Prevention is cheaper. So why does India still pay for rescue?

India has expanded primary care and insurance, but weak screening and rising metabolic disease threaten to overwhelm those gains

BY INVITATION
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While it is widely acknowledged that prevention is better than cure, health systems tend to be reactive to disease rather than proactive about preserving health. Unfortunately, the focus on rescue over prevention costs dearly; coming mostly from the patient's pocket in India. In diseases such as cancer, mounting costs of care at advanced stages are well-known causes of catastrophic health expenditure, with two-thirds of affected families estimated to suffer impoverishment. The case for preventing illness before it becomes too expensive is clear, needing a continuum of primary prevention, early detection, and financial protection during advanced care.

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Where India Stands Now

Let us start with the numbers. The recently published National Family Health Survey's sixth round (2023-24) shows the metabolic disease epidemic getting worse. High blood sugar or diabetes among men climbed from 15.6% to 20.9% in the four years since the last round; among women, from 13.5% to 17.8%. Overweight and obesity surged; it was the worst among urban women.

Hypertension prevalence edged down slightly, a solitary bright spot. Over the same period, the Ayushman Arogya Mandir network expanded rapidly, creating a national platform for screening and longitudinal care; whether it contributed to this decline requires direct evaluation. However, the risk factors feeding tomorrow's expensive heart attacks, strokes, kidney failure and cancers are accumulating faster than the system is clearing them. Primary prevention is key, as is early diagnosis and effective management at the stage when treatment is cheap.

When severe illness does strike, Indian households pay for it themselves. This is a key problem. A study found mean annual out-of-pocket spending of Rs 3.3 lakh per cancer patient — more than India's entire per-capita income. Even 'cheap' chronic metabolic diseases bleed families slowly. The same group found one in five diabetes patients incurring catastrophic costs, relative to their personal finances, on routine medicines and tests. Although these tertiary-centre findings are not nationally representative, they illustrate the financial burden of sustained treatment.

Set against our peers, there is a clear gap. The clearest mirror is China. Measured by the same WHO yardstick, between 2000 and 2019 China cut the chance that a 30-year-old dies of a non-communicable disease (NCD) before turning 70 by nearly a third (from 23% to 16%). India cut the same risk by barely a tenth, from 25% to 22%. Although both countries carry large burdens of tobacco use, hypertension and other metabolic risks, China has achieved a substantially larger reduction in premature NCD mortality. Comparable international estimates place out-of-pocket spending at approximately 32% of health expenditure in China, 10% in Thailand and 37% in Malaysia, compared with 43% in India, highest of this group.

Illustration: Uday Deb

Trajectory Of Public Health Services

The past decade has moved fast where architecture is concerned. The Ayushman Arogya Mandir network represents a genuinely large expansion of India's primary-care platform where preventive and screening services can be delivered. Household health-insurance coverage jumped from 41% to 60% between the two NFHS rounds.

Publicly financed insurance now explicitly covers cancer, and where families actually use it, PM-JAY has reduced inpatient out-of-pocket and catastrophic spending among eligible users, although estimated effects vary and substantial gaps remain. Publicly supported generic pharmacies sell the same drugs at a fraction of private prices. The tools of financial protection exist.

The trouble is that coverage on paper has not become protection in practice. A systematic review found that insurance reliably raised access to care but did not sufficiently reduce what they paid out of pocket. Insurance denials, complex paperwork and delayed reimbursement are real problems. Worse, whatever support does exist flows to direct medical bills, while associated personal costs like transport, lodging, and, above all, lost wages go unaddressed. Sadly, cancer screening still reaches almost no one: barely 1-2% of eligible adults have ever been screened.

What 'Developed' Should Honestly Mean

The right benchmark for India is not that of a high-income nation. It is the tier India can realistically reach next: middle-income living standards with genuinely universal basic services — Malaysia today, or China a decade ago. In practical terms that means three things: primary prevention via healthier lives and environment, hypertension and diabetes brought under control in more than half of patients, not the low teens we manage now; cancers caught early rather than at the incurable stage; and out-of-pocket spending cut to 20% or less.

Under sustained high reform, covering expansion of insurance coverage as well as preventive health services, delivered via India's ambitious digital health mission, it will probably take another decade and half, if not more, based on past trajectories of our peers. There is hope that successful deployment of the ambitious strategy for AI in health for India (SAHI) may allow us to bypass some of the structural bottlenecks in this journey.

What It Would Take

Three essential factors will decide the trajectory from here. First, prevention at the root cause of disease. This includes difficult decisions like taxing tobacco and sugar-sweetened beverages, setting sodium-reduction targets, and regulating the marketing of unhealthy ultra-processed foods. This is truly the proverbial stitch in time that saves nine.

Second, ease of accessing care. We need seamless transition from primary-care to secondary or tertiary-care, with timely referrals and prevention of expensive complications. Last, but not least, more investments. Public health spending must rise from roughly 1.5% of GDP toward 2.5-3%, enough to make primary and outpatient NCD-care free. Importantly, financial protection for more advanced care must cover the real cost of illness, with entitlements reaching patients quickly and easily.

None of this requires scientific invention. The principal interventions are already known but delivering them reliably will require investments into the unglamorous, continuous machinery that connects prevention to screening to treatment to financial protection. Whether this takes one generation or two depends primarily on our willingness to spend on prevention what we currently spend on rescue.

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