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EDITORIAL ANALYSIS

The Alarming Rise of Medicalisation in India: From Public Health to Pharmaceutical Dependence

THE HINDU

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INTERVIEW ANGLE

"India's out-of-pocket health expenditure remains ~47% of total health spending. In this context, is the arrival of anti-obesity drugs (GLP-1 agonists like Ozempic/Wegovy) at scale a public-health advance, or a commercial shift that medicalises problems solvable by food policy and physical infrastructure?"

EDITORIAL SUMMARY

The arrival of GLP-1 anti-obesity drugs at scale in India has reignited debate on the medicalisation of lifestyle conditions. With 47% out-of-pocket health expenditure and weak structural prevention (food labelling, sugar taxation, active transport), pharmacological solutions risk substituting for — rather than complementing — cheaper public-health measures. A regulatory framework that funds prevention first and regulates pharmaceutical pricing second is essential.

THE BACKDROP

GLP-1 receptor agonists — a class of drugs originally developed for type-2 diabetes — have emerged as blockbuster anti-obesity treatments over the past 3-5 years globally. Brand names familiar now in Indian metros:

- **Ozempic / Wegovy** (semaglutide; Novo Nordisk)
- **Mounjaro / Zepbound** (tirzepatide; Eli Lilly)
- **Rybelsus** (oral semaglutide)
- **Indian biosimilars** from Biocon, Dr Reddy's, Lupin — under development; expected market entry 2026-27

These drugs produce **15-22% body weight loss** over 6-12 months — clinical trial evidence is robust. But they are taken **indefinitely** (effect reverses on discontinuation), priced at **₹20,000-50,000/month** in India, and carry significant side-effects.

THE MEDICALISATION THESIS

Medicalisation is the process by which non-medical conditions (social, behavioural, environmental) are defined as medical problems requiring medical intervention. Applied to obesity:

- **Pre-medicalisation framing:** Obesity as a lifestyle condition addressable through diet, exercise, and environmental design (walkable cities, affordable fresh food, reduced UPF consumption)
- **Medicalisation framing:** Obesity as a chronic metabolic disease requiring lifelong pharmacological management

Both framings have partial truth — some obesity cases have genuine endocrine/metabolic roots; but most of India's rising BMI is driven by food system and physical environment changes, not medical pathology.

THE CONCERNS

1. Equity

- GLP-1 monthly cost (₹20,000-50,000) exceeds **median Indian household monthly income**
- Creates a two-tier health landscape
- Urban elite access, rural access near-zero

2. Sustainability

- Indefinite medication → lifelong drug dependence
- Reversal on discontinuation → unsuitable for periodic use
- Opportunity cost: resources spent on drugs unavailable for prevention

3. Side-effects and Secondary Pharma

- Sarcopenia (muscle loss) — requires BCAA supplementation
- Gastrointestinal (nausea, vomiting, constipation) — requires acid suppressants
- Gallbladder inflammation — requires cholesterol-lowering agents in some cases
- Psychiatric — depression, anxiety reported; SSRIs sometimes follow

Each side-effect creates a new market. The **total lifetime pharmaceutical spend** on managing GLP-1 therapy can be 2-3x the drug cost alone.

4. Regulatory Gaps

- **FSSAI front-of-pack labelling** — draft since 2019; still not mandatory
- **Sugar tax** — under discussion; no national implementation
- **UPF (ultra-processed food) taxation** — none
- **Direct-to-consumer pharmaceutical advertising** — CDSCO oversight weak
- **Aggressive marketing** to upper-middle-class urban consumers in tier-1 metros

THE CHEAPER ALTERNATIVE — PUBLIC HEALTH

International evidence strongly supports structural interventions:

INTERVENTION	COST-EFFECTIVENESS	EVIDENCE BASE
Sugar-sweetened beverage tax	Very high (Mexico 2014, UK 2018)	8-12% consumption reduction; Type-2 diabetes incidence decline
Front-of-pack labelling	Moderate-high	Chile 2016 — warning labels on UPF caused 25% reduction in sugar purchases
Active transport infrastructure	Very high	Bogotá, Copenhagen; significant reduction in population BMI
School meal reform	High	UK's Jamie Oliver reforms; Kerala's mid-day meal fruit inclusion
Workplace wellness	Moderate	Mixed evidence; infrastructure-dependent
GLP-1 drugs	Individually high; population low	Requires 20-30% of adult population to shift outcomes

India's policy focus remains skewed toward treatment over prevention.

ETHICAL DIMENSIONS

Autonomy vs Paternalism

- Individual right to access approved medications — legitimate
- But state has a duty to ensure structural conditions favour health
- Balance: regulate pharmaceutical pricing + advertising, don't restrict access

Equity

- Treatments available to wealthy should not normalise a two-tier health landscape
- Requires **DPCO inclusion** of GLP-1 drugs once patent-expires
- India's **compulsory licensing** regime (Section 84 Patents Act 1970) provides tool — used for Bayer's Nexavar in 2012

Public-Health Ethics

- Mission LiFE's environmental framing — sustainable diets, physical activity — aligns with structural prevention
- But requires parallel regulatory muscle — sugar/UPF taxation, food labelling, active-transport infrastructure

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THE INSTITUTIONAL ARCHITECTURE NEEDED

1. **CDSCO strengthening** — Direct-to-consumer advertising rules, post-market surveillance
2. **NPPA expansion** — Include lifestyle drugs in price control; cap innovator-drug prices once critical mass reached
3. **FSSAI reform** — Mandate front-of-pack warning labels (similar to Chile model)
4. **Finance Ministry action** — Sugar and UPF taxation (GST Council)
5. **MoHFW focus** — National Action Plan on Obesity Prevention (currently absent)
6. **Ministry of Housing & Urban Affairs** — Active-transport infrastructure in AMRUT 2.0 and Smart Cities

Coordinated, this would address the **root causes** (food system, physical environment) rather than only the **symptoms** (individual weight).

UPSC RELEVANCE

PAPER	ANGLE
GS2 — Health/Governance	CDSCO, NPPA, FSSAI, NHP 2017, National Health Accounts, PMJAY
GS2 — Social Justice	Equity in health; OOP expenditure; health impoverishment
GS3 — S&T	GLP-1 mechanism; biosimilar development; pharmaceutical innovation
GS4 — Ethics	Medicalisation vs autonomy; pharmaceutical profit vs public health; Mission LiFE
Mains Keywords	Medicalisation, GLP-1 agonists, Ozempic/Wegovy/Mounjaro, out-of-pocket expenditure, FSSAI, sugar tax, NPPA, Section 84 Patents Act, Mission LiFE

KEY ARGUMENTS AT A GLANCE

The rise of pharmacological solutions for what were once lifestyle, social, or environmental conditions — obesity, anxiety, loneliness, ageing — reflects a structural shift toward commodified healthcare that risks displacing cheaper, more equitable public-health approaches and deepening out-of-pocket expenditure burdens on Indian households.

✓ SUPPORTING

- Anti-obesity drugs (GLP-1 receptor agonists — Ozempic, Wegovy, Mounjaro) entered the Indian market in 2024-25 with prices of ₹20,000-₹50,000/month, beyond reach of most Indians — yet have become the cultural reference point for obesity management.
- Side-effect management is creating secondary pharmaceutical markets: GLP-1 users experience sarcopenia (muscle loss) requiring branched-chain amino acid supplementation; gastrointestinal issues requiring acid suppressants. Each condition creates a new revenue stream.
- The 47% out-of-pocket health expenditure share (National Health Accounts 2023) makes pharmaceutical cost-escalation a direct driver of 'health impoverishment' — NFHS-5 estimates ~35 million Indians pushed into poverty annually by health expenses.
- India's Food Safety and Standards Authority (FSSAI) has reduced enforcement of front-of-pack labelling reform; regulatory clarity on sugar taxation remains absent — creating

conditions where prevention is weak and treatment is commercialised.

⚠ COUNTER

Pharmacological interventions are legitimate medical tools that address real pathologies. Opposing their availability on 'medicalisation' grounds risks elite paternalism — denying access to treatments widely available globally.
Public-health prevention and pharmaceutical treatment should coexist, not compete.

→ WAY FORWARD

Four-pillar regulation: (1) Public funding of structural prevention — front-of-pack labelling, sugar/UPF tax, active-transport urban planning; (2) Price regulation of lifestyle drugs (Drug Price Control Orders + National Pharmaceutical Pricing Authority); (3) Stricter CDSCO oversight on direct-to-consumer advertising; (4) Conflict-of-interest rules for clinician prescribing patterns; and public awareness that lifestyle drugs are complement, not substitute, to public-health infrastructure.

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✍ MAINS ANSWER FRAMEWORK

QUESTION

The 'medicalisation' of lifestyle conditions — via anti-obesity drugs, anti-ageing therapies, and pharmacological solutions for social problems — has intensified in India. Analyse the ethical, public-health, and economic implications, and suggest a regulatory framework that balances innovation with over-medicalisation concerns. (250 words)

INTRODUCTION

India's health expenditure is increasingly dominated by pharmacological spending — on drugs, diagnostics, and devices — while structural public-health infrastructure (sanitation, urban planning, food regulation, active transport) receives far less priority. The arrival of anti-obesity GLP-1 drugs at scale marks a further turning point in this 'medicalisation' of lifestyle conditions, raising ethical, public-health, and distributional questions.

BODY

The shift has four dimensions. **First, commodification of lifestyle**: GLP-1 agonists (semaglutide — Ozempic/Wegovy; tirzepatide — Mounjaro) priced at ₹20,000-50,000/month have become the cultural reference for obesity management — but are beyond reach of 90%+ of Indians. This creates a two-tier health system where wealth determines access to pharmaceutical solutions. **Second, side-effect industry**: GLP-1 users experience sarcopenia (muscle loss), gastrointestinal issues, gallbladder complications — each requiring secondary drugs, creating escalating pharmaceutical dependence. Branched-chain amino acids, proton pump inhibitors, and urso-deoxycholic acid have seen prescription surges alongside GLP-1 rollout. **Third, out-of-pocket impact**: India's 47% OOP health expenditure share (National Health Accounts 2023) already pushes ~35 million into poverty annually (NFHS-5). Pharmaceutical cost-escalation amplifies this. **Fourth, regulatory vacuum**: FSSAI's front-of-pack labelling draft has stalled; sugar/UPF taxation debate is unresolved; CDSCO direct-to-consumer advertising oversight is weak.

The net effect: weak prevention, commercialised treatment. Ethically, this raises Article 21 questions — does the right to health include a right to affordable structural prevention, not just theoretical access to expensive drugs?

CONCLUSION

Regulating medicalisation requires four parallel reforms: strengthening structural public-health (FSSAI front-of-pack labelling, sugar/UPF taxation, active-transport urban planning); pricing regulation of lifestyle drugs via DPCO/NPPA; CDSCO oversight on direct-to-consumer advertising; and conflict-of-interest norms for prescribers. The goal is not to oppose GLP-1 access — which is a legitimate medical tool — but to ensure it does not become the default where prevention, education, and environmental redesign should be primary.

A public health system funds water, food, and movement before it funds molecules.

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