CATMOCK DAILY CAPSULE

A SLIGHTLY DIFFERENT EXPLAINER ON THE LPG CONUNDRUM

- Finshots

One could argue that the current LPG shortage for households is due to the US/Israel-Iran war. And that's true to some extent. After all, India is the world's second-largest consumer of LPG, and we import 60% of our requirement primarily from Qatar and other Middle East countries.

However, India was not always this dependent on LPG. We can largely attribute India's LPG consumption to the *Ujjwala* gas scheme (PMUY) started in 2016. This scheme provided LPG connections to women and persons below the poverty line without any security deposits.

And over time, we have had over 32 crore LPG connections in 2024, up from around 15 crore when the scheme started. India is one of the biggest clean-energy success stories in the world. The length of our operational Natural Gas Pipelines also increased from around 15,000 km in 2014 to 25,000 km in 2024.

The broader objective was clear: move millions of households away from fuels such as firewood and kerosene and into a cleaner, formal energy system.

In many ways, that objective has been achieved. Rural households that once had smoky kitchens now have access to cleaner LPG cylinders. In a way, we can also say that this fortunately trickled down to better public health and lower indoor air pollution, and the programme became a flagship example of how subsidy-led energy transitions can scale (Unlike solar.)

And naturally, as demand surged, the government has increasingly tried to prioritise domestic supply. In periods of tight availability, policymakers have nudged distributors to prioritise households receiving cylinders. In some regions, this has meant restricting or slowing the supply of commercial LPG cylinders, especially as household refill waiting periods begin to rise.

So businesses that depend on them, mainly restaurants, have either shut shop or are scrambling to find whatever LPG cylinders they can. And that's exactly where the problem begins.

You see, domestic cylinders are cheaper than commercial cylinders, and when commercial supply becomes tighter, the price difference creates an opportunity for arbitrage.

Recent police raids across several cities have uncovered LPG diversion rackets operating within this gap. Investigations in places such as Nagpur and Noida revealed networks in which subsidised domestic LPG cylinders were siphoned off and sold in the black market.

However, enforcement agencies suggest that the issue goes beyond isolated criminal activity. The Comptroller and Auditor General (CAG) has pointed to structural weaknesses in how the LPG subsidy programme itself has been implemented.

One concern relates to beneficiary identification. According to the audit, about 42% of LPG connections were issued solely based on Aadhaar verification, without additional cross-checks against other household databases. In several cases, connections were issued despite incomplete household records or mismatched identities. The audit also identified more than 12.5 lakh instances where beneficiary names in the LPG database did not match official census records, raising the possibility that some connections may have gone to unintended recipients.

Furthermore, the system failed to enforce eligibility criteria, resulting in 1.9 lakh connections being wrongfully released to men instead of the intended women from Below Poverty Line (BPL) households.

There was also an unusually high consumption level among certain beneficiaries. Some households recorded more than 12 refills per year, far above the typical household's consumption level. In at least one instance, distributors issued multiple refills to the same beneficiary on the same day. In fact, nearly 14 lakh beneficiaries used between 3 and 41 cylinders in a single month.

Such patterns strongly suggest that cylinders were being diverted from domestic kitchens into black-market supply chains.

And even when irregularities are detected, enforcement is not straightforward. India's LPG distribution network is vast, involving thousands of distributors and delivery routes spanning rural and urban regions. Once a cylinder leaves a warehouse and enters the last-mile delivery network, tracking its final destination becomes difficult. Monitoring every transaction across such a large system requires far more granular data and oversight than currently exists.

And that makes it easy to divert cylinders from their intended use.

Consider the price structure. A domestic LPG cylinder may cost around ₹800-₹900 without subsidies, while a commercial cylinder can cost ₹1,900 (currently over ₹3,200 in the black market). That difference creates a powerful incentive. If a distributor diverts even a small fraction of domestic cylinders into the commercial market, the margin can be substantial. A few hundred diverted cylinders each month can generate lakhs in profits.

Police investigations suggest that the diversion chain follows a predictable pattern.

First, access to subsidised cylinders is secured. Distributors receive quotas intended for household delivery, but rackets may inflate demand by using ghost households or fake registrations to increase their allocations.

Second, the gas is siphoned. LPG from domestic cylinders may be transferred into commercial cylinders or sold directly to businesses in smaller containers.

Third, the diverted cylinders are sold at a discount to commercial users. Restaurants, street vendors, and small eateries often prefer these unofficial cylinders because they are cheaper than officially priced commercial LPG. Even when sold below the official commercial rate, the distributor can still earn a margin.

The system persists because each participant benefits in the short run. The distributor earns the price difference. Businesses generally receive cheaper fuel. And enforcement remains difficult because the distribution network is so extensive.

The unintended consequence is that genuine households may face longer waiting periods for refills. In some cases, households that cannot obtain official refills quickly enough are pushed toward the same informal market that created the shortage.

And this, folks, reveals a paradox.

India's LPG programme succeeded in expanding access to clean cooking fuel. But the same subsidy programme that supports households has also created a price distortion large enough to sustain a parallel market.

Direct benefit transfers were originally designed to reduce leakages by transferring subsidies directly to beneficiaries rather than intermediaries. Yet as long as domestic cylinders remain significantly cheaper than commercial ones, the incentive for diversion remains embedded in the system.

The more durable fix lies in redesigning how the subsidy works. If domestic and commercial cylinders are priced closer to market levels and subsidies are directly transferred to verified domestic customers' bank accounts, the incentive to siphon cylinders would largely disappear. Technology could further strengthen this through improved refill tracking, stronger identity verification, and real-time monitoring of distributor behaviour.

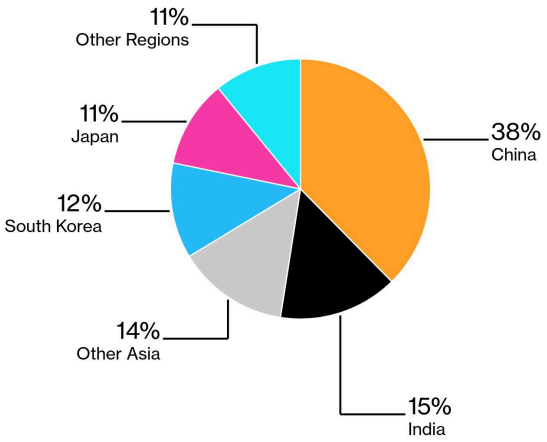
Until that happens, the LPG programme will continue to live with an uncomfortable paradox. A policy designed to deliver clean fuel to household kitchens will continue to create opportunities for diversion, where those same cylinders find their way into restaurants and street stalls instead.

Ultimately, the LPG diversion problem is not simply about shortages. It reflects how such programmes can unintentionally reshape market incentives and pose consequences.

TRUMP WARNS NATO

- Bloomberg

Where Does Hormuz Oil Go? Mostly Asia



Source: Bloomberg Economics, US Energy Information Administration
Note: Data are for 1Q25

Bloomberg

Donald Trump is stepping up calls for other nations, especially European allies, to aid the US in reopening the Strait of Hormuz. He's also threatened to delay his summit with Xi Jinping if China resists sending help.

"It's only appropriate that people who are the beneficiaries of the Strait will help to make sure that nothing bad happens there," Trump said in an interview with the Financial Times. "If there's no response or if it's a negative response I think it will be very bad for the future of NATO."

Trump stressed China's dependence on oil from the Middle East, adding that his trip to Beijing slated for the end of this month would be too late.

He subsequently told reporters on Air Force One that it would be interesting "to see what country wouldn't help with a very small endeavor" to get oil tankers flowing through the critical waterway. Trump also took direct aim at the UK prime minister, saying he told Keir Starmer that the US "will remember" if it gets support for the war or not.

His threats come as the war continues with no obvious end in sight. Israel has expanded operations in Lebanon, while Iraqi militias have signaled a new phase of attacks on US and other foreign targets. Oil prices are climbing higher, with Brent crude trading above $105 a barrel. A top aide to Trump said the Pentagon estimates the Iran war would take between four and six weeks.

The incentives for other countries to assist the US in forcing open the Strait of Hormuz are low, especially after Iranian Foreign Minister Abbas Araghchi said the coastal corridor was only shut to ships from "enemies." Two tankers carrying liquefied petroleum gas to India sailed through the strait — a route that normally handles about a fifth of the world's oil supplies.

So far, signs are the US president will be rebuffed. Australia ruled out deploying naval vessels, while Japan's defense minister said the nation currently has no plans to send warships. Chinese officials have so far condemned Trump's war on Iran and would be unlikely to send ships, in part because some carriers bound for China still appear to be getting through. European allies will be wondering about Trump's demands just months after he threatened to annex Greenland.

How Trump will react if his calls aren't answered remains to be seen. —*Richard Frost*

What You Need to Know Today

Iran denied Trump's assertion that it wants ceasefire talks, launching fresh attacks across the Persian Gulf and forcing a suspension of flights at Dubai's main airport.

The United Arab Emirates and Saudi Arabia reported drone and missile attacks overnight into Monday. Dubai halted flights at its main airport following a fire at a fuel tank that it said was caused by an Iranian drone. It announced a gradual resumption a few hours later, though Emirates said some of its scheduled flights for the day would be canceled.

The key UAE oil-export port of Fujairah was hit again on Monday, following a strike on Saturday that forced it to suspend some shipments for about a day. In Abu Dhabi, a Palestinian civilian was killed because of a missile falling on a car, authorities in the UAE capital said.

Trump said over the weekend that Iran is ready to make a deal to end the war, but the US wants better terms, including a commitment by Tehran to abandon nuclear activities. Iranian Foreign Minister Abbas Araghchi denied seeking talks or a ceasefire with the US.

SAVAGE CARE

- Aeon

I suffered from a bad conscience before the case even began. My patient was in his late 70s, partially blind from narrow-angle glaucoma. He had undergone a colonoscopy a few days before and now needed emergency abdominal surgery for a perforated bowel. Before his colonoscopy, he'd had a slight fever, which the surgical team – including myself, the anaesthesiologist – had dismissed, but which later proved to be an early sign of sepsis. Two voices now vied for supremacy in my head. The first asked: *Why did you overlook his fever?* The second replied: *How could I have foreseen what would happen?* The first shot back: *A smart doctor is only a smart doctor if he does foresee things. It doesn't take a smart doctor not to foresee things. Anyone can do that.*

The man was on several intravenous drugs called ‘vasopressors’, which cause the heart to eject more blood and the small arteries to squeeze down, thereby raising blood pressure. Without the drugs the man would die.

I told the man my plan was to place a breathing tube in his windpipe while he was still awake, as the sedation normally used to put patients to sleep would cause his blood pressure to crash. He offered no response. His eyes sitting in his grey, haggard face were remote and sad, as though overflowing with all the mute loneliness that preys upon a solitary individual close to death inside a hospital.

I numbed his throat with local anaesthetic. His sorrowful glance was filled with entreaty as I inserted the flexible scope into his mouth. When I manoeuvred the scope past his throat, he jerked his head from side to side. As I went deeper, he bucked with a pained expression on his face, squinting his eyes and contorting his mouth, his illness having prevented me from numbing his windpipe beforehand.

Was my inflicting of pain unethical? The field of bioethics arose in the 1960s to answer such questions. But it had nothing new to say in my case. The philosophy of utilitarianism, which justifies inflicting pain on a sick, speechless patient to save that patient’s life, had conquered everyday medical practice long before bioethics came along.

Bioethics has surprisingly little to offer practising physicians in general. Other than the principles of informed consent and patient confidentiality, the field has had no impact on my three-decade career, nor on the career of any other anaesthesiologist I know. Surgeons have told me something similar. We took the Hippocratic Oath upon graduating from medical school, but we already had a firm sense of right and wrong before then. My own code of ethics drew, cafeteria plan-like, from a variety of sources: a secularised version of Judeo-Christian teachings such as ‘respect human life’ and ‘be kind’, notions that undergird most civilisations; a strong belief in individual freedom and agency, courtesy of my southern California upbringing; an Aristotelian sensibility that perfect justice is an abstraction, without meaning in the real world; and the pragmatic view that ‘moderation in all things’ is a wise dictum to follow, when you can.

When my colleagues and I ran into moral dilemmas our own codes of conduct couldn’t resolve, it was often technology – not bioethics – that supplied the workaround. Special ‘holding’ bags could keep blood connected to the bloodstream and make emergency transfusions acceptable to Jehovah’s Witness patients. Translation apps, meanwhile, could spare me the prospect of urgently anaesthetising a non-English-speaking patient before I understood their medical history.

In fact, during all my years practising medicine, I never met a bioethicist at my hospital, even after the 1980s, when bioethics launched a specific focus on ‘clinical bioethics’ to advise doctors in their daily practices. In that first decade, only 1 per cent of US hospitals had a clinical bioethics committee; today, an estimated 97 per cent of US hospitals have one. Yet clinical bioethics, like general bioethics, which covers all the life sciences, tends to focus on obscure issues, such as human subject research or the appointment of healthcare proxies. Often, a bioethics committee sets broad policy for the hospital without focusing on any individual patient case.

Personnel accounts for some of bioethics’ irrelevance for practising physicians. The field has long been under the control of non-physicians who focus – understandably – more on patients’ rights than on doctors’ inner experience. A hospital bioethics committee, for instance, typically has a doctor on it, but other members might be nurses, lawyers, sociologists, clergymen or even just laypeople. In fact, anyone can call themselves a bioethicist; it is an unregulated field without

formal certification for the title. Non-physician bioethicists tend to overlook doctors' complaints of 'burnout' and their struggle to preserve their decision-making independence inside large companies.

As a result, bioethics tends to ignore the hospital rooms where a doctor's bad conscience lives. Inflicting severe pain on a patient creates a kind of moral residue for a physician that begs for relief – something utilitarianism alone cannot supply. A routine intubation on an unconscious patient may prompt, at most, quiet professional satisfaction; a difficult one performed successfully can arouse in a doctor the feeling athletes experience when registering a sports record. An awake intubation is different. It means passing a breathing tube into a conscious person's windpipe, a procedure that can mimic suffocation. And when the airway cannot be numbed beforehand, the doctor doesn't just perform the act; the doctor absorbs it – feeling the event deep within.

Recently, bioethics has paid more attention to what it calls 'moral distress', a concept created with the launch of clinical bioethics to capture what doctors experience when their consciences feel violated, comparable to post-traumatic stress disorder. Yet the field still doesn't penetrate the doctor's psyche all that deeply. Typically, it focuses on moral distress stemming from insufficient resources, as during the COVID-19 pandemic, when doctors had an inadequate number of ventilators amid high patient volume, or when cost controls prevent doctors from prescribing patients the best medication with the fewest side-effects. It is why the field so often emphasises healthcare re-organisation as a corrective, presuming that, with more resources available, doctors will face fewer morally compromising situations. Still, nothing about a lack of resources is unique to the plight of doctors.

Bioethicists say ethics is 'central to a physician's identity', and that ethics is about compassion, empathy and virtue. But most doctors think quite differently. They think being a doctor is first and foremost a burden because the doctor's moral sense and civilised sentiments are always playing defence against the savagery of physical existence.

In the operating room that day, I did not see myself as the compassionate and empathetic caregiver portrayed in bioethics, but as an ordinary worker doing a dirty job the best he could; not as someone on a higher plane, but of this world; not super-earthly but the sum and substance of all that is earthly. I tried to imagine myself functioning more vigorously than the average person; that my senses were keener; that they saw and heard more acutely and more consciously, enabling me to keep my patient's pain to a minimum – not unlike the 19th-century surgeon, who, when performing an amputation before the age of anaesthesia, prided himself on being fast. I did not see myself as inspired, idealistic or especially principled. Instead, I saw myself as thoroughly human, working in reality, only it was reality raised to the *n*th power.

Can bioethics be made more relevant to everyday physician practice? With my difficult case uppermost in mind, I doubt it.I passed the breathing tube. Before connecting it to the ventilator, I stared at the man's face. It reflected the horror he had just gone through. It also expressed bewilderment and a tense, agonising question – a foreboding of fresh misfortune, inevitable and unavoidable, as though expecting a blow that he wanted to turn aside but could not.

I turned the dial on the anaesthetic gas canister to a low dose. The man grew still. When I turned the dose a notch higher, his blood pressure fell dramatically, so I quickly dialled back. It was clear that his fragile cardiovascular system would tolerate very little anaesthesia.

The surgeon cut. Quickly, the man's bare abdomen lost the familiar appearance of human flesh. Each time I tried to give more anaesthetic gas, the patient's blood pressure collapsed, at one point leading to cardiac arrest. It was almost as if his body *needed* to feel pain to live. It needed

the outpouring of adrenalin caused by his pain to constrict his blood vessels and accelerate his heart to maintain blood pressure.

I had paralysed the patient with a muscle relaxant, tying a tourniquet around his left forearm in advance so that his left hand would move if he was still conscious. Now, I placed a second intravenous line in his left wrist. Shockingly, I felt the man's unparalysed fingers find my hand and squeeze it. In the past I had received approving squeezes from patients who wanted to say thanks, or sometimes an anxious, childlike squeeze designed to allay the patient's own anxiety. But this squeeze had desperation in it.Taping a patient's eyes shut is routine in all general anaesthetics to protect against eye injury. I had not yet done so, as the man's eyes were closed naturally. I lifted the lids and studied them. They remained unchanged in position and committed themselves to nothing, but when I looked down into them, I thought I saw the swift passage of thought. The eyes see! Or so I feared. I debated whether to tape them shut or leave them open. To be in horrible pain *and* unable to open one's eyes seemed awful, like a surgical version of being buried alive. Nevertheless, I taped them.

I was a wreck. Not surprisingly, clinical bioethics was nowhere to be seen. While ethics committees in some hospitals offer consultations, such services are rarely available 24/7. The committee at my hospital met just once a month.

Yet even if a consultant had been available, the field's abstract principles would have been useless to me. The concept of *principlism* refers to the four core principles outlined in the (now classic) textbook *Principles of Biomedical Ethics* (1979) by Tom L Beauchamp and James F Childress: patient autonomy, beneficence, non-maleficence, and justice. These principles have canonical status in clinical bioethics. Yet doctors in everyday practice know the real god of medicine is not a principle, nor even science, but chance. Sometimes, they may seduce themselves into thinking medical practice can be a smooth ride along polished rails, but deep down they know that chance will inevitably assert itself and ruin their day. When it does, they know they will stumble, scratch their heads, cut corners, flail, fail and worry about getting sued – while still being very respectable doctors.

The four principles represent prototypes of upright behaviour and are meant to awaken higher and better feelings in doctors. Vain the desire, vain the attempt, for often the principles cannot be squared with one another – an awake and painful intubation, for instance, pits the principle of beneficence against the principles of non-maleficence and autonomy. During medical emergencies, these idealised principles are like weak reeds in a storm, bending right and left, having no wish to be broken, useless as a foundation, and waiting for calm so they might rise again, and pretend to be strong and true.