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EDITORIAL ANALYSIS

India's Diabetes Epidemic Meets GLP-1 Drugs: A Case for Controlled Access

HINDUSTAN TIMES

8 August 2026 · SCIENCE & TECH · SOCIAL ISSUES · GS2 · GS3

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Hindustan Times 8 August 2026 GS2 GS3

Every fact web-verified against primary sources

THE LIFT LINE

A drug this good should not be rationed by price alone, and it should not be handed out by price alone either.

WHY THIS EDITORIAL MATTERS FOR YOUR EXAM

Health policy answers on India's disease burden often stop at citing prevalence numbers. This editorial supplies the harder governance question that follows a genuinely effective new therapy: when a drug has dual approved uses, one clinical and one aesthetic-adjacent, who gets first access, and what mechanism decides that, rather than leaving it to who can pay.

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

GS Paper 3: Science and technology developments and their applications; issues relating to intellectual property rights in the pharmaceutical sector.

CONCEPT	MEANING	WHY IT IS TESTABLE
GLP-1 receptor agonist	A drug class mimicking the gut hormone glucagon-like peptide-1, which stimulates insulin release, slows gastric emptying and increases satiety	Dual-use mechanism (diabetes control and weight loss) is the core of the access debate
ICMR-INDIAB study	India's national cross-sectional study on diabetes and prediabetes prevalence, covering all states	Standard citable source: 101 million diabetic, 136 million prediabetic
National Health Authority (NHA)	The apex body implementing Ayushman Bharat PM-JAY	Institutional link to the author's policy authority
Eligibility criteria (in drug access)	Clinical rules restricting subsidised or programme-based access to a defined patient group	The design tool that prevents a dual-use drug's benefits flowing to the wrong population
Phased pilot rollout	Testing a policy in a limited number of states before national scale-up	Standard Indian public health governance instrument, distinct from an unrestricted market launch

BACKGROUND AND CONTEXT

India's **diabetes burden** is large and well documented. The **ICMR-INDIAB study**, the country's most comprehensive national survey on the subject, estimates **101 million adults living with diabetes** and a further **136 million in the prediabetic stage**, drawing on data collected across all states and union territories. This is the reference figure Indian health policy now works from.

GLP-1 receptor agonist drugs, a class that includes semaglutide, entered clinical use as a treatment for type 2 diabetes and have since accumulated strong trial evidence for cardiovascular and mortality benefit in appropriately selected patients, benefits that go beyond blood sugar control alone. The same appetite-suppressing mechanism that helps regulate blood sugar has also made these drugs effective, and commercially prominent, for weight loss, creating a second, much larger potential market beyond the diabetic population.

Indu Bhushan, the author, is the founding CEO of the **National Health Authority (2018 to 2021)**, the body that designed and implemented **Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (PM-JAY)**, India's flagship public health insurance scheme. That background is directly relevant to why his proposal favours a controlled, phased introduction over an open market rollout.

THE ANALYSIS

1. The scale of the underlying disease burden is not in dispute. At 101 million diabetic and 136 million prediabetic Indians, this is one of the largest single disease burdens the health system manages, and the clinical case for a genuinely effective new therapy is strong on its own terms.

2. The dual approval is the actual policy problem. A drug approved for both diabetes management and weight loss does not automatically serve the diabetic population first when access is left to the market; ability to pay, not clinical need, tends to determine who obtains the drug first in an unrestricted rollout.

3. Affordability is a real constraint, not a marginal one. Even the lower end of the current Indian pricing range for these drugs represents a significant recurring cost for most households, meaning that without a designed access mechanism, benefit is likely to concentrate among patients who could afford care regardless.

4. A phased pilot is a governance instrument India already uses. Testing an intervention in a defined number of states before national scale-up, with eligibility criteria and monitoring, is a standard tool for sequencing high-cost health interventions, distinct from either an unrestricted commercial launch or an indefinite delay.

5. The author's institutional background gives the proposal specific credibility. Having built Ayushman Bharat PM-JAY, Bhushan has direct experience of what happens when a large health intervention scales nationally without adequate cost and equity safeguards built in from the start.

6. The counter-argument about pace deserves serious weight. A pilot confined to four or five states, without a fixed timeline for evaluation and expansion, risks becoming a permanent gatekeeping mechanism rather than a stepping stone, leaving most of a 100-million-plus patient population without access to a proven therapy for years.

DATA AND INSTITUTIONS VAULT

PRELIMS-GRADE FACTS:

ICMR-INDIAB study: 101 million Indians living with diabetes, 136 million prediabetic, India's standard national reference figure

GLP-1 (glucagon-like peptide-1): a naturally occurring gut incretin hormone; GLP-1 receptor agonist drugs (including semaglutide) mimic it

Mechanism: stimulates insulin secretion, slows gastric emptying, increases satiety

Dual approved use: type 2 diabetes management AND weight loss/obesity management

Indu Bhushan: founding CEO, National Health Authority (2018 to 2021); architect of Ayushman Bharat PM-JAY

Proposed access model: phased pilot in four or five states, with strict eligibility criteria and monitoring before wider rollout

WATCH THE TRAP: DO NOT WRITE THAT GLP-1 DRUGS ARE APPROVED IN INDIA ONLY FOR WEIGHT LOSS; THE DIABETES INDICATION CAME FIRST AND REMAINS THE PRIMARY CLINICAL JUSTIFICATION FOR SUBSIDISED OR INSURANCE-LINKED ACCESS.

THE DEBATE

Argument FOR a controlled, phased rollout. A dual-use drug with strong commercial demand for its weight-loss indication will, left to the market, direct scarce affordable access toward patients who can already pay rather than toward the diabetic population with the strongest clinical case. Eligibility criteria and a phased pilot are the tools that correct for this, and testing the model in four or five states before national scale-up limits the fiscal and administrative risk of getting the design wrong at full scale.

Argument AGAINST prioritising caution over pace. A disease burden of over 100 million people is not well served by a pilot confined to a handful of states with no stated timeline for expansion; the language of resisting "commercial interests" can just as easily become a justification for indefinite delay, denying a proven, evidence-backed therapy to patients who need it now, particularly those with diabetes and documented cardiovascular risk.

Balanced verdict. The two positions are reconcilable if the pilot is designed with a fixed evaluation window and published outcome data rather than left open-ended: strict eligibility criteria protect equity of access, while a defined timeline for expansion protects against caution becoming permanent gatekeeping. The design choice that matters most is not whether to phase the rollout, but whether the phase has a deadline.

HOW TO THINK ABOUT THIS

The transferable pattern: **when a new health technology has more than one approved use, and the uses differ sharply in who can afford them, ask who captures access first under an unrestricted rollout, and build the eligibility rule around correcting that, not around slowing adoption for its own sake.**

Any dual-use or multi-indication technology, a drug, a diagnostic tool, a therapy with both a high-need and a high-willingness-to-pay application, creates the same distributional risk: the higher-willingness-to-pay use tends to crowd out the higher-need use unless a deliberate access rule intervenes. The correct response is not to resist adoption but to design the eligibility criterion around the gap between need and ability to pay.

This same structure recurs in genomic testing, where diagnostic uses compete with elective or lifestyle applications for laboratory capacity; in advanced diagnostic imaging, where screening for high-risk patients competes with elective use; and in newer biologic therapies more broadly, where a single molecule's multiple approved indications create exactly this kind of access-prioritisation problem.

DIAGRAM-IN-WORDS

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THE GLP-1 ACCESS PROBLEM

DIABETES BURDEN (India)
101 million diabetic + 136 million prediabetic
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        v
GLP-1 DRUG (dual approved use)
        |
   _____|_____
   |           |
DIABETES    WEIGHT LOSS
MANAGEMENT  (aesthetic-adjacent demand)
   |           |
strongest    higher willingness
clinical     to pay, often
need, often  wealthier patients
lower
ability
to pay
   |           |
   v           v
UNRESTRICTED MARKET ROLLOUT
   =
benefit concentrates in weight-loss use,
diabetic population underserved

VS.

PHASED PILOT (4-5 states) + ELIGIBILITY CRITERIA
   =
access directed to diabetic/cardiovascular-risk
patients first, evaluated, then expanded

RISK IF NO TIMELINE SET: pilot becomes permanent gatekeeping
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TAKEAWAY BOX

An unrestricted rollout lets the market decide who gets the drug. A phased, criteria-based rollout lets the disease burden decide instead.

ICMR-INDIAB: **101 million diabetic, 136 million prediabetic***; GLP-1 mechanism (insulin secretion, gastric emptying, satiety); dual approved use (diabetes AND weight loss); Indu Bhushan, founding CEO* **National Health Authority (2018 to 2021)***, architect of* **Ayushman Bharat PM-JAY***; proposed pilot in* **four or five states**.

when a limited-access health intervention has both a high-need, low-ability-to-pay population and a high-demand, high-ability-to-pay population, does the state have an obligation to actively restrict the second group's access in order to protect the first, or does that cross into paternalism?

UPSC has repeatedly examined universal health coverage, NCD (non-communicable disease) burden and equitable access to health technology; this editorial supplies a live, named case, a specific dual-use drug class, to argue that access design, not just availability, determines equity outcomes.

"A health technology with dual approved uses, one addressing a large disease burden and one addressing a smaller but higher-paying demand, cannot be left to an unrestricted market rollout without producing an inequitable outcome." Discuss with reference to GLP-1 drug access in India.

Sources: Hindustan Times, ICMR, PIB

KEY ARGUMENTS AT A GLANCE

Indu Bhushan argues that India's diabetes epidemic, now affecting over 100 million adults, coincides with the arrival of GLP-1 receptor agonist drugs carrying proven cardiovascular and mortality benefits, but that access should be built through a controlled, phased programme, starting with a pilot in four or five states with strict eligibility criteria and monitoring, rather than an immediate national rollout driven by commercial interests.

✓ SUPPORTING

- The ICMR-INDIAB study, India's standard reference for diabetes prevalence, estimates 101 million Indians are living with diabetes and a further 136 million are prediabetic, a scale that makes any access programme for a genuinely effective therapy a matter of significant public health consequence, not a niche prescribing decision.
- GLP-1 receptor agonist drugs work by mimicking a naturally occurring gut hormone that stimulates insulin secretion after meals, slows gastric emptying and increases satiety; the class, which includes semaglutide, was developed and approved first for type 2 diabetes management and has since also been approved and widely marketed for weight loss, a dual approval that is central to the access debate.
- That dual approval creates a specific distributional risk: without eligibility criteria, subsidised or insurance-linked access is more likely to flow toward weight-loss use among wealthier, better-connected patients than toward the diabetic population with the strongest clinical justification and, often, the least capacity to pay out of pocket, since these drugs remain expensive relative to typical Indian incomes even at the lower end of the domestic pricing range.
- Indu Bhushan writes from the vantage point of having built one of India's largest public health financing programmes: he was the founding CEO of the National Health Authority from 2018 to 2021, where he designed and implemented Ayushman Bharat Pradhan Mantri Jan Arogya Yojana, giving his call for a phased, cost-conscious rollout particular authority on how India actually scales large health interventions.

⚠ COUNTER

A phased, government-controlled pilot confined to four or five states risks being too slow and too narrow relative to a disease burden of over 100 million people; caution framed around resisting "commercial interests" could also be read as excessive gatekeeping that delays a proven, evidence-backed therapy for patients, particularly those with diabetes and existing cardiovascular risk, who would benefit from it now rather than after a multi-year pilot concludes.

→ **WAY FORWARD**

Design the pilot with a hard eligibility line, prioritising patients with type 2 diabetes and documented cardiovascular risk over weight-loss-only indications, publish interim outcome and cost data from the pilot states on a fixed timeline rather than an open-ended one, and use that data to decide expansion speed, so caution functions as a design discipline rather than an indefinite deferral.

✍ MAINS ANSWER FRAMEWORK

QUESTION

India's diabetes burden and the arrival of high-efficacy GLP-1 therapies together raise a fresh public health access question. Examine the case for a phased, criteria-based rollout of GLP-1 drugs in India as against an immediate market-driven expansion. (250 words)

INTRODUCTION

India’s diabetes burden, estimated by the ICMR-INDIAB study at 101 million people living with diabetes and 136 million prediabetic, has arrived at the same moment as GLP-1 receptor agonist drugs, a class with genuine, trial-backed cardiovascular and mortality benefits. Indu Bhushan, writing in Hindustan Times, uses this convergence to argue for a phased, criteria-based access programme rather than an immediate national rollout.

BODY

GLP-1 drugs mimic a gut hormone that regulates insulin secretion, slows gastric emptying and increases satiety; the class was developed for type 2 diabetes and, because the same mechanism reduces appetite, has also been approved and marketed for weight loss. This dual approval is the crux of the access problem: a poorly designed rollout is more likely to channel subsidised or insurance-linked access toward weight-loss use among patients who can already afford care, rather than toward the diabetic population with the clearest clinical case and often the weakest ability to pay, since even the lower end of India’s current pricing range for these drugs remains a significant recurring cost for most households.

Bhushan’s proposed response, a pilot in four or five states with strict eligibility criteria and monitoring before wider expansion, treats this as a design problem to be solved with evidence rather than a market opportunity to be opened immediately. His authority on this rests partly on experience: as founding CEO of the National Health Authority from 2018 to 2021, he built Ayushman Bharat PM-JAY, India’s largest public health financing programme, and understands what a poorly sequenced national rollout of a high-cost intervention can do to a public health budget and to equity of access.

CONCLUSION

The strongest version of the counter-argument, that phased caution risks under-serving a 100-million-plus patient population, deserves a real answer rather than dismissal: the way to reconcile scale with caution is a pilot with a fixed evaluation timeline and published outcome data, not an open-ended one. A phased programme that expands on evidence is compatible with urgency; a market-driven rollout with no eligibility criteria is not compatible with equity.

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