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EDITORIAL ANALYSIS

A Lopsided Fix: On the Cough Syrup Prescription Rule

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The Hindu 19 June 2026 GS2

Source: ujiyari.com — researched, fact-checked & UPSC-mapped

INTERVIEW ANGLE

"When a product kills because it was badly made, is restricting who can buy it the right response? How should a regulator distinguish a quality-control failure from a consumption problem?"

Source: Original editorial ↗ The Hindu

Every fact web-verified against primary sources (https://ujiyari.com/how-we-verify/)

WHY THIS MATTERS NOW

A fresh proposal to pull **cough syrups** out of **Schedule K** and require a doctor's **prescription** follows a string of tragedies in which syrups contaminated with **ethylene glycol and diethylene glycol** killed children. For an aspirant, this is a GS2 case on **health governance and regulatory design**: when a product harms because it was badly made, does restricting who can buy it fix anything?

THE CRUX IN 60 WORDS

The deaths came from **toxic contamination** at the manufacturing stage, not from over-the-counter access. Making syrups prescription-only treats a **quality-control failure** as a **consumer-access problem**. The real remedy is upstream: **raw-material and batch testing**, a properly staffed **drug inspectorate**, and stronger **CDSCO** enforcement under the **Drugs and Cosmetics Act, 1940**. A prescription gate misses the cause.

THE ISSUE, DECODED

ELEMENT	WHAT IT IS	WHY IT MATTERS
Schedule K	Drugs and Cosmetics Rules schedule allowing certain OTC sales	Removing syrups from it triggers the prescription rule
EG / DEG contamination	Toxic industrial solvents in syrup	The actual cause of the deaths
CDSCO / DCGI	Central drug regulator and controller	Hold the enforcement mandate (https://ujiyari.com/vocab/mandate/) that is failing
Drug inspectorate	Field officers checking manufacturing	Severely understaffed for the units they police

THE ANALYSIS: WHY THE FIX MISSES THE CAUSE

1. **The harm originates upstream.** Adulterated raw materials and untested batches, not OTC sale, killed children.
2. **A prescription tests nothing.** It records a sale; it does not check whether the bottle is chemically safe.
3. **Enforcement, not law, is the gap.** The Drugs and Cosmetics Act already mandates quality; the inspectorate is too thin to enforce it.
4. **The burden falls on the wrong people.** Patients, doctors and the rural poor bear the cost, while manufacturers escape scrutiny.

DATA AND INSTITUTIONS VAULT

the **Drugs and Cosmetics Act, 1940** *and the* **Drugs and Cosmetics Rules, 1945** *(including* **Schedule K***, which permits limited OTC sale of certain preparations).* **Regulators:** *the* **Central Drugs Standard Control Organisation (CDSCO)***, headed by the* **Drugs Controller General of India (DCGI)***; state drug controllers share enforcement.* **The adulterants: diethylene glycol (DEG)** *and* **ethylene glycol (EG)***, industrial solvents that cause acute kidney injury.* **Concepts:** *regulatory capture; enforcement deficit; pharmacovigilance; the difference between access regulation and quality regulation.* **Linkage:** *Right to health (Article 21); consumer protection; pharmaceutical export reputation.*

THE DEBATE

Argument for the prescription rule: It adds a layer of oversight to a poorly governed market, curbs misuse of codeine-based syrups, and creates a paper trail for accountability.

Argument against: The deaths were caused by contamination, not access; a prescription does not test safety, burdens the poor, and may drive demand to informal sellers while the supply-chain failure persists.

The balanced verdict: A prescription rule may have marginal merit for misuse-prone formulations, but it is a **category error** as a response to contamination. The proportionate fix targets the manufacturing stage: **mandatory testing, a stronger inspectorate, and real penalties**.

HOW TO THINK ABOUT THIS (TRANSFERABLE SKILL)

> *A weak answer accepts the framing offered ("make it prescription-only") and debates it on its own terms. The strong answer first asks where did the harm originate? and then tests whether the proposed fix touches that point. Here, harm originates at manufacturing; the fix targets the point of sale; therefore the fix is mismatched. The same diagnostic, "trace the harm to its source," applies to food safety, environmental and financial regulation alike.*

DIAGRAM-IN-WORDS

`Untested raw material + weak batch testing -> EG/DEG contamination -> deaths`. The proposed fix: `restrict OTC sale -> prescription gate`, which lands on `point of sale`, not on `manufacturing`. The matched fix: `mandatory raw-material + batch testing + larger inspectorate + CDSCO enforcement -> safe product at source`.

THE WAY FORWARD

1. **Mandate testing** of pharmacopoeial-grade raw materials and every finished batch before release.
2. **Expand and empower** (https://ujiyari.com/vocab/empower/) **the drug inspectorate** to match the number of manufacturing units.
3. **Strengthen CDSCO and DCGI enforcement** with real penalties for non-compliant firms.
4. **Target the supply chain**, not the point of sale, so the remedy fits the failure.

THE TAKEAWAY BOX

"Repeated drug contamination tragedies reflect a regulatory enforcement deficit rather than a consumer-access problem." Critically examine in the context of India's drug regulation. (250 words)

"The deaths were a quality-control failure, and quality control is where the remedy must sit; a prescription rule is a visible gesture, testing and enforcement are the substance."

Drugs and Cosmetics Act, 1940 · Schedule K · CDSCO · DCGI · diethylene glycol · ethylene glycol · pharmacovigilance.

When a product kills because it was badly made, is restricting who can buy it an honest response or a way to be seen acting?

Connects to GS2 PYQs on health-sector governance, regulatory bodies and the Right to Health; a probable question is the enforcement-versus-access framing above.

static GS2 on health regulation and the Drugs and Cosmetics framework; the pharmaceutical export-quality debate.

Sources: The Hindu (https://www.thehindu.com/opinion/editorial/), CDSCO (https://cdsco.gov.in)

KEY ARGUMENTS AT A GLANCE

Pulling cough syrups out of Schedule K and mandating prescriptions treats a manufacturing-quality failure, the toxic contamination of syrups with ethylene glycol and diethylene glycol, as if it were a consumer-access problem, when the real remedy lies in raw-material and batch testing, stronger CDSCO enforcement, and a properly staffed drug inspectorate.

✓ SUPPORTING

- The deaths arose from toxic adulterants entering the supply chain, not from over-the-counter availability, so a prescription gate does not touch the cause.
- India's drug inspectorate is severely understaffed relative to the number of manufacturing units, leaving quality enforcement weak at the point where it matters most.
- A prescription requirement burdens patients and doctors and pushes demand toward informal channels, without testing the chemical safety of the product itself.

⚠ COUNTER

Some argue that a prescription requirement at least curbs misuse and creates a paper trail, adding one layer of oversight to a poorly governed market.

→ WAY FORWARD

Mandate testing of pharmacopoeial-grade raw materials and finished batches, expand and empower the drug inspectorate, strengthen CDSCO and DCGI enforcement, and act on the supply-chain failure rather than the point of sale.

MAINS ANSWER FRAMEWORK

QUESTION

"Repeated drug contamination tragedies reflect a regulatory enforcement deficit rather than a consumer-access problem." Critically examine in the context of India's drug regulation. (250 words)

INTRODUCTION

When children die because a syrup was poisoned at the factory, the question a regulator must ask is where the poison entered, not who bought the bottle. The move to make cough syrups prescription-only answers the wrong question.

BODY

The recurring tragedies in which cough syrups contaminated with industrial solvents, ethylene glycol and diethylene glycol, have killed children point to a precise failure: adulterated or untested raw materials and finished batches reaching the market. The Drugs and Cosmetics Act, 1940, and the Central Drugs Standard Control Organisation (CDSCO) under the Drugs Controller General of India (DCGI) already provide the legal architecture for quality control; what is missing is enforcement.

India's drug inspectorate is badly understaffed relative to the thousands of manufacturing units it must police, so substandard product slips through. Moving cough syrups out of Schedule K, which permits certain over-the-counter sales, and requiring a prescription does nothing to test whether a given bottle is chemically safe.

It shifts the burden onto patients and prescribers, lengthens access for the poor and the rural, and may push demand toward informal sellers, while the contaminated-supply problem remains untouched. The honest counter is that an extra layer of oversight has some value, and a prescription does create a record.

But a record of a sale is not a test of safety. The fix that matches the failure is upstream: compulsory testing of pharmacopoeial-grade raw materials and every finished batch, a larger and better-resourced inspectorate, real penalties for non-compliant manufacturers, and a CDSCO able to enforce them. Regulation must target the point where harm originates, not the point where it is most visible.

CONCLUSION

The deaths were a quality-control failure, and quality control is where the remedy must sit. A prescription rule is a visible gesture; testing and enforcement are the substance.

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