

including the poor in services can reverse the Inverse Care Law. In Argentina, Cambodia, Ghana, Zambia, Nepal, Peru, and South Africa health-care programmes aimed at favouring the poor did so. They included maternal and child health, primary health care, insecticide-treated bed nets, adolescent health, feeding programmes for poor children, and voluntary counselling and testing services for HIV.

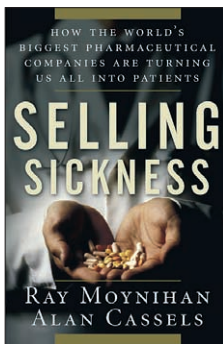
What of SEWA's good intentions? Good results in urban areas; less so in rural communities. The report evaluates three health services provided by SEWA—reproductive health, detection and treatment of tuberculosis, and women's education—that were otherwise unavailable to the poor. They used the metric common to all 11 studies in the book: the distribution of services among population groups

defined by quintiles of wealth. In urban areas, for all three services, a third or more of clients came from the poorest 20% of the population. By contrast, the wealthier 20% of the population accounted for no more than 1–2% of beneficiaries of these services. But in rural areas, the services did not reach the poorest selectively. Despite attempts to provide accessible services at minimal cost, both accessibility and cost were identified as barriers to use.

There's nothing half so much worth doing (to quote from *Wind in the Willows*) as a good intellectual argument. But there's nothing like a bit of evidence to shed light on an issue. *Reaching the Poor* provides evidence in abundance; it is a powerful and encouraging report that tells us that the Inverse Care Law can be changed but changing takes effort,

care, and attention. Simply providing a service "for everyone" and hoping won't do. Such a programme in a poor or middle income country will typically provide perhaps 10–20% of its benefits to the poorest 20% of the population—the group with the greatest need. But with the special attention that these studies gave to reaching the poor, between 30% and 40% of benefits went routinely to the population's poorest 20%. No recipes, I am afraid. Only as the authors conclude: study approaches proven to be effective, adapt to local conditions, experiment first, monitor the experience, and adjust in the light of such monitoring. That's a pretty impressive set of results for one report.

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Selling Sickness: How the World's Biggest Pharmaceutical Companies Are Turning Us All Into Patients
Nation Books, 2005.
Ray Moynihan, Alan Cassels.
Pp 254. US\$25.00.
ISBN 1-56025-697-4.

In brief

Book An ill for every pill

There's something very wrong here, I thought, my feverish 2-year-old in my lap, as we sat in a paediatrician's dingy waiting room one afternoon. Not a single intact children's book to take my son's mind off his misery, but plenty of colourful displays freshly stocked with glossy brochures touting drugs for attention deficit hyperactivity disorder (ADHD).

You'll see this sort of thing in almost any doctor's office in the USA—Zoloft clocks, Paxil pens, peppy pamphlets advising you to "take charge of your health" by asking your doc about this or that medication—all of it much newer than the magazines on offer. And as *Selling Sickness* shows, this is just the tip of the iceberg. Beneath the surface, there's some much more sophisticated salesmanship going on.

Ray Moynihan, a journalist, and Alan Cassels, a policy researcher, describe in ten chapters—each one about a different "sickness"—how the

pharmaceutical industry has pushed to widen diagnoses for various conditions, and even in some cases create them, so more people will take the drugs they sell. Given its lax regulations on drug marketing, the USA figures heavily in the book, but the authors' focus is global.

The book opens with a quote from the former head of Merck, who candidly told *Forbes Magazine* 30 years ago that he dreamed of being able to "sell to everyone" by making drugs for healthy people. Using a dazzling array of techniques, and plenty of cash, the industry has come a long way toward making this dream a reality.

Enlisting doctors—from free pizza for medical students to thousands in consulting fees to physician "opinion leaders"—is an essential part of the strategy. But the key is to convince as many people as possible that they need a drug. To accomplish this, the industry creates "patient advocacy groups", complete with web sites;

launches education campaigns for patients; and enlists celebrities willing to "share their stories". What these celebs don't share is that they're getting paid. Media outlets often take the bait, doing their part to raise awareness of these so-called diseases.

Moynihan and Cassels interview physicians free of drug industry influence fighting to get the word out to patients that they may not need a pill for every ill—or as one puts it, "an ill for every pill." And the authors close by citing what they see as two hopeful examples: the journal *PLoS Medicine*, which takes no drug industry advertising and doesn't run pharma-funded studies, and the American Medical Student Association, which urges members to eschew free lunches from pharma and all that entails. Let's hope that by the time my son is old enough for ADHD drugs these forces prevail.

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