



UPSC & STATE PCS CURRENT AFFAIRS · UJIYARI.COM

EDITORIAL ANALYSIS

Beyond the Prescription Pad: India's Antibiotic Resistance Problem Is Systemic

 INDIAN EXPRESS

30 July 2026

SOCIAL ISSUES

GS2

GS3

CURATED & WRITTEN BY

**Bharat Choudhary**

UPSC Educator & Content Creator

 [linkedin.com/in/epicbharat](https://www.linkedin.com/in/epicbharat)

ALSO FROM THE CREATOR

BharatNotesFree UPSC notes, MCQs, PYQ analysis. **100% Free.**bharatnotes.com → **ADVERTISE****Advertise with Ujiyari**

Reach thousands of UPSC aspirants daily.

 epicbharat@gmail.com

Beyond the Prescription Pad: India's Antibiotic Resistance Problem Is Systemic

 The Indian Express

30 July 2026

GS2

GS3



INTERVIEW ANGLE

"If prescriber-focused interventions have limited effect because the real leakage is over-the-counter sales, why do policy responses keep targeting doctors first? Is this a genuine misdiagnosis, or is it simply the easier lever to pull?"

✓ Every fact web-verified against primary sources

THE LIFT LINE

A prescription pad is the last, most visible link in a much longer chain of antibiotic misuse. Fixing the last link while leaving the rest of the chain untouched changes what gets written down, not what actually happens at the counter.

WHY THIS EDITORIAL MATTERS FOR YOUR EXAM

Antimicrobial resistance is a growing GS2/GS3 health-governance theme, and this editorial's systemic framing is exactly the kind of multi-causal analysis UPSC Mains answers reward over a single-cause explanation.

GS Paper 2: Issues relating to development and management of Social Sector/Services relating to Health; government policies and interventions for health-sector development.

GS Paper 3: Science and technology, health; awareness in the field of biotechnology relevant to antimicrobial resistance.

For **Prelims**, fix the Schedule H/H1 classification under the Drugs and Cosmetics Rules, since drug-scheduling questions are a recurring **statutory**-detail testing ground.

CONCEPT	MEANING	WHY UPSC TESTS IT
Antimicrobial Resistance (AMR)	The ability of microorganisms to survive exposure to drugs that would normally kill or inhibit them, driven substantially by antibiotic overuse	A recognised global health priority, frequently linked to India's high antibiotic consumption
Schedule H / H1 drugs	Categories under the Drugs and Cosmetics Rules, 1945 requiring a valid prescription for sale	Tests statutory drug-regulation knowledge, distinct from Schedule X (narcotic-adjacent) drugs
Over-the-counter (OTC) leakage	Antibiotic sales occurring without a valid prescription despite legal requirements	The specific enforcement gap this editorial identifies as under-addressed
Systemic versus targeted intervention	A systemic response addresses multiple causal nodes; a targeted response addresses only one	The analytical distinction the editorial's core argument rests on

BACKGROUND AND CONTEXT

FACTOR	DETAIL
Legal framework	Drugs and Cosmetics Rules, 1945; Schedule H and H1 require prescription for antibiotic sale
Enforcement gap	Widely documented OTC dispensing of antibiotics without valid prescriptions
Access driver	Weak primary healthcare access pushes patients toward self-medication
Demand driver	Patient expectation for a prescription pressures doctors toward overprescribing

India's National Action Plan on Antimicrobial Resistance (NAP-AMR), aligned with the WHO's Global Action Plan, has similarly identified multiple intervention pillars, awareness, surveillance, infection prevention, optimised antibiotic use, and research, reflecting official recognition that AMR is a multi-causal problem even where implementation has lagged.

THE CORE ARGUMENT / ISSUE

Why prescriber-focused fixes have a ceiling

A prescription-guideline reform can only change behaviour within a formal doctor-patient consultation. It has no purchase on antibiotic purchases that never involve a doctor at all, over-the-counter sales driven by patient self-diagnosis or informal pharmacist recommendation, which independent surveys and studies have repeatedly found to be a substantial share of India's total antibiotic consumption despite the Schedule H1 prescription requirement.

The access-driven self-medication loop

Where primary healthcare access is poor, particularly in underserved rural and peri-urban areas, a formal consultation carries real costs in time, travel and money that a direct pharmacy purchase avoids. This creates a structural incentive toward self-medication that exists entirely independent of prescriber behaviour, and no reform aimed at doctors touches it.

The demand-side pressure on doctors

Even within a formal consultation, patient expectation plays a documented role: patients who expect a prescription, particularly for symptoms they associate with infection, can create pressure that leads to prescribing “to be safe” or to meet patient expectation, rather than based on clinical necessity alone. This is a genuine contributor to overprescribing, but it originates in patient behaviour and awareness, not solely prescriber judgment.

The case for prescriber-focused reform, taken seriously

None of this makes prescriber-side reform pointless. It remains one of the few interventions a health system can implement relatively quickly, through professional-body guidelines, hospital protocols and prescription audits, using regulatory and professional-accountability mechanisms that already exist. Waiting for a comprehensive systemic fix before acting on the prescriber side would forfeit real, immediate gains.

Why the systemic frame still matters

The reply is about proportion and sequencing, not exclusivity. A prescriber-only strategy, however well-executed, addresses one node in a multi-node problem and will show diminishing returns once prescriber-side overuse is brought down, because the larger leakage, OTC sales and self-medication, remains untouched. A systemic strategy pursues all nodes in parallel rather than treating the prescriber-side intervention as sufficient on its own.

HOW TO THINK ABOUT THIS (ANALYTICAL FRAME)

Map the full causal chain before targeting an intervention. When a policy problem has a visible, easily regulated actor at one end (the prescribing doctor) and a diffuse, harder-to-regulate set of actors elsewhere (pharmacies, patients, access gaps), policy attention tends to concentrate on the visible actor by default, not necessarily because it is the largest causal contributor, but because it is the easiest lever to pull. The correct analytical move is to map the full causal chain first, then allocate policy attention according to where the actual leakage is largest, not according to where regulation is administratively simplest.

THE DIAGRAM IN WORDS

Picture antibiotic misuse as water leaking from a pipe with three distinct joints: the doctor's prescription pad, the pharmacy counter, and the patient's own medicine cabinet where leftover antibiotics get self-administered later. A reform that tightens only the first joint, prescriber guidelines, stops some leakage there, but water continues flowing freely through the other two joints, pharmacy sales without prescription and patient self-medication, exactly as before. The total leak barely narrows, even though the first joint now looks well-sealed on inspection, because inspection only checked the joint that was fixed.

WAY FORWARD

- 1 **Enforce Schedule H1 prescription requirements at the pharmacy level** through regular inspection and penalties for non-compliant OTC antibiotic sales, closing the largest documented leakage point.
- 2 **Expand primary healthcare access** in underserved areas, reducing the structural incentive toward self-medication as a substitute for formal consultation.
- 3 **Run direct public-awareness campaigns** targeting patient expectations around antibiotic prescriptions, reducing the demand-side pressure on doctors.
- 4 **Maintain and strengthen prescriber-side guidelines** as one component of a broader strategy, not as the primary or sole intervention.
- 5 **Track AMR outcomes disaggregated by intervention type**, so policymakers can see which lever, prescriber reform, pharmacy enforcement or access expansion, is actually driving improvement, rather than assuming a single intervention is sufficient.

PYQ LINKAGE AND PRACTICE

UPSC has tested antimicrobial resistance, public health governance, and pharmaceutical regulation as recurring GS2/GS3 themes; this editorial's systemic framing offers a strong template for a multi-causal Mains answer structure.

Practice question: "A policy problem with a visible, easily regulated actor at one end often receives disproportionate policy attention relative to its actual causal contribution." Examine this claim with reference to India's antimicrobial resistance crisis and the limits of prescriber-focused interventions. (250 words, 15 marks)

Interview angle: If prescriber-focused interventions have limited effect because the real leakage is over-the-counter sales, why do policy responses keep targeting doctors first? Is this a genuine misdiagnosis, or is it simply the easier lever to pull?

Sources: Indian Express, Ministry of Health and Family Welfare, World Health Organization

Source: Beyond the Prescription Pad: India's Antibiotic Resistance Problem Is Systemic — Ujiyari.com | Free UPSC & State PCS Editorial Analysis

● KEY ARGUMENTS AT A GLANCE

India's antimicrobial resistance crisis cannot be fixed by targeting doctors' overprescribing alone, because much of the problem originates in over-the-counter antibiotic sales, patient demand, and weak pharmacy-regulation enforcement, factors a prescriber-focused intervention does not touch.



✓ SUPPORTING

- India permits antibiotic sales that are, in practice, frequently dispensed without a valid prescription despite Schedule H/H1 requirements under the Drugs and Cosmetics Rules, making pharmacy-level enforcement, not prescriber behaviour, the larger leakage point.
- Poor primary healthcare access pushes patients toward self-medication and pharmacist-recommended antibiotics as a substitute for a proper diagnosis, a structural access problem no prescribing guideline addresses.
- Patient demand itself drives overprescribing in many consultations, where doctors face pressure to prescribe something, including antibiotics, regardless of clinical necessity.



⚠ COUNTER

Prescriber behaviour remains a genuine and measurable contributor to overuse, and tightening prescription protocols is one of the few interventions health systems can implement quickly and enforce through existing regulatory and professional-body mechanisms.



→ WAY FORWARD

Pair prescriber-side reforms with stricter pharmacy enforcement of Schedule H1 sale rules, expanded primary healthcare access to reduce self-medication incentives, and public-awareness campaigns targeting patient demand directly.


MAINS ANSWER FRAMEWORK
QUESTION

India's antimicrobial resistance crisis is often framed as a doctor-prescribing problem. Examine why this framing is incomplete and outline a systemic policy response. (250 words)

INTRODUCTION

Antimicrobial resistance (AMR) is increasingly recognised as a major public health threat in India, and policy responses have often centred on curbing doctors' antibiotic prescribing practices, a framing this editorial argues is incomplete.

BODY

India's Drugs and Cosmetics Rules, 1945 classify most antibiotics under Schedule H or H1, requiring a valid prescription for sale, but enforcement at the pharmacy level remains weak, and over-the-counter dispensing without prescription is widely documented despite the legal requirement. This means a significant share of antibiotic misuse occurs entirely outside any doctor's prescribing decision, through direct pharmacy purchase driven by patient self-diagnosis or pharmacist recommendation.

Compounding this, weak primary healthcare access in many parts of India pushes patients toward self-medication as a practical substitute for a formal consultation, and even where a consultation occurs, patient expectation and demand for a tangible prescription can pressure doctors into overprescribing regardless of clinical indication. A policy response focused solely on prescriber guidelines addresses only one node in a multi-node problem.

CONCLUSION

A systemic AMR response needs to combine prescriber-side reform with pharmacy-level enforcement of existing Schedule H1 rules, expanded primary healthcare access to reduce self-medication incentives, and direct public engagement to shift patient demand away from reflexive antibiotic use, rather than treating doctors as the primary lever.

RELATED DAILY ARTICLES

30 Jul **Trapped Behind the Scam: Human Trafficking's New...**

29 Jul **Custody, Pellets and a Report Card: What the NEET...**

29 Jul **Four Serotypes, One Season: What Dengue...**

28 Jul **Current Affairs Today, July 28, 2026**



CURATED & WRITTEN BY

Bharat Choudhary

UPSC Educator & Content Creator

[in linkedin.com/in/epicbharat](https://www.linkedin.com/in/epicbharat)[Read Full Article on Ujiyari →](#)<https://ujiyari.com/editorials/2026/07/ie-antibiotic-resistance-systemic-response-2026/>

ALSO FROM THE CREATOR

BharatNotes

Free UPSC study platform — subject-wise notes across all 4 GS papers, Prelims MCQs, Mains answer frameworks, PYQ analysis & progress tracking. **100% Free • No Login Required.**

[Start Preparing → bharatnotes.com](#)

📢 OPPORTUNITY

Advertise with Ujiyari

Reach **thousands of serious UPSC & State PCS aspirants** daily through our PDFs, website, and social channels.

Ideal for: Coaching institutes • EdTech platforms • Book publishers • Exam prep apps

[✉ epicbharat@gmail.com](mailto:epicbharat@gmail.com)

Write to us for rates & media kit

Free UPSC & State PCS Current Affairs · ujiyari.com · bharatnotes.com