Mangling the COVID Crisis: India’s Response to the Pandemic

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To cite this article: Sumit Ganguly (2020) Mangling the COVID Crisis: India’s Response to the Pandemic, The Washington Quarterly, 43:4, 105-120

To link to this article: https://doi.org/10.1080/0163660X.2020.1850005

Published online: 11 Dec 2020.
In early September, India recorded the second largest number of COVID-19 cases in the world, surpassed only by the United States. The growth in the number of cases since March 24, despite Prime Minister Narendra Modi’s three-week nationwide lockdown imposed that day, has been nothing short of dramatic: at that time, India had a mere 500 recorded cases and fewer than 10 deaths. By mid-July, it had become the third country in the world, after the United States and Brazil, to have over a million confirmed COVID-19 cases.1

India, tragically, is no stranger to pandemics. A mostly overpopulated tropical country, it has suffered through a range of them in the last century, including cholera and the bubonic plague in the nineteenth century.2 Worse still, in the late 1980s, India faced a dramatic crisis as AIDS swept across it and much of the world.3 Despite a rickety and overburdened public health infrastructure, the post-independence Indian state has had a remarkable record of containing pandemics—even if, once they successfully tackled the crises, they paid scant attention to everyday matters of sanitation and health care.

With COVID-19, however, the Modi government’s response has been mostly shambolic. Compounded by his own feckless decision-making, the blame must be squarely attributed to three critical choices made by Prime Minister Modi complicated by three fundamental structural conditions in India: a lack of state and central coordination, structural deficits, and regional variations and inequities.

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Critical Choices: Blunders and Lapses

The Modi government’s decisions and lapses when confronted with the entry of COVID-19 into India has been fitful and lacking in sound judgment. Given the contagiousness and the lethality of the pathogen, it was going to pose a significant challenge for India regardless of Modi’s decisions. However, three critical choices—including a delayed international flight ban, a drastic and poorly planned national lockdown, and a shortage of medical equipment and testing—especially at the onset of the pandemic, made matters considerably worse.

Delayed International Flight Ban
The first and perhaps most important error on the part of Modi’s government was its failure to ban international flights into India until as late as March 22. This was an important oversight, given that the first case had been detected in the south Indian state of Kerala as early as January 30, involving a student who returned from the city of Wuhan in the People’s Republic of China (PRC), the epicenter of the outbreak.4 If the government had acted to ban travel then, further cases could have been prevented.

Instead, the government acted only after the first death in India was reported on March 12. Barely 10 days later there were over 236 cases nationwide.5 It formally declared the outbreak a national disaster on March 14, which enabled it to invoke appropriate legislation to tackle the impending crisis. However, it waited for another eight days to ban all international flights into India, which initially was only in effect for one week. Subsequently, the ban was extended until July 31, then to August 31, and again to October 31.

Failure of Nationwide Lockdown
The second choice, fraught with significance, was the Modi government’s abrupt decision to impose a 21-day nationwide lockdown on March 24. The stated reason for this draconian action, which prohibited most economic activity and limited movement outside homes to specific tasks, such as seeking medical care or obtaining groceries, was to prevent extensive community spread. Obviously, a range of advanced industrial states had resorted to this strategy with fairly salutary results.6 However, this model was singularly inappropriate for India’s social and economic conditions. In a densely populated country where entire communities live cheek by jowl, the possibilities of social distancing are extremely
limited. One third of India’s urban population and at least a quarter of rural dwellers live in extremely cramped conditions with five or more individuals sharing a single room.\textsuperscript{7}

The lockdown was announced with barely four hours’ notice and with no prior preparation. As a result, it left close to 40 million migrant workers stranded across the country.\textsuperscript{8} Since the government had made few provisions for them to shelter in place, and as their employers assumed no responsibility for their well-being, the workers were, in effect, left to find their own way home, sometimes thousands of miles away —without bus and train services, which had been suddenly suspended. It was not until May 1 that these transportation services were restored. The government organized special trains to enable stranded workers to return to their remote villages, but the state-run railway system did not waive or lower the fares for these hapless workers. Worse still, travel conditions on these trains left a great deal to be desired with few, if any, provisions made for supplying food on these long journeys. According to a survey that an NGO, the Stranded Workers Action Network, released in early April of this year, a mere 0.6 percent of all migrant workers found refuge in government-sponsored relief shelters, and a scant 2.2 million of them had received any food assistance.\textsuperscript{9}

The plight of the stranded workers, as numerous accounts in the Indian news media revealed, was nothing short of dire. For most of them, already living on the edge of poverty, wending their way back to their native villages proved to be a most daunting task. One story in particular was truly heart-rending. It involved a 15-year old girl who cycled some 700 miles to take her injured father back home.\textsuperscript{10} Another episode that drew international attention involved two young men, one an “Untouchable” (referred to as Dalits) and the other a Muslim, who had left their village in the populous and desolate state of Uttar Pradesh to find work in the western state of Gujarat over a thousand miles away. As the pandemic struck, both of them were laid off. Unable to shelter in place as their savings dwindled, they cobbled together their meager funds to pay a truck driver to take them (and others) back to their native village. Sadly, along the way, the young Dalit man, faced with dehydration and unable to get to a hospital on time, died, leaving the family he had supported virtually destitute.\textsuperscript{11}

There is little or no question that this decision left hapless millions in acute distress. Worse still, it led to extensive community spread as the workers, with no other viable recourse open to them, returned to their villages across the country. Many of them had picked up the virus at their work sites and were
asymptomatic when they had embarked on their long and arduous journeys home. Since most of them returned to rural areas where health facilities are both sparse and inadequate, their ability to obtain medical care was limited at best. In the words of the noted Indian economist Kaushik Basu, in effect, “some 4 to 5 percent of India’s population were literally sent off like sprinklers across the nation.”

In addition to the human toll, virtually shutting down the entire country overnight for three weeks also exacted a significant toll on the economy, which was already in the doldrums before facing the full brunt of the pandemic. Economic growth in the first quarter of 2020 had plummeted to 3.1 percent—the lowest in decades. In early October of 2020, the IMF predicted that the Indian economy would contract by as much as 10.3 percent in 2020.

A better model, as some Indian epidemiologists suggested, would have involved isolating only “hot zones” where major outbreaks had occurred. Such an approach could have avoided considerable economic hardship and may have also prevented widespread community transmission. Indeed, this strategy was implemented in Dharavi, Asia’s largest slum in the city of Bombay (Mumbai) where 650,000 people live within a square mile, with fairly successful results.

Instead of enacting more meaningful and effective policies, the government, with Modi’s characteristic penchant for fanfare and no doubt in an effort to distract major urban populations from their immediate cares, organized a fly-past of Indian Air Force aircraft and helicopters that showered flower petals over India’s hospitals on May 3. The ostensible reason for doing so was to boost the morale of hard-working, front-line medical personnel. Earlier, it had asked the population of major metropolitan areas to light oil lamps and bang metal cooking utensils at an appropriate evening hour to have the same effect.

**Testing and Equipment Deficits**

The third blunder on the part of the Modi government was its failure to ramp up testing on a national scale from the very outset. The government also failed to use the opportunity that the lockdown provided to fashion a rigorous testing and tracing regimen. Furthermore, it failed to act in a concerted fashion to acquire and distribute personal protective equipment (PPE), ventilators, and oxygen tanks on a nationwide basis. When the nationwide lockdown was imposed, just 6,500 samples had been tested, and daily capacity in mid-March was only around 1,400 per day. Since then, testing capacity has improved significantly: at the end of July, India had ramped up its testing capacity to about 500,000 per day. However, by that time, the number of those infected had risen to 1.5 million. In early August, the number breached two million. The worst part
of it was that the latter figure was reached in a span of a mere twenty days, indicating an exponential growth in the spread of the disease.

In the meantime, the disease had dispersed into much of India’s rural areas where access to health care across much of the country is rudimentary during normal times. With COVID-19 cases rising rapidly, the rickety health care infrastructure is now under severe duress. Amidst this extremely distressing milieu, the government has committed itself to spending a mere 0.04 percent of GDP on additional public health expenditure.\textsuperscript{17}

In considerable part, some critics argue, this haphazard testing regimen, quite apart from the paucity of adequate supplies and suitable nationwide organization, stems from the Modi government’s unwillingness to consult even the national task force that it had constituted under the aegis of the apex research organization, the Indian Council of Medical Research (ICMR). This disregard for appropriate scientific expertise was also evident from a briefing that a senior government official had provided on April 24. At this conference, he asserted, based on a deeply flawed mathematical model, that the number of cases would significantly ebb in early May and that the country would see no more cases after May 16.\textsuperscript{18} Worse still, despite the existence of significant bodies of medical and epidemiological expertise in the country, the government has, for the most part, relied on the advice of Dr. Vinod Paul, a pediatrician, and Dr. Balaram Bhargava, a cardiologist who heads up the Indian Council of Medical Research.

In the meantime, the government has continued to tout the apparently low mortality rate in India as evidence of the country’s success in limiting the worst effects of the virus. In early August, for example, it was 2.82 per 100,000, as compared to 47.53 in the United States and 44.92 in Brazil.\textsuperscript{19} These figures, however, should be contextualized and viewed with some skepticism. The Indian case-fatality rate can, in part, be attributed to the much lower age of its overall population. Some in India’s medical community have also suggested that the exposure of large numbers of Indians to a host of pathogens on a routine basis may have also contributed to a degree of immunity against COVID-19.\textsuperscript{20} On the other hand, given the limitations of proper medical facilities in rural areas, many deaths can be attributed to underlying medical conditions as opposed to the complications from contracting COVID-19.

The contested figures that the government is promoting is not its most egregious lapse. Some Cabinet-level ministers, to the dismay and horror of Indian medical and scientific communities, have made a series of statements promoting utterly dubious cures for the disease. Shripad Naik, an Indian Cabinet minister, had publicly announced that Prince Charles had been cured of COVID-19.
through the use of Ayurvedic potions, based on a traditional Indian system of medicine. Others within his party claimed that consuming cow urine was efficacious in curing the viral infection.21

**Feckless Decision-Making**

A populist with profound authoritarian leanings, Modi has a distinctive mode of decision-making that has proven to be most inapt to tackling the crisis. He is known for making abrupt decisions without much prior consultation or reliance on professional expertise. More to the point, he has often demonstrated an appetite for drama and fanfare over substance.

On at least two other occasions, he has made decisions without appropriate discussion or debate and with significant adverse consequences—one of these involved the demonetization of higher denomination currency notes in 2018 that affected nearly 80 percent of the money in circulation in the Indian economy. This sudden decision, ostensibly designed to unearth untaxed funds and to disrupt terrorist financing, caused extraordinary social hardship and widespread damage to the Indian economy.22

Another involved the decision, without any parliamentary discussion, to revoke the special constitutional status of the disputed state of India’s only Muslim-majority state, Jammu and Kashmir, in August 2019. His decision to abrogate the constitutional provisions that had granted the state a unique position in the Indian federation stemmed almost entirely from an ideological commitment on the part of the ruling Bharatiya Janata Party (BJP). Since last year’s decision, all political activity in the region has been effectively suspended, and the bulk of its political establishment is now under house arrest. The vast majority of the population of the area remains sullen, cowed, and alienated, and the government has yet to delineate a pathway for the restoration of normal politics in the now-bifurcated state.23

This abrupt style of decision-making has characterized Modi’s response to this pandemic. Without any meaningful consultation with public health authorities, his government has taken a series of drastic and precipitate decisions that have had disastrous consequences for significant swaths of India’s vast population and have disproportionately affected the plight of the country’s poor.24 The costs of these choices have been sweeping and far-reaching and may have significant long-term consequences for India’s economic and societal health.

**Lack of State and Central Coordination**

Specific choices on the part of the Modi government have had significant consequences for the spread of COVID-19 in India. These include the invocation
of existing legislation, the disregard for the principles of federalism, and the lack of adequate social protection.

Even though India is formally a federal polity, constitutional arrangements grant extraordinary powers to the Central (national) government, made greater by the Disaster Management Act of 2005, now invoked, which grants the government sweeping powers to take suitable measures that it deems necessary to protect public health in the event of a major disease outbreak. Individual states were also able to invoke a colonial-era law, the Epidemic Diseases Act of 1897, which, curiously enough, remains on the books. Among other matters under the provisions of this act, governments at both the national and state levels are given sweeping powers to inspect any mode of transportation and quarantine infected individuals, and they are protected from legal action as long as they are deemed to be acting in good faith. The striking feature of both these acts is that they can grant both the Central and state governments expansive powers to limit civil liberties.

Invoking these acts has had important consequences for the way the Central government has responded to the ongoing crisis. These have had ramifications in a number of different areas ranging from access to health care to the principles of federalism. In this context, a number of India’s institutions have not served the country well. For example, even though the parliament has the ability to scrutinize actions, it has mostly rubber-stamped them. In considerable part, this has been the case because Modi’s party, the BJP, has a clear-cut majority in parliament. Additionally, the highest judicial body in the land, the Indian Supreme Court, long a bastion of independent legal judgments, has proven to be remarkably deferential toward the government during this crisis. For example, it had initially agreed to hear a petition for free testing (given the extent of poverty in India). To its credit, it had also ruled in favor of the plaintiffs. However, in a second ruling, it narrowed the scope of its initial decision, stating that only those covered under an existing government insurance scheme were eligible for free testing.

The Central government also showed scant regard for the principles of federalism in other areas with significant adverse consequences for India’s states. Among other matters, it issued directives for the country without taking into account the needs of particular states. Furthermore, it consulted little with particular states when making decisions and issuing contradictory directives. For example, a week before the end of the initial nationwide quarantine, it opened up domestic air travel without first consulting the states. This decision created havoc across the air
transportation sector as some states, fearful of continuing transmission, refused to allow flights from other states to land.26

The Central government, mostly concerned with containing the fiscal deficit, proved to be quite reluctant to spend public funds to alleviate the economic distress that the pandemic has caused. It provided two tranches of funds in efforts to mitigate the pandemic’s economic consequences. The first, a sum of US$22.6 billion in a stimulus package released in March, was almost symbolic in terms of its size, as it amounted to about 0.8 percent of India’s GDP.27 It also involved a provision of five kilograms of rice or wheat and one kilogram of legumes per person for three months to about 800 million of India’s poor. Unfortunately, these amounts are hardly enough to sustain anyone for this duration of time. Finally, it included cash transfers of 500 rupees (roughly seven dollars) a month to a segment of this population.28

The second tranche of funds and relief efforts, at least in principle, appeared much more ambitious and was released in mid-May. This package amounted to almost US$308 billion and included the provision of a two-month supply of food grains to those migrant workers who were not covered under the terms of the National Food Security Act of 2013. Despite this seemingly large figure, critics quickly contended that a substantial portion of these funds was actually already in the spending pipeline and was essentially just reallocated to deal with the effects of the pandemic.29

This failure of the Central government to fund relief was compounded when it insisted that state governments were responsible for undertaking essential public health measures to deal with the crisis and then coping with the economic effects of the lockdown. This left a number of states, especially those with a limited tax base, in dire straits. The Central government then limited states’ ability to borrow, thereby hobbling them in their efforts to deal with the adverse effects of the pandemic on economic activity.30

At least partially because of this lack of funding from the state or Central governments, rural communities especially have borne the brunt of the economic impact from the pandemic. Gao Connection, an Indian rural news platform, and the Center for the Study of Developing Societies (CSDS), a highly reputed think tank in New Delhi, published results of a nationwide survey of rural conditions in early August. The survey had been conducted across as many as 20 states between May 30 and July 16. The results indicate the level of distress across rural areas in India. Some of the salient findings are disturbing. For example, as many as 68 percent of the households surveyed indicated that they faced a monetary crisis due to a loss of employment resulting from the pandemic. 28 percent of migrant workers who had returned to their homes revealed that their employers had failed to pay past wages after the pandemic hit. At least 23 percent had to borrow money to make ends meet, while 8 percent had sold...
some prized possession such as a bicycle or a cell phone to meet everyday needs. Perhaps most distressingly, a mere 27 percent indicated that they had received their quota of the promised wheat and rice from the government. This failure to provide relief was also reflected in other statistics. The survey found that 35 percent of the respondents had, on multiple occasions, gone without food for a whole day. And as many as another 46 percent reported that they had been forced to reduce food consumption on a number of occasions.31

**Structural Deficits**

At the outset, India was singularly ill-prepared to tackle a pandemic of these colossal dimensions. For complex reasons, India has long neglected its public health care system even as its high-end, private health care is equal to or better than global standards. Indeed, in recent years, several Indian metropolitan areas have emerged as hubs of global health tourism because a range of medical procedures can be carried out at a fraction of the cost in advanced industrial states.32

However, the state of India’s public health system is, for the most part, Dickensian. Even under the best of times, it is frequently found wanting. This is hardly surprising since the country’s spending on public health is only slightly over 1 percent of its Gross Domestic Product (GDP) and thereby is among the lowest in South Asia.33 The low levels of spending are also reflected in other pertinent statistics. A quick comparison of the availability of hospital beds, for example, per thousand of the population is revealing. India has fewer hospital beds per person than Bangladesh, Bhutan, Nepal, Sri Lanka, or the People’s Republic of China34 and fewer physicians per person than Pakistan, Sri Lanka, or the PRC.35 Several of these countries, it needs to be underscored, are less prosperous than India. These aggregate statistics do not even adequately disclose the profound disparities in health care that exist between urban and rural areas. For example, in rural India there is one bed per 3,125 inhabitants, when the World Health Organization (WHO) recommends one per 300. Disturbingly, a mere 19 percent of rural doctors are adequately trained.36

Given the state of India’s public health infrastructure, it is hardly surprising that with flawed choices and feckless decisions, the pandemic simply could not be contained. Past governments coped far better with major disease outbreaks under similar structural constraints not only because they had responded to them with alacrity but also with considerable thought, care, and organization.
In fairness, however, the country had never confronted a pathogen that is as contagious and lethal as SARS-CoV-2.

**Regional Variations**

There is little or no question that the national government failed to forthrightly tackle this crisis from the outset. Its subsequent efforts to contain it have been both fitful and halting. However, despite the constraints of India’s federal system that grants states leeway in certain areas of public policy but not others, there has also been considerable variation across states in terms of their responses to the pandemic.

Of the 28 states in the Indian Union, the case of the southern state of Kerala is perhaps the most successful response. It is the home of hundreds of thousands of expatriate workers in the Gulf and the Middle East. The vast majority of these workers had to be repatriated following the outbreak of the disease. As a consequence, the state’s exchequer suffered a considerable loss of income as the remittances drew to a close. This financial shock notwithstanding, the state’s health authorities acted with remarkable alacrity to deal with the looming crisis. They started a rigorous regimen of testing and tracing and provided suitable, prompt medical treatment to those afflicted with the disease.

What explains Kerala’s remarkable response? One of the last bastions of Communism in India, the state has a well-developed primary health care system, built-in social welfare provisions, and a highly literate population. All these factors, combined with swift action on the part of the Chief Minister (the functional equivalent of a governor in the United States), helped stem the tide of the disease.

The contrast with another Indian state, Maharashtra—which is far more prosperous and more populous, with a total population of about 115 million— to Kerala could not be more striking. Apparently, the state also acted quickly, but not as swiftly as Kerala and not nearly as effectively. Maharashtra had not had much prior experience in dealing with major viral outbreaks, unlike Kerala, which had dealt with a Nipah virus outbreak back in 2018 without the loss of a single life. Most importantly, Maharashtra had no contact tracing system in place and so was less able to limit the spread of the disease from the outset. As a consequence, it has one of the worst case records in all of India. In mid-October, it was leading the country with nearly 200,000 cases.

In some states, the spread of the disease was all but inevitable. For example, in Uttar Pradesh, India’s most populous state which also has some of the worst social indicators, press reports have emerged that patients fled some hospitals due to the state of their facilities. To compound matters, the state’s chief minister, Yogi
Adityanath, a Hindu priest, has been more preoccupied with organizing the construction of a temple on the site of a demolished mosque than with taking stern measures to contain the pandemic. Not surprisingly, in early October, it had one of the highest COVID-19 case counts in the country.

Others states, such as West Bengal, had initially taken swift and decisive actions designed to curb the spread of the virus. However, as economic activity virtually ground to a halt—especially in the wake of a disastrous cyclone, Amphan, which brought devastation across much of the state and following the lifting of the nationwide lockdown—it started to ease its restrictions. Faced with a state-level election next year, it allowed electoral considerations to affect its epidemiological choices. To that end, it started to make exceptions to strict quarantine rules for a number of religious holidays. Not surprisingly, this led to a surge of cases especially in the vast capital city, the metropolis of Calcutta.

As this analysis demonstrates, the responses of Indian states have varied considerably. A range of factors, not any one variable, explains the differential responses to this health crisis. More importantly, it needs to be underscored that some states that had responded swiftly and had put in place reasonable policies subsequently faltered, owing to a variety of reasons.

A Mangled Crisis and Future Prospects

Since its independence in 1947, India has not been a stranger to the outbreak of major diseases. In every previous case, however, national and state authorities, despite the inherent shortcomings of India’s public health system, managed to mobilize resources and coordinate their actions to contain transmission. After initial fears of widespread dispersion, in every case, the scope of the disease was limited or entirely suppressed. On this occasion, however, due almost entirely to a deeply unsatisfactory set of responses on the part of the Central government, the disease spread rapidly with alarming consequences for a vast swath of the population and is still going. Fitful and contradictory choices—particularly to not ban international flights in a timely manner, to abruptly and poorly communicate lockdown of the country for 21 days, and to not effectively address testing and equipment deficits—without suitable regard for sound medical and epidemiological advice, contributed to this debacle.

Obviously, the underlying structural conditions that exist in India—including poor coordination between state and central government, a poor public health system, and different regional responses—have not helped matters in dealing with the pandemic. Indeed, this unprecedented health crisis has laid bare the skeletal features of India’s public health system. The extraordinary
contagiousness of this virus, coupled with its sheer lethality in conjunction with questionable choices, has all but overwhelmed the country’s limited capacity to effectively cope with it.

Despite the mangling of this crisis, once an effective vaccine is on hand, hopefully the Modi government, which still has the better part of three years in office, will handle its dissemination with a modicum of skill and competence. In this regard, India has some built-in advantages because of its sprawling and sophisticated pharmaceutical industry and its capacity to produce a vaccine on a mass scale. Indeed, one private Indian firm, the Serum Institute of India, located in the city of Pune, has already reached an agreement with the Swiss pharmaceutical giant, AstraZeneca, and the University of Oxford to produce millions of units of a vaccine as soon as it clears all the requisite regulatory hurdles. It has also announced that its primary focus will be to produce the vaccine for India and other developing countries and at an affordable price. Since the company has a proven track record of producing reliable vaccines on a mass scale, there is little reason to doubt that once a viable vaccine is found, it can deliver on its promises.

Once the pandemic ebbs, and hopefully in the wake of a campaign of mass vaccination, the government might also consider taking serious stock of India’s long-neglected public health care sector. Assuming that economic growth is restored as the pandemic recedes, it should then devote significantly greater budgetary resources toward addressing the lacuna that has dogged the national health care infrastructure for decades. Along with efforts to bolster this system, it should also redouble its efforts toward ensuring the provision of potable water, better sanitation, and improved waste disposal. These are steps that previous governments, and especially the present one, had taken, but in a fitful fashion.

However, despite these piecemeal efforts, none of them had even attempted to bring about sweeping reforms in the health sector. Indeed, a peculiar feature of India’s political culture is that major reforms are only undertaken in the aftermath of an unprecedented crisis that delivers an extraordinary shock to the polity. For example, India only undertook major agricultural reforms in the aftermath of a looming famine in the late 1960s. These reforms contributed to the Green Revolution and made the country more than self-sufficient in food. Similarly, only after facing the prospect of major defaults to international banks in 1991 did the country take on significant liberal economic reforms. Those, in turn, placed it on a path of sustained, high economic growth for nearly two decades.
Perhaps this crisis will similarly induce the country to undertake long-deferred action to address critical shortcomings in its public health care delivery system. Short of sweeping, coordinated, and sustained action on these fronts, much of India's vast population will remain vulnerable to the onslaught from a possible future novel pathogen—a prospect that is hardly unlikely.47

Notes


34. Index Mundi (website), “Hospital Beds (per 1,000 People),” accessed September 21, 2020, https://www.indexmundi.com/facts/indicators/SH.MED.BEDS.ZS.
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