAL POPULATION.

While elites could afford to stay indoors, overlapping vulnerabilities, deprivations with regards to water, sanitation and cooking fuel among the poor have placed millions at risk.⁷⁸ Only 6 percent of the poorest 20 percent has access to non-shared sources of improved sanitation, compared to 93.4 percent of the top 20 percent.⁷⁹ 37.2 percent of SC households and 25.9 percent of ST households have access to non-shared sanitation facilities, compared to 65.7 percent for the general population.⁸⁰ It is the poor and marginalized groups that have been exposed and are vulnerable to the virus the most while the rich could conveniently protect themselves.

The majority of Indian states^{iii,81} were unprepared to support their citizens to stay indoors and observe social distancing. A study examined the ability of various states to observe social distancing from the perspective of public health as access to water and sanitation. It found that the states with high ability to maintain distance are Chandigarh, Kerala, Meghalaya, Nagaland, Pondicherry, Tripura and Uttarakhand. States with medium ability to maintain distance or socially distance themselves are Andhra Pradesh, Assam, Goa, Himachal Pradesh, Jharkhand, Maharashtra, Manipur, Mizoram, Odisha, Punjab, Tamil Nadu, Telangana. Lastly, states with low ability to maintain distance or socially distance themselves are Bihar, Chhattisgarh, Delhi, Gujarat, Haryana, Jammu and Kashmir, Karnataka, Madhya Pradesh, Rajasthan, Uttar Pradesh, and West Bengal. However, it is important to note that there will be variations in the ability to socially distance within every state. As previously specified, crowded areas with high density of population and poor socio-economic conditions will experience a higher rate of infection.



Best Practice: Proactive government action

Dharavi has a population density of over 277,136/km² - which is 1.3 times the density of Mumbai's population--the most densely populated city in the world. Just three days after the first case of the coronavirus was discovered, a fever clinic was set up by the Brihanmumbai Municipal Corporation. Additionally, 2450 government health workers were deployed, regular sanitization of all community places, including community toilets took place and community quarantine centres were established. Rigorous tracing, tracking, testing and treatment were applied. Initially, door-to-door screening was done and later community clinics for testing and screening were set-up. In the absence of testing, the oxygen saturation through oximeter readings were measured. As of November 14, 2020 Dharavi had only 28 active cases.⁸²

Dharavi shows that proactive government action can reduce and contain the spread of infection even in high density areas.

2.2.1 The unprepared public health infrastructure

The experience of the pandemic has highlighted consequences of chronic neglect of the public healthcare systems, particularly for people living in poverty. Underfunded and weak public health systems

lack the capacity to effectively control the spread of the virus, or to provide appropriate and timely healthcare for everyone who needs it. India has the world's fourth lowest health budget⁸³ in terms of its share of government expenditure. This has resulted in a fragile, weak and understaffed public healthcare

iii The study did not include Sikkim and Arunachal Pradesh

system where people pay 58.7 percent of their total health expenditure out of pocket.⁸⁴ Despite this, only half the population has access to even the most basic healthcare services.⁸⁵ Data indicates that countries with high out-of-pocket expenditure have poorer health outcomes and have a higher risk of mortality during the pandemic.⁸⁶

The consequence of this under-investment is that existing Primary health centre (PHC) facilities in India are constrained in their functioning during COVID-19 pandemic. A study of PHC facilities indicates that 57 percent reported inadequate ventilation, 75.5 percent had negligible airborne infection control measures while N95 masks were unavailable in 50 percent of the facilities. These factors contribute to suboptimal patient safety and infection control measures.⁸⁷ Again, it is often the poor who have had to bear the consequences of the weak public healthcare system. In contrast, the rich could access personalized healthcare experience at private hospitals.

2.2.2 Unequal impact of non-COVID-19 health services on the marginalized and women

The disruption of transportation facilities and diversion of healthcare resources were major factors behind the disruption of non-COVID-19 related essential health services during the lockdown. A study⁸⁸ found a 64 percent spike in mortality between March-May 2020 and a 25 percent excess mortality in the four months after the imposition of lockdown among patients needing life-saving chronic care; the poor and SC patients faced the greatest disruptions to their care, which may also explain their higher mortality. Women faced higher non-COVID-19 centered mortality because of lower care-seeking by households for females.

Expectant mothers had to face challenges in accessing health care due to the closure of doctors' clinics, outpatient departments (OPDs) of hospitals and Anganwadi centres (AWCs).⁸⁹ It is predicted that the closure of family planning services will result in 2.95 million unintended pregnancies, 844,483 live births, 1.80 million abortions (including 1.04 million unsafe abortions) and 2,165 maternal deaths.⁹⁰ Several districts in Uttar Pradesh like Lucknow, Moradabad and Agra witnessed a drop in C-section deliveries by up to



IT IS PREDICTED THAT THE CLOSURE OF FAMILY PLANNING SERVICES WILL RESULT IN 2.95 MILLION

UNINTENDED PREGNANCIES, 844,483 LIVE BIRTHS, 1.80 MILLION ABORTIONS (INCLUDING 1.04 MILLION UNSAFE ABORTIONS) AND 2,165 MATERNAL DEATHS.

two-third.⁹¹ Furthermore, women were preferring home deliveries with the assistance of personal physicians. However, there is a distinct class privilege here since only the rich can afford a personal doctor and online consultations. Pregnant women belonging to poor families were often left unassisted as most public health care institutions were turned into COVID-19 testing facilities and hospitals.⁹² Moreover, 1 million fewer children were vaccinated in the month of April, 2020 risking the health of the next generation.⁹³

Disruption of health services was significantly higher in rural compared to urban areas. This can be attributed to the closure of all primary health centres and deployment of the staff on COVID-19 duties in rural areas, which already has comparatively sparse health infrastructure and human resource availability compared to its urban counterparts. In rural India, 17.6 percent of the population depends on sub-centres and government hospitals and 26 percent depends on PHCs and CHCs.⁹⁴ On the one hand, the rural, poor and vulnerable population is left without many alternatives for addressing their non-COVID-19 related health needs while the rich can afford private health care and online consultations. On the other hand, of those who managed to access healthcare found that the cost of treatment, the price of medicines and other indirect costs had increased manifold while supplies declined.⁹⁵ This resulted in an outrageously high healthcare cost burden on them, which may have resulted in catastrophic expenditure for many. If India's top 11 billionaires are taxed at just 1 percent on the increase in their wealth during the pandemic, it will be enough to increase the allocation of Jan Aushadi Scheme by 140 times, which provides affordable medicines to the poor and marginalized.⁹⁶

Profit-making during the pandemic

A stranded migrant worker was in dire need of Vigabatrin, an anti-epilepsy drug for his child. The marketing consultant who was helping him, found that the drug was in short supply. The pharmacies which had the drug were selling it at a high price: One strip of 10 Vigabatrin tablets that normally costs around INR 450 was selling at INR 700 by February 2020, and at INR 3,500 by April 2020.⁹⁷ Another cancer survivor, who was dismissed by his employers could no longer afford the medicines and eventually stopped taking many of the drugs.⁹⁸



IF INDIA'S TOP 11 BILLIONAIRES ARE TAXED AT JUST 1 PERCENT ON THE INCREASE IN THEIR WEALTH DURING THE PANDEMIC,

IT WILL BE ENOUGH TO INCREASE THE ALLOCATION OF JAN AUSHADI SCHEME BY 140 TIMES, WHICH PROVIDES AFFORDABLE MEDICINES TO THE POOR AND MARGINALIZED.

2.2.3 Unaffordable and frequently absent private healthcare

Due to the exponential rise in cases, government hospitals in areas with high case-load were soon overwhelmed. Due to this, state governments asked private hospitals to reserve beds for COVID-19 positive patients. The number of beds reserved in private sector have varied across the states depending upon the patient load.

In many instances, private hospitals were slow and reluctant to respond. In Bihar, the Principal Secretary of Health had expressed concern at the “almost complete withdrawal” of the private health sector in providing its services to the people of the state. He wrote,

“THE ALMOST COMPLETE WITHDRAWAL OF THE PRIVATE HEALTH SECTOR IN THE STATE IS PALPABLE AND THOUGHT-PROVOKING. PRIVATE SECTOR HAS 48,000 BEDS AS COMPARED TO 22,000 IN PUBLIC AND DOES ALMOST 90 PERCENT OF ALL OPDS (OUTDOOR PATIENT DEPARTMENT). FORGET COVID-19, EVEN REGULAR SERVICES HAVE BECOME UNAVAILABLE.”⁹⁹

Moreover, the urgent need for healthcare resulted in massive profiteering for many private health establishments. The rates of health services and facilities increased manifold overnight, making it difficult for even the middle-class to afford them. For instance, Max Healthcare in Delhi set the cost for ICU with ventilator at INR 72,500 a day; and that’s just the cost of ICU with consultation fees, medicines and consumables being billed over it. This growing unaffordability of private healthcare, even for the middle class forced the government to cap the rates of COVID-19 tests and treatments.

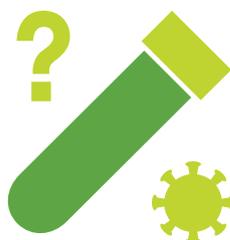
Despite the capping of prices for private hospitals across the country, treatment at a private hospital remained unaffordable for the poor and uninsured leading to catastrophic out-of-pocket expenditure and debts. The cost of treatment of COVID-19 at a super-specialty private hospital can go up to 83 times the monthly income of the 13 crore people in India that are living in extreme poverty and 31 times the average monthly income of an Indian citizen.¹⁰⁰

The government did take steps to make COVID-19 services affordable by including them under Ayushman Bharat- Pradhan Mantri Jan Arogya Yojna (PMJAY). However, the scheme only covers the below poverty line (BPL) population leaving out the uninsured poor and the middle class. Moreover, its beneficiary list is based on the SECC (Socio-Economic Caste Census) data, which is outdated. As a result, thousands of people could not avail COVID-19 services under PMJAY. The Parliamentary standing committee on COVID-19 Outbreak raised concerns on the scheme’s exclusion criteria, which caused many of those eligible from

marginalized sections of society to lose out on the benefits of PMJAY and hence to pay out-of-pocket for COVID-19 treatment.¹⁰¹ Moreover, 66 percent of the SC and 79 percent of the ST households lacked awareness about free testing and treatment provisions under the Ayushman Bharat Scheme. Only 14 percent of both SC and ST households are registered with the scheme, excluding those most in need.^{iv}

While the middle class and poor alike were struggling to get admitted, the rich, elite and powerful of the country were 'booking' ICU beds, even when they did not show COVID-19 symptoms.¹⁰² Patients who merely needed home quarantine booked ICU beds denying lifesaving care to poorer patients. The massive unavailability of beds in Maharashtra led to the health minister taking cognizance of the situation and directing authorities to not admit patients without symptoms in ICUs.

This does not bode well for the mechanics of the roll out of the COVID-19 vaccine where there is a risk of the influential and the well-connected receiving the vaccine ahead of those at greater risk.



66 PERCENT OF THE SC AND 79 PERCENT OF THE ST HOUSEHOLDS LACKED AWARENESS ABOUT FREE TESTING AND TREATMENT PROVISIONS UNDER THE AYUSHMAN BHARAT SCHEME. ONLY 14 PERCENT OF BOTH SC AND ST HOUSEHOLDS ARE REGISTERED WITH THE SCHEME, EXCLUDING THOSE MOST IN NEED.

Best Practice: Regulating price of COVID testing and treatment in private health facilities

In a bid to make COVID-19 services affordable, the government capped the rates of various services. More than 10 other states in India, including Uttar Pradesh, Tamil Nadu, Bihar, Odisha, Chhattisgarh and Jharkhand brought in policies to cap rates for COVID-19 treatment in private hospitals. If similar price capping policy measures are adopted in the long-term, several instances of overcharging beyond COVID-19 can be prevented. This could prevent private hospitals from exploiting patients and prevent thousands of people falling into poverty due to healthcare costs every year.

2.3 UNEQUAL IMPACT ON LIVELIHOOD

The economic fallout of the pandemic manifested in job losses and salary cuts for both informal and formal sector. The labour force participation rate fell to an all-time low from 43 percent to 35 percent from January to April 2020 and unemployment rose sharply since March 2020.¹⁰³ Eight in ten households have seen a decline in their income during the lockdown.¹⁰⁴

The job loss for the low-income households with no other alternative earnings and no social security has been the most troubling and will find it extremely difficult to cope with and recover from the slowdown. **AROUND 46 PERCENT OF THE LOWER INCOME GROUP HAVE RESORTED TO BORROWING MONEY TO RUN THEIR HOUSEHOLD.**¹⁰⁵

iv Moreover, insurance schemes are restricted in its approach. They cover hospitalization expenses only and long-term outpatient care, medicines and consultations are borne out-of-pocket. As such, it isn't viable to solely depend on an insurance scheme. Public health care systems should be strengthened to cater to make quality health care available to all sections of the society.



THE LABOUR FORCE PARTICIPATION RATE FELL TO AN ALL-TIME LOW FROM 43 PERCENT TO 35 PERCENT FROM JANUARY

TO APRIL 2020 AND UNEMPLOYMENT ROSE SHARPLY SINCE MARCH 2020

The economy is gradually opening up but the picture still remains grim for the many unemployed people. There are concerns that the impact would be beyond the temporary earning losses for unemployed workers.

2.3.1 Informal workers hit the hardest

The pandemic had a staggering impact on India's informal workers and small businesses. Out of a total 122 million who lost their jobs, 75 percent which accounts for 92 million jobs were lost in the informal sector.¹⁰⁶ These workers are engaged in small businesses and casual labour and are at a high risk of being pushed into poverty.¹⁰⁷ Informal workers also have relatively less opportunities to work from home and have suffered more job loss compared to the formal sector.



OUT OF A TOTAL 122 MILLION WHO LOST THEIR JOBS, 75 PERCENT WHICH ACCOUNTS FOR 92 MILLION JOBS WERE LOST IN THE INFORMAL SECTOR.

The formal sector on the other hand has also seen job loss of around 18.9 million out of which 3.9 million jobs were regained in June 2020 and then 5 million jobs were lost in July 2020.¹⁰⁸ Though the white-collar jobs could work remotely from home preventing themselves from infection, and are relatively less volatile, these jobs once lost are difficult to retrieve. The biggest job loss among the salaried employees is in high paid professional analysts which include 5.9 million workers between May-August 2020 as several companies across sectors took to job cuts, salary reduction and leave without pay.¹⁰⁹

2.3.2 Distress to migrant workers

The plight of the informal workers as a result of the lockdown and loss of income got reflected in the panic exodus of migrant workers in their desperate attempt to get back to their homes in the hope of getting food and work in the harvesting season. India has about 40-50 million seasonal migrant workers working in construction sites, factory manufacturing units and services activities.¹¹⁰ According to a Stranded Workers Action Network's report in April, 2020, 50 percent of the respondents had no rations left even for a single day; while 96 percent had not received rations, 70 percent had not received cooked food from the government; and 78 percent of the respondents had less than INR 300 left.¹¹¹

With transportation system initially shut down, many had to walk hundreds of miles. More than 300 migrant workers died due to the lockdown, with reasons ranging from starvation, suicides, exhaustion, road and rail accidents, police brutality and denial of timely medical care.¹¹² They were exposed to inhuman beating, disinfection and quarantine conditions turning the pandemic into a humanitarian crisis.¹¹³ The National Human Rights Commission recorded over 2582 cases of human rights violation as early as in the month of April 2020. Their exodus was considered reckless whereas the reasons that sparked it—lack of income, no access to food and water, fear—remained unexamined. While Indians stranded abroad were given the option to fly back home through special flights and provisions for quarantining in hotels were made, no such travel arrangements were made for the



IN APRIL, 2020, 50 PERCENT OF THE RESPONDENTS HAD NO RATIONS LEFT EVEN FOR A SINGLE DAY; WHILE 96 PERCENT HAD NOT RECEIVED RATIONS, 70 PERCENT HAD NOT RECEIVED COOKED FOOD FROM THE GOVERNMENT; AND 78 PERCENT OF THE RESPONDENTS HAD LESS THAN INR 300 LEFT.



THE NATIONAL HUMAN RIGHTS COMMISSION RECORDED OVER 2582 CASES OF HUMAN RIGHTS VIOLATION AS EARLY AS IN THE MONTH OF APRIL 2020.

migrant workers. It was only at the end of May 2020, as a relief to the migrant workers and their families, that travel arrangements were made to return to their homes. Buses were arranged for interstate movement and the Indian Railways introduced Shramik special trains for the relocation of the migrant workers. However, recently the migrants have started returning to cities due to the lack of earning opportunities in the villages. Some have returned to the job market while a large chunk is still searching for jobs.¹¹⁴

2.3.3 Women bear the brunt

It is being speculated that “[w]omen are likely to bear the brunt of job losses the most because much of their work is invisible, and they are more likely to work in informal work arrangements”.¹¹⁵



SEVENTEEN MILLION WOMEN LOST THEIR JOB IN APRIL 2020. THEREFORE, UNEMPLOYMENT FOR WOMEN ROSE BY

15 PERCENT FROM A PRE-LOCKDOWN LEVEL OF 18 PERCENT. THIS INCREASE IN UNEMPLOYMENT OF WOMEN CAN RESULT IN A LOSS TO INDIA’S GDP OF ABOUT 8 PERCENT OR USD 218 BILLION.¹¹⁶ WOMEN WHO WERE EMPLOYED BEFORE THE LOCKDOWN ARE ALSO 23.5 PERCENTAGE POINTS LESS LIKELY TO BE RE-EMPLOYED COMPARED TO MEN IN THE POST-LOCKDOWN PHASE.¹¹⁷

A survey by the Institute of Social Studies Trust¹¹⁸ found that among those who could retain their jobs, around 83 percent of women workers faced severe income drop. Sixty-six percent of the respondents also experienced an increase in unpaid care work and 36 per cent reported an increased burden of child and elderly care work during this period. Before the pandemic, rural and urban women spent 373 minutes and 333 minutes per day respectively in paid and unpaid activities combined.¹¹⁹ The total time spent in both paid and unpaid activities has risen with the increase in the workload as a result of being stuck at homes. The work-from-home culture has also blurred the lines between working hours and personal downtime. Women have been working longer hours and simultaneously managing the daily chores of the household, the educational needs of the children and care for all members of the family.

COVID-19 fuels violence at home

Uncertainty, economic hardships and growing anxiety during emergencies often fuel violent and abusive behaviour directed towards women and the pandemic has been no exception. This has unfortunately led to an increase in cases of domestic violence. As per statistics, between March 25 and May 31, 2020, the National Commission for Women (NCW) received 1477 complaints of domestic violence from women in India—a 10-year high than the complaints received between March and May prompting them to launch a WhatsApp helpline for women providing a safer option to those who couldn’t make calls for the fear of being overheard.¹²⁰ The number of cases has increased since May 2020. The highest number of cases were registered in July at 660 but have remained at least above 450 each month since June 2020.¹²¹ As of November 30, 2020, cases of domestic violence stand at 4687 compared to 2960 in 2019—a 58 percent rise.¹²² The highest number of cases has been from Uttar Pradesh (1576), followed by Delhi (906) and Bihar (265).

Frontline health workers such as ASHAs (Accredited Social Health Activists) whose work can be seen as an extension of care work have experienced a phenomenal increase in their work. But the remuneration is way too measly—a mere INR 1000 for the COVID-19 duties

assigned to them.¹²³ It is estimated that if India's top 11 billionaires are taxed at just 1 percent on their wealth, the government can pay the average wage of the nine lakh ASHA workers in the country for 5 years.¹²⁴

Best Practice: Livelihood generation

Self-help groups comprised of women in Jharkhand under the Jharkhand State Livelihood Promotion Society are manufacturing hand-sanitizers using medicinal plants.¹²⁵ More than 2500 women associated with 853 self-help groups in Chhattisgarh too have produced face-masks and sanitisers to tackle its shortage. They produced 87,544 masks in just a day.¹²⁶

2.4 DILUTION OF LABOUR LAWS:

As many as ten states have passed ordinances and regulations that would dilute the existing labour laws and their application. Changes have been brought in national labour laws, mainly in The Factories Act, 1948, The Industrial Disputes Act, 1947, and The Labour Laws (Exemption from Furnishing Returns and Maintaining Registers by Certain Establishments) Act, 1988 with a stated intention to kick-start economic activities, attract foreign investment and boost growth prospects.¹²⁷

These changes in the labour laws violate the established standards of the International Labour Organisation and are disadvantageous to the workers leading to the filing of a number of Public Interest Litigations (PIL). For instance, the working hours were increased from eight to twelve hours in a day. The PILs



INDIA HAS 170 MILLION BLUE-COLLAR WORKERS. TRADE UNIONS FEAR THAT 70 PERCENT OF FACTORIES IN THE STATES WILL FALL OUTSIDE THE PURVIEW OF LABOUR LAWS.

eventually pressurised the Uttar Pradesh government to withdraw the 12-hour work shift. Many other states, however, have continued with the 12-hour work shift, six days a week which has transgressed the mandated 48-hour week as per global standards.

Many state governments have also brought changes that would allow workers to be hired at lower wages. There has also been evidence of workers being partially paid or not being paid at all.¹²⁸ According to the Mobile Vaani survey, around 57 percent reported having pending wages and 20 percent had not received any support from their employers in the informal sector.¹²⁹ As such, blue-collar workers who are mostly informal and daily wagers have to work longer hours with low wages in premises that lack clean drinking water, toilet, medical and other occupational safety measures in the light of industrial inspection being suspended.



AROUND 57 PERCENT REPORTED HAVING PENDING WAGES AND 20 PERCENT HAD NOT RECEIVED ANY SUPPORT FROM THEIR EMPLOYERS IN THE INFORMAL SECTOR.

India has 170 million blue-collar workers.¹³⁰ Trade unions fear that 70 percent of factories in the states will fall outside the purview of labour laws exposing

workers to exploitation with no legal safeguards while large private corporates gain from the dilution of the labour laws.¹³¹

2.5. INADEQUATE GOVERNMENT HELP

Despite the adverse impact that the lockdown has had on informal, migrant workers and the economy, studies show that the relief packages have been miniscule. Additional expenditure of the government in the first relief package announced was only 0.5 percent of the GDP and the total additional public spending promised by all the relief measures announced by the end of May 2020 amounted to only around 1 percent of the GDP.¹³² Much of it has not reached the intended beneficiaries.¹³³

While the announcement of additional food grains was welcome, it has also highlighted the weaknesses of India's Public Distribution System. A study reports¹³⁴ that despite having a hold of 77 million tonnes of foodgrain, more than three times the buffer stock requirement before the lockdown, only 2.2 million tonnes of this had been distributed to states. Eventually, public stocks increased to more than 100 million tonnes by the beginning of June 2020, which



ADDITIONAL EXPENDITURE OF THE GOVERNMENT IN THE FIRST RELIEF PACKAGE ANNOUNCED WAS ONLY

0.5 PERCENT OF THE GDP AND THE TOTAL ADDITIONAL PUBLIC SPENDING PROMISED BY ALL THE RELIEF MEASURES ANNOUNCED BY THE END OF MAY 2020 AMOUNTED TO ONLY AROUND 1 PERCENT OF THE GDP.

meant that some of the stock effectively rotted in the storage facilities. Moreover, the food packages announced through the PDS system and fair price shops were not applicable for most of the migrants outside their home town due to sedentary bias^v that makes ration cards made in the source state of the migrants unusable in the destination state.

Best practices: Individual states extending social protection benefits to the poor and marginalized

There were a few good practices at the national and state level that offer hope for increasing social protection and food security for informal sector and migrant workers. The provision of additional 5 kg wheat/rice per person along with 1 kg dal (per household) under the Pradhan Mantri Garib Kalyan Ann Yojana to 80 crore individuals played an important role in increasing food security for the most vulnerable. An extension of these entitlements beyond the pandemic would be crucial to ensure continued food security.

Additionally, Odisha¹³⁵ and Madhya Pradesh¹³⁶ extended work days under MNREGP to 200 days for specific districts to make up for lost employment and prevent distress migration. Extending this to other parts of the country would play an important role in offering social protection to workers.

^v Belonging of migrants to their cultural background and/or the geographic territory of their countries of origin is considered a natural and normal feature of their positioning. (<https://bit.ly/39FL3hV>)

3. THE WAY FORWARD

The pandemic has shaken the world to its very core. It has exposed the fault lines in our societies and economies but has also paved a way for transformative policies for a just and equal world. Newer and creative ways of catering to the needs of the masses is possible if governments are committed to the needs of its people. It is time for the Government of India to take specific and concrete actions that will build a better future not led by billionaires, but by citizens' voices who seek a more equal and just future. Doing so entails:

3.1 REINFORCING COMMITMENT TO REDUCING INEQUALITY

It is for a new tryst with destiny where India recommits itself to the constitutional principle of equality. Aligning with the SDG-10, the Government of India has identified a set of indicators and formulated an index to measure the performance to reduce inequality. To strengthen this initiative, government must set a timeline for regular revisiting and tracking of the indicators and index at the state and national level. There is also a need for the involvement of civil society organisations and think tanks in the monitoring of inequality at different levels. However, the government also needs to design an annual plan of action every year to reduce inequality and make it public on a regular basis.

3.2 ENACTING A FUNDAMENTAL RIGHT TO HEALTH FOR EVERY CITIZEN OF INDIA

While provision for healthcare is mandated in Part IV of the Indian Constitution (Directive Principles of State Policy), it is unenforceable. On the backdrop of an unprecedented health crisis, it is time India introduced a legal obligation on the government to fulfil basic healthcare rights. India should, furthermore,

- Localise the targets and indicators to reduce health inequality at the sub-state (district) level and design a community based monitoring system through the involvement of Gaon Kalyan Samitis (GKS) and Village Health Sanitation and Nutrition Committee (VHNSC) to monitor health outcomes and inequality;
- Enhance its budgetary allocation to the tune of 2.5 percent of GDP to reinvigorate the public healthcare system, reduce out-of-pocket expenditure and strengthen health prevention and promotion;
- Deliver a peoples' vaccine that is free and available to all;
- Commit to regulate private health care providers. All the state governments must adopt and implement the Clinical Establishment Act. To protect patients from exploitation, all states must notify the Patients' Rights Charter forwarded to them by Ministry of Health and Family Welfare;
- Collect gender, religion and caste disaggregated data of COVID-19 testing, infection and death rates and make data publicly available;
- Eradicate inequalities in access to quality healthcare based on place of residence or income. Establish medical colleges with district hospitals, more specifically those in hilly, tribal or rural areas with less health infrastructure. This would facilitate availability of medical services and human resources in those areas as well as increase the number of medical professionals in the country. Strengthen Primary Health Centers

(PHCs), sub-centres, Community Health Centers (CHCs) and government hospitals with adequate number of doctors, nurses, paramedics, equipment and other infrastructural requirements as per Indian Public Health Standard (IPHS) norms to make quality health service available within 3 Km radii of peoples' residence or workplace. In addition, free medicine and diagnostic facility must be available at the health centres.

3.3 ADDRESSING NEW AND OLD EDUCATIONAL INEQUALITIES

The COVID-19 pandemic-induced crisis has put the future of young people at risk, as too many are foregoing or losing access to education, especially girls and other economically and socially excluded groups. India must:

- Ensure safe and equitable reopening of educational institutions. State governments should reopen schools for early grades to ensure that younger children who cannot learn independently get access to learning through in-person classes as well as due entitlements such as Mid day meal, uniforms and textbooks;
- Provide a stimulus package that mitigates learning losses and gets marginalized children and girls into school;
- Increase—or at least maintain—public education expenditure, in line with its commitments made as part of the 2020 Global Education Meeting declaration;
- Ensure right to educational equality of children in schools that remain closed by facilitating small-group Mohalla classes to support a gradual transition to the reopening of schools;
- Protect rights of parents and children. Place a moratorium on private schools from hiking their fees through issuance of a notification under the provisions of Section 10 (2) (1) of the Disaster Management Act. Develop and enforce a comprehensive regulatory framework for private schools including fee regulation to prevent overcharging, exploitation and exclusion of children.

3.4 BUILDING ECONOMICALLY RESILIENT COMMUNITIES

COVID-19 has shattered the livelihood of the communities dependent on wages. This has also led to a dramatic loss of human life worldwide and presents an unprecedented challenge to food systems and the world of work. Bringing the economy into track would require actions to reset lost livelihoods and income of the communities. Thus, India must:

- Revise minimum wages and enhance it at regular intervals on the basis of Consumer Price Index. Monitoring mechanisms should also be endorsed to ensure that informal workers as domestic workers receive minimum wages;
- Informal workers should be formalised through written contracts and provided access to social security benefits such as medical, paid and maternity leave, and Provident Fund;
- Standard Operating Procedures (SOP)s for the employers who are employing migrant labourers to make provision of minimum facilities at the work place and on their behaviours towards the workers during pandemic;
- Maintaining a MIS of informal and migrant workers (inflow and outflow) by the district labour officers;

- Sustainable economic rescue and recovery packages targeted to the poor, informal workers and vulnerable groups made available;
- Unpaid care work should be recognized and efforts at the community level made to normalize the redistribution of care work across genders as well as provision of state support mechanisms such as crèches at work sites; access to safe drinking water, sanitation and cooking gas;
- Institute an urban employment guarantee scheme along the lines of MGNREGA to ensure a safety net for informal sector and migrant workers in urban areas who have been disproportionately affected by the pandemic;
- Extend days of work under MNREGP to 200 to make up for lost employment and prevent distress migration; Odisha¹³⁷ and Madhya Pradesh¹³⁸ have already extended work days under MNREGP for specific districts;
- Continue provision of 5 kg wheat/rice per person along with 1 kg dal (per household) to eligible individuals under the Pradhan Mantri Garib Kalyan Ann Yojana even after the worst of the pandemic is over, to ensure continued food security of the most marginalised families and individuals;
- Create a INR 50,000 crores Emergency Workers Welfare Fund which can add to and complement the state relief packages and allow states with limited fiscal capacity to rely on central assistance.

3.5 ADOPTING PROGRESSIVE TAX POLICIES:

The COVID-19 crisis must be a turning point in the taxation of the richest individuals and big corporations. Progressive taxation of the richest members of the society must be the cornerstone of any equitable recovery from the crisis:

- Impose an additional surcharge of 2 percent on income tax for the tax payers in the income slab of more than INR 50 Lakhs;
- Introduce a temporary tax on companies making windfall profits during the pandemic;
- Reduce/exempt GST on essential goods and services to reduce the burden on the poor.

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Lowest minimum wage in the country (Rajasthan unskilled worker) is INR 225 per day (<https://d1ns4ht6ytuzzo.cloudfront.net/oxfamdata/oxfamdatapublic/2020-10/INDIA%20CRI%202020.pdf>)
Time it would take for the worker to make what Ambani made in an hour: $[900000000/(225*365)] = 10,958.9$, or 10,000 years
Time it would take for the worker to make what Ambani made in a second: $[900000000/(225*60*60*365)] = 3.04$ years or 3 years
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- 16 The increase in wealth of the top 11 billionaires of India during the pandemic could sustain the NREGS scheme or the health ministry for the coming 10 years.

	Mar 18, 2020 (USD bn)	Dec 9, 2020 (USD bn)
Mukesh Ambani	36.8	77.5
Radhakishan Damani	13.8	18.6
Shiv Nadar	11.9	21.7
Uday Kotak	10.4	15.5
Gautam Adani	8.9	27.7
Sunil Mittal	8.8	10.3

Cyrus Poonawalla	8.2	11.4
Kumar Birla	7.6	9.9
Lakshmi Mittal	7.4	13.6
Azim Premji	6.1	8.1
Dilip Sanghvi	6.1	9.6
Total	126	223.9

Increase in the wealth of top 11 billionaires- INR 720989 crore

Health budget 2020-21 – INR 67,112 crore

NREGS budget 2020-21 – INR 63,000 crore

This 720989 crore is equal to 10 years of health budget and that of NREGS scheme.

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20 Ambani earned INR 299,755 crore during the pandemic [His wealth increased from 36.8 bn USD (<https://www.forbes.com/sites/naazneen-karmali/2020/04/07/indias-10-richest-billionaires-in-2020/#556e7dc77c23>) on March 18, 2020 to 77.5 bn USD on December 9, 2020 (<https://www.forbes.com/real-time-billionaires/#493d420f3d78>)]. Poverty line, as per Rangarajan Committee is INR 1407 per month for an individual. Duration for which Ambani’s wealth during the pandemic can keep the 40 crore informal workers above the poverty line: $[299755/(40*1407)]=5.3$ months, rounded up to 5 months.

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 People living in extreme poverty- 9% (World Poverty Clock) living at a threshold of INR 140 a day or INR 4200 month.
 350000/4200 is 83, the cost can go up to 83 times of the monthly income of these 13 crore people living in extreme poverty.
 Per capita income estimated (2019-20) is INR 134226, Monthly income is INR 11185
 350000/11185 is 31, the cost can go up to 31 times the average monthly income of an Indian citizen
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1% of this is INR 16,442 crore

Number of ASHA workers- 900,000

Average wage of an ASHA worker per month- INR 3000 (non-pandemic)

Total wages come to: (900,000 * 3000) or 270 crore per month

Number of months that ASHA workers can be paid their wages: 60.8 months or can be rounded off to 5 years.

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