

How Wide is the ‘Treatment Gap’ for Antidepressants in India?

Ethnographic Insights on Marketing Strategies

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***Abstract:** This article aims to show that current estimates of treatment gaps for antidepressants in India do not take sufficient notice of the actual availability and affordability of antidepressant drugs. Specifically, the authors try to show that antidepressants are widely given without prescription and that uses are often beyond the control of licensed service providers. Overprescription and misuse of antidepressants might be just as problematic as a lack of drugs and treatments. The driving force in the proliferation of psychotropic drugs even in developing countries like India is private industry pharmaceutical marketing.*

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I

Introduction

During the 1990s, mental health moved from a marginal to a central position within global health policies. This shift culminated in the publication of the World Health Report 2001, which claimed that depression will be the world’s second leading health problem after heart disease by the year 2020, if calculated by disability adjusted life years (DALYs). To fight the rise of depression, WHO and other organizations embraced the extensive use of psychopharmaceuticals, among them the latest generation of antidepressants, the selective serotonin reuptake inhibitors (SSRIs). Even if SSRIs were often more expensive than older types, such as tricyclics, the greater expenditure was “offset by a reduced need for other care and treatment” [World Health Organization 2001: 61]. According to the 2001 Report, SSRIs were a great success in countries of the global North. These new antidepressants were also an “attractive and affordable prescribing option in lower-income countries” (2001: 61).

Once there were unambiguous guidelines in favour of antidepressants in place,

the next step was to assess the gaps in the provision of these drugs worldwide, and it emerged instantly that there is a wide “treatment gap” for depression between developing and developed countries. Closing these treatment gaps is the objective of several high-profile campaigns. For example, the WHO-sponsored Mental Health Gap Action Programme (mhGAP) juxtaposes governmental investments for the treatment of mental, neurological, and substance use disorders (MNS) in low and lower-middle income countries with those in richer countries. It states that national investments in these treatments show a vast treatment gap and urges an immediate increase in spending. mhGAP (WHO 2008) argues that the psychiatric treatment gap is “more than 75 per cent” worldwide, that is, only 25 per cent of people who need treatment receive it. Divided by different types of mental disorders, the treatment gap was found to range from 32 per cent for schizophrenia to 78 per cent for alcohol use disorders. Depression treatments showed a gap of 56 per cent. These numbers were only about the global situation, so the treatment gaps had to be deeper in developing countries.

There can be little doubt that the overall assessment of a psychiatric “treatment gap” is correct, if one accepts the premises of DALYs, the efficacy of drugs, and the lack of government spending in this area. Yet what we aim to show in this article is that the “gap” has so far been calculated on a very tenuous base of data. We suggest here that current estimates of treatment gaps do not take sufficient notice of the actual availability and affordability of antidepressant drugs in India. Specifically, we try to show that antidepressants are widely given without prescription and that uses are often beyond the control of licensed service providers. We conclude that overprescription and misuse of antidepressants might be just as problematic as a lack of drugs and treatments. The driving force behind the proliferation of psychotropic drugs even in developing countries like India is private industry pharmaceutical marketing.

II

Concepts and Methodology

The data presented here are drawn from the ESRC/DFID-funded project ‘Tracing Pharmaceuticals in South Asia’. Our initial research proposal responded to a call from a joint initiative of ESRC and DFID to fund social science research that had the potential to show new ways of understanding the causes and consequences of global poverty. Research should contribute to poverty-reduction strategies (especially the Millennium Development Goals) by designing and testing new methodological approaches. Our team proposed to find novel ways of studying economic inequality in India and Nepal in relation to pharmaceutical production, distribution, prescription, and regulation. For this we proposed to study the social life

of three drugs in depth: oxytocin, rifampicin and fluoxetine. The three drugs belong to three different therapeutic segments, namely, reproductive health, tuberculosis, and mental health.

We expected that fluoxetine—and psychopharmaceuticals in general—would be predominately used only in the private sector. Fluoxetine only recently entered the essential drugs lists in South Asian government hospitals. For example, fluoxetine was only made available in West Bengal government hospitals since 2007. Mental health is not included in the MDGs set forth by the United Nations, and it has also never been a priority of government policy in India. To be sure, there has been a National Mental Health Program (NMHP) in place in India since 1983. Budget allocations for the NMHP have been growing rapidly: the programme's 10th Five Year Plan (2003-2008) had a budget allocation of US\$ 42 million, which was seven times more than the budget for the 9th Five Year Plan (US\$ 6 million). The budget for the 11th NMHP, to run from 2009 to 2014, is predicted to increase exponentially, to US\$ 200 million (Sinha 2009). But the role of the state in the provision of antidepressant treatments still seems small in comparison to what is available privately. Our choice of fluoxetine, instead of older antidepressants—such as amitriptyline, which is long used in government facilities—was meant to highlight the private sector further.

We started our research by following each of the three drugs and visited almost everyone the drug who knew about the drug. This took us to doctors, manufacturers, medical representatives, wholesaler, and retailers.

A conceptual starting point for our research was the realization that disease categories are co-constituted by the available diagnostic procedures and treatments. Today it is hardly controversial to say that biomedicine, despite its best efforts to portray itself as a universal and objective science, has seen its diagnostics and therapies change drastically over time. What remains controversial is the question of what drives these changes. According to standard biomedical explanations, it is continual scientific progress and an ever closer grip on the biology of health and disease that bring these changes. An alternative view comes from critical science studies, which argues that the availability of treatments, especially of pharmaceuticals, transforms the way that diseases are described and categorized. Indeed, the transformative powers of pharmaceuticals are not even limited to health and healing, but they also have a much broader impact on society: “As medical technology, pharmaceuticals are not only products of human culture, but producers of it” [Van der Geest, Whyte & Hardon 1996: 155].

Applied to mental health, this means that one can *first* look at what kinds of drugs are actually available and who is using them. Such an approach advocates a reversal of commonsense ideas in both public health research and medical anthropology. In both

fields, it seemed obvious that mental health problems needed to be studied as a causal and temporal sequence. It is commonsensical to ask, firstly, how mental symptoms are perceived by patients, then to ask what causes the symptoms, and then to ask what kind of treatment would be best to cure sickness. This model presupposes that sickness episodes truly *start* with a patient's perception of symptoms, which are then given diagnostic meaning by a doctor, and which are then treated with the best available medicines. But if one *starts* with evidence on what pharmaceuticals are used and only then asks how "depression" is recognized and treated, a different picture emerges.

The social importance of material things has long been studied by anthropologists (e.g., Appadurai 1986; Latour 2005; Henare, Holbraad & Wastell 2007). Applying a notion of "social biographies of things" to the anthropology of pharmaceuticals, Van der Geest, Whyte & Hardon (1996: 153) observe the same power of concreteness in medicines: "By applying a 'thing', we transform the state of dysphoria into something concrete, into some thing to which the patient and others can address their efforts." The materiality of medicines is particularly pronounced in the domain of psychopharmacology where, as many critics claim, "it is actually the drug, rather than the depressed patient, that serves as stable reference point" [Lakoff 2002: 72]. The "thinginess" of drugs allows an anthropologist to study "depression" with a crosscultural perspective even if there is no consensus about the symptoms of "depression." Even if psychiatry has persistent problems in finding physical referents for its categories and in measuring their severity, the drugs that are used are concrete enough to be compared.

Hence it is especially fruitful to start crosscultural research on depression with observable treatments rather than with symptoms and causes. In our research, we did not start with epidemiological assumptions about burdens of disease, nor with evidence-based claims about the efficacy of various drugs, nor with comparisons of how much money is spent on mental health treatments in South Asia as opposed to Europe or North America. Instead, we decided focus on the molecule fluoxetine and to discover its actual availability and spread in South Asia.

II

Proliferation of Brands

In the initial phases of our research, we collected existing evidence of how widely fluoxetine is available. One excellent starting point was the product listings in the ready drug reckoners used in India. These are registers of pharmaceutical products according to therapeutic segments. Printed as cheap paperbacks, such drug reckoners are sold widely, to such an extent that urban street hawkers sell them alongside popular magazines and pirated bestsellers. For each active ingredient, a short description of indications, side

effects, and similar drug information is given, followed by an alphabetical listing of existing brands by name, with details about dose, packaging, and recommended retail prices. CIMS India, which is the market leader in this type of publication, is owned by a London-based corporation, CMPMedia. CIMS India also has an online directory designed to look like a Google search page. A CIMS search in March 2009 showed that there are sixty-six different brands of fluoxetine available in the Indian market, many of them in three to four different doses (ranging from 10mg to 80mg) and form of packaging (tablets, capsules, suspensions). Among these, 23 products were combinations of fluoxetine and alprazolam, and three products combined fluoxetine with olanzapine. When we first looked up various drug reckoners in the winter of 2006, the number of brands listed was roughly similar to what they are today.

The drug reckoners do not give any indication of what the market share of each of these brands is. This information is primarily collected by IMS-ORG, an international market research company (<http://www.orgims.co.in/>). To obtain the latest data from this company is so costly that only larger pharmaceutical companies can afford to pay for it; our budget did not stretch that far. In India, then, the situation is the same as in other countries, where there is a “private life of numbers” [Lakoff 2005] on which drugs are sold in what quantities. It is a “private” life because neither government agencies nor international organizations such as the WHO actually have this information.

This proliferation of fluoxetine brands can be partly explained by the drug patent laws that were in place from the 1970s until 2005. Unlike many other pharmaceutical markets in developing countries, the Indian market is dominated by domestic generic manufacturers, not by Euro-American giants. This situation emerged from 1972 onwards, when the then Indian government under Indira Gandhi introduced a new patent law that only acknowledged process patents but not product patents. When new molecules were introduced in Northern markets, these could be reverse-engineered in India and be sold at a much lower price than the branded original. This patent regime was in place until India’s full accession to the Agreements on Trade-Related Intellectual Property Rights (TRIPS) under the World Trade Organization (WTO) till 2005. It allowed Indian firms to outdo multinationals and to turn India into the world’s leading producer of generic medicines by volume. Non-Indian drugs firms capture less than 25 per cent of the Indian market, with the rest divided up by thousands of national and regional generics manufacturers.

This applies also to the psychopharmaceuticals market, where almost all the dominant firms are Indian. And it applies particularly to fluoxetine: Eli Lilly’s branded Prozac was never even introduced in India. Lilly never bothered to bring Prozac to India because it could not hope to make any serious profits there. In the US in 2009, Eli Lilly’s Prozac 20mg sells for around US\$ 40 per 10 capsules. In India, where the market is completely

dominated by generics, the typical price charged for 10 capsules of fluoxetine 20mg is less than US\$ 1. Other multinationals that took their products to the Indian market had to do so at a heavily reduced price. For example, Pfizer India sells sertraline under the brand name Daxid at a vastly lower price than its Zoloft brand in the US. In 2009, more than thirty rival versions of sertraline were available. Faced with such competition, Pfizer sells Daxid at a price that is even lower than some of its generic competitors (for example, Torrent's Serenata and Ranbaxy's Serlift). Fierce competition between generic manufacturers is the first reason fluoxetine is relatively affordable to Indian patients.

Many analyses of the Indian pharmaceutical market stop at manufacturing and the drug patent laws. We found, however, that the patent regime is not enough to explain the wide circulation of antidepressant drugs in India. R&D and patent monopolies are not what distinguish drug companies from one another, but above all their marketing strategies. What approaches are there to the marketing of antidepressants?

III

Marketing Antidepressants Directly to Prescribers

Prescription pharmaceuticals present a unique challenge for marketing, because the 'target customer' is the prescribing doctor and not the patient who is buying and consuming the drugs. It is the prescriber who diagnoses the disease and arrives at the conclusion of what kind of medicine the patient should take. In South Asia, prescriptions are written using brand names of the medicines, rather than the generic names. For example, doctors write 'Fludac 20mg' instead of 'fluoxetine 20mg'. The Medical Council of India actually asks licensed doctors to prescribe by generic names as far as possible. Many state ministries of health in India, such as those of Rajasthan and Kerala, have tried to make it mandatory for doctors to prescribe in generic name, but have generally failed to enforce it. When a doctor not only chooses the generic molecule but also a company's brand, he or she becomes even more important for the pharmaceutical marketing efforts.

A key factor that makes it even more interesting for marketing antidepressants is the absence of a strict measure for depression. There is no pathogen that can be identified in the patient suffering from, and there is not even a conclusive theory about the pharmacological action of antidepressants (Moncrieff 2008). Lack of reliable measures allows prescribers to interpret depression in more than one way, and the clinical uses of "antidepressant" drugs are constantly expanding beyond symptoms of "depression," and now include social phobia, premature ejaculation, or insomnia. As Kalman Applbaum (2006: 107) points out, the effects of SSRIs on the body are so ambiguous that there is great scope for marketing-drive reinterpretations and diagnostic expansions.

Most psycho-pharmaceutical companies not only visit psychiatrists but also doctors

not specialized in this field. In fact, GPs are seen as the main source of prescriptions for SSRI antidepressants such as fluoxetine. As soon as a drug is securely lodged with psychiatrists, GPs come into marketing focus. According to a Zonal Sales Manager, sales of fluoxetine are not anymore at the centre of his attention, and that his campaigns concentrate on launching newer antidepressants. During an interview with us in early 2007 he explained:

Things like [Fluoxetine] are cash cows. It is productive. We have to build brands now to build our future. [Fluoxetine] was one of the brands giving very good dividends. Kolkata and all the suburbs starting selling fluoxetine. We started promoting to GP segment, not psychiatric. We are not focusing on psychiatry, we are focusing on GP segment. And we also got the results. Suddenly there was the increase in the sales..... This tremendous sales we got but not from psychiatry, but from physicians but from diabeto, cardio and all.

A senior MR of an MNC showed us a visual chart he uses during doctor visits. The promotional material contains colourful diagrams of the stomach and the brain. At the bottom of the chart was a picture of a sad-looking man looking down his body, towards his belly. The ad text suggested a connection between depression and gastroenterological problems. A marketing director explained such promotional strategies as follows:

I can tell you that people with stomach problem, [or] arthritis, go to the GPs. Patients normally complain to doctors that 'I am taking this medicine such a long time still I am not cured. Gas is still there (sir aapne kya dawayi diya hai ke pet ka dard thik nahi ho raha hai... gas to ho raha hai).' The doctor gets confused about what kind of problem it is.... It is generally seen all over the world now that if the treatment of the physiological disease is not accompanied with psychological treatment then the overall management of the disease is not there. This is one message we give to GPs. And we also have a programme for educating doctors, and we are doing that quite successfully. We are explaining it to the doctors, 'Sir, this is very important. If you don't do this, then the patient will not get better.' This concept was not there with the doctors earlier.

Marketing antidepressants aims at displacing non-pharmacological interventions, such as counselling, as much as possible. Depression "management" might need interventions that include both medication and other alternative means, but pharmaceutical producers try to convince doctors that drugs must always be prescribed. Still now, doctors are often engaged in counselling the patient and trying to unearth the "cause" of depression is important to them. One of the GPs interviewed in a poorer area of Kolkata explains that as a GP, he also plays the role of a family counsellor. At the same time, many GPs try to avoid medication for mild symptoms of depression. A gastroenterologist from Kolkata found it useful to keep his patients away from antidepressants altogether, as he is worried that the patient may get hooked on to it and in the long run it may prove to be more harmful than useful:

I was never fond of prescribing medicines that I was not specialized in. [Q: Others are saying that lots of gastric troubles are psychosomatic] Yes, that is true. But my way of dealing with them is: look, you don't have to take anything, get lost! [Laughs] I really don't use psychotropic medicines ... once they have taken a prescription for tranquilizers, and maybe they got some temporary relief, what they start doing is, they ignore your advice and keep on taking it without your advice. And eventually they will become dependent on that.

The above case again illustrates how the doctor is the first and foremost agent that pharmaceutical marketing needs to convince of the absolute necessity of drug prescribing. In this case, patients of the gastroenterologist do not buy psychotropics because he thinks that they can cope without it.

Doctors always strive to be seen as “up-to-date” with the latest medical developments, and it is primarily the pharmaceutical industry which tries to be the supplier of know-how. Continuing Medical Education (CME) is an important form of drug marketing. CME events are organised and sponsored by drug manufacturing companies. These usually take place in small conference rooms. GPs and other non-specialists are invited by pharmaceutical companies along with a specialist ‘opinion formers’ who elaborates on the latest drugs and disease management. Within the pharmaceutical industry, doctors are usually categorised into categories of ‘opinion formers’ and ‘followers’. The ‘opinion formers’ are specialists who can influence the prescribing habits of doctors who are in other therapeutic sectors. The marketing executives also classify doctors into ‘core’ and ‘non-core’ group based on their ‘potential’ as measured by the number of patients he sees per day. An MR told us, “We visit the core doctors at least twice a month and for the non-core doctors, we usually schedule a single visit a month.”

III

Marketing Antidepressants Indirectly: ‘Floating Prescriptions’

Prescription pharmaceuticals present a unique challenge for marketing, because the ‘target customer’ is the prescribing doctor and not the patient who is buying and consuming the drugs. It is the prescriber who diagnoses the disease and arrives at the conclusion of what kind of medicine the patient should take. In South Asia, prescriptions are written using brand names of the medicines, rather than the generic names. For example, doctors write ‘Fludac 20mg’ instead of ‘fluoxetine 20mg’. The Medical Council of India actually asks licensed doctors to prescribe by generic names as far as possible. Many state ministries of health in India, such as those of Rajasthan and Kerala, have tried to make it mandatory for doctors to prescribe in generic name, but have generally failed to enforce it. When a doctor not only chooses the generic molecule but also a company’s brand, he or she becomes even more important for the pharmaceutical marketing efforts.

Another very important route through which non-psychiatrists learn about psychotropics is through ‘floating prescriptions’. For drug manufacturers, psychiatrists have enough expertise to set a prescription trend, whereas non-specialists only want to prescribe drugs that are firmly established. According to both the psychiatrists and marketing specialists we interviewed, the route through which the non-specialists learn about the most common antidepressant treatments was not through medical marketing, but through prescriptions that patients carried around with them, from one prescriber to another. A psychiatrist interviewed in Lucknow in 2007 explained the phenomenon of the floating prescription as follows:

...depending on how much we [psychiatrists] use it, those [fluoxetine] prescriptions generally go to the suburban and rural areas, or to the general physicians in the cities also. Because the patient who has come to see me, who is on fluoxetine, and he has some gastric problem tomorrow, and goes and sees some gastroenterologist, or his family physician. He gets to know that a product called fluoxetine is there in the market, and is being used by the psychiatrists. ... So the next time when he gets a similar kind of patient, he experiments and prescribes fluoxetine to him.

There are different situations in which a psychiatrist’s prescription might travel with the patient to a non-specialist. A patient could regularly see a psychiatrist but also seek treatment from a GP for illnesses that do not require specialist attention. In another common scenario, a patient may pay several visits to a psychiatrist and then stop consulting him, perhaps because access is too cumbersome, or because his fees are too high: “They continue with the drug by the consultant and then, if they face any problems, they go to the GP. The GP learns about the prescriptions and he will immediately ask what the actual problem was,” said one of the marketing managers we interviewed. One important reason why GPs and other non-specialists try to imitate the prescription style of psychiatrists could be their fear that the patient might go back to the psychiatrist and reveal the GP’s ignorance about diagnosis and treatment. Copying prescriptions and forming a consensus about a ‘good drug’ from a ‘good company’ avoids loss of face among doctors.

Floating prescriptions are possible because prescription drugs are easily available over the counter. Theoretically, if a drug has a legal classification as a Schedule H drug, it cannot be sold over the counter. Many packets are stamped with messages such as: “SCHEDULE H DRUG: Warning: To be sold by retail on prescription of a Registered Medical Practitioner only”. In reality, such drugs are easily available from any medicine shop. It does not matter if a prescription is old or was written for another person, because almost any drug can be bought without any prescription whatever.

The retailers whom we interviewed excuse this illegal practice with reference to India being a poor country: why should anyone be forced to waste money on doctors’ fees if the required medicine can be obtained directly from the shop? For the retailers, this is not just about making money, but also about maintaining good relations with customers. Making

a fuss about prescriptions or even turning down a customer's request to buy a drug is bad business.

What is striking about floating prescriptions is how long they can linger: some seem to drift through a series of doctor-patient encounters for up to 10 years. Marketing managers told us that they often can only guess at where demand for a product is generated, since floating prescriptions widened the gap between active promotion to doctors and actual sales in shops.

Floating prescriptions not only bring fluoxetine from psychiatrists to the GPs; they also carry the drug from licensed to unlicensed prescribers. Here again, floating prescriptions both establish fluoxetine as a trusted molecule in the treatment of depression, and particular brands as trusted products that can be safely prescribed even by people without formal training. The floating prescription is a key link in a wider chain of people and processes that together account for the widespread use of antidepressants in South Asia over the past decade.

Unlicensed allopathic prescribers, usually called Rural Medical Practitioners (RMPs), are also important players in the social life of antidepressants. They have been able to survive in the interstices of legality and illegality, not least because their toleration takes some pressure off the state's own crumbling health services. According to many of our respondents, patients in the rural and suburban India will be the first victims if the laws of licensed prescribing were to be strictly enforced. But the shady legality of many retail practices also produces high "collateral" costs, and customers have to bear the risks of getting the wrong drugs from the hands of untrained prescribers.

Most of the RMPs get into this profession as a form of self-employment with a very low threshold of entry. The RMPs call themselves "friend of the poor" and say that this profession gives them a sense of "serving the society." Their backgrounds are similar: they belong to the poorer section of the society themselves; they have had some contact with a licensed prescriber as their assistant, relative, hospital or pharmacy staff.

Being the first point of contact for many patients in the rural areas, the RMP also sees a regular turnover of medical representatives (MR) at their doorstep. Once we accompanied an MR of fluoxetine producing company to an RMP sitting in bustling central Kolkata. His small chamber in the middle of a slum was crowded by patients of all ages. We had to wait outside for a few patients to leave before we could step in. Our MR was ready with his visual flipchart to remind the doctor of his brands. He started with his brand of fluoxetine, telling him about the anti-depressants in one sentence and requesting him repeatedly to write it. The MR later told us that he has been promoting fluoxetine to RMPs quite some time and with 'good results'.

Pressure of the high sales targets on the marketing divisions of the pharmaceutical companies also aid the proliferation of antidepressant prescriptions among the lowest

qualified doctors, including RMPs. While talking to people working at different levels of the same marketing division, we saw that people who are in the ‘field’, actually visiting the doctors, would go an extra step to meet their sales target for the quarter. The marketing division of the pharmaceutical companies follow the same pattern of reporting. It is a five tier system with medical representatives at the bottom tier with ‘area sales managers’ in the tier above them. The area sales manager reports to the zonal or regional marketing manager of the division, who in turn reports to the national marketing head. The vice president of the division works closely with the national marketing head and is responsible for the overall progress of that division. We spoke to the national marketing head, the regional marketing manager and an MR of a leading fluoxetine brand in South Asia on who they perceive as their target customers. According to the national marketing head, the company caters “only to psychiatrists, neurologists and neurosurgeons, people who deal with the brain.” The regional marketing manager, however, includes GPs and other select non specialists like cardiologist as his target customers though ‘by policy’ RMPs are not targeted. Yet, for the MR working under him, the RMPs play a crucial role in meeting his targets: “if we wish to increase our business, we have to go to them ... Market potential is there. How to exploit it depends upon us.” For all different customers there are different strategies as he explains:

...we have to arrange something for the doctors like camps and perhaps premium payments. But in the interior parts, sometimes, an emotional part comes into play. There, you go from Kolkata and tell the RMP that you’re coming from a long distance away and, ‘as you know, fluoxetine is a very good drug, so please help me out by giving me three or four prescriptions a day.’ There’s a form of sympathetic dealing.

Drug companies never officially endorse unlicensed prescribers, such as the RMPs. However, in practice they have begun targeting them individually, almost as if they were licensed GPs.

IV

A New Approach for Research on Global Mental Health

The current WHO mental health strategy on closing the treatment gap between richer and poorer countries is based on an outdated research methodology. In this paper, we bracketed the question if antidepressants are pharmacologically as effective as the WHO claims them to be. We also left aside the debatable issue of how DALYs and macroeconomic costs of depression are calculated for countries like India and Nepal. Here, we only focused on how WHO methodologies starts with epidemiological assessments of disease prevalence, and argued that in the case of depression, there is no specific pathogen (as for TB/rifampicin) or clinical situation (as for delayed labour/oxytocin) that could vouch for these findings to be valid independent of a complex web of

cultural, economic, and historical circumstances. That the WHO studies have to draw on epidemiological studies that are up to 25 years old and that do not consider the immense changes in the recognition and treatment of depression that have taken place since the late 1980s is, we think, a grave weakness of its methodology. Even more seriously, the exclusive focus on licensed prescribers and a lack of data on what treatments are actually provided makes it impossible to put exact figures on any ‘treatment gap’. Above all, a failure to notice of how widely antidepressants are used in South Asia’s private health markets renders its claims about the treatment gap undependable. The lack of proper evidence motivates a misplaced effort to make antidepressants more widely available through government health services. If there is a problem, it seems to be neither the scarcity nor the price of antidepressants, but their overuse and wrong prescription. The willingness to prescribe antidepressants might be more of a cause for alarm, than otherwise.

It might seem easy to dismiss the findings on wide circulation of fluoxetine in South Asia as merely anecdotal. It might seem that an ethnographic study of a limited number of people who deal with one particular drug molecule cannot be representative of what happens in depression treatments in South Asia as a whole. We would counter this argument by saying that, in the case of depression and its treatments in South Asia, it is more truthful to work with less exact numbers than with misleadingly precise ones.

We would also hold that an ethnographic study of only a few strategic nodes in drug distribution networks can shed far more light on what is happening today “on the ground” than any attempt to produce ahistorical pictures of disease prevalence and treatment gaps. That there are more than sixty generic versions of fluoxetine available, that even untrained Rural Medical Practitioners are using the drug, that prescriptions are “floating” in the market thanks to doctor-shopping patients and the easy over-the-counter availability cannot be anecdotal evidence, because for any of these findings to be possible, they *must* reveal large-scale relations of production and distribution in South Asia. If, for example, ten shops in Kolkata, ten shops in Kathmandu, and ten shops in Delhi all name the same handful of brands as their best-selling products; and if all of them say that patients often come with “floating prescriptions” (be it old prescriptions or emptied packets), then this will hold true, in all reasonable likelihood, for these regional markets in general. When specialists and non specialists alike are prescribing antidepressants in all the three sites of the study, then in all likelihood, antidepressants have established a much larger market for themselves than what some other numbers might indicate.

Any strategy for better mental health treatments in South Asia must take into account how much antidepressants are already used in the region. Interviews in local medicine shops on what brands of antidepressants are on sale and who the main prescribers are of these drugs can yield far more useful information far more quickly than any of the data sets used by the WHO to date.

References:

- Agarwal, S P. (Ed). (2004): *Mental Health: An Indian Perspective 1946-2003*. New Delhi: Elsevier (for the Directorate General of Health Services, Ministry of Health & Family Welfare).
- Appadurai A (Ed.) (1986): *ial: An Introduction to Actor-Network-Theory*. Oxford University Press, Oxford
- Lemelin, J, S Hotz, R Swensen, T Elmslie (1994): 'Depression in primary care. Why do we miss the diagnosis?' *Canadian Family Physician* 40: 104-108
- Mani, R (2009): Doctors not prescribing generic drugs. *Times of India*, 3 February, 2009. (downloaded at: http://timesofindia.indiatimes.com/Allahabad/Doctors_not_prescribing_generic_drugs/articleshow/4071213.cms)
- Moncrieff, J (2008): *The Myth of the Chemical Cure: A Critique of Psychiatric Drug Treatment*. Houndmills: Palgrave Macmillan.
- Narendranath, K (2007): Control Prescription to cut health cost. *Economic Times* December 19, 2007. (downloaded at: http://economictimes.indiatimes.com/Economy/Control_prescription_to_cut_health_cost/articleshow/2632849.cms)
- Patel, V, Araya R, Chatterjee S, et. al. (2007): Treatment and prevention of mental disorders in low-income and middle-income countries. *The Lancet (Online)*, 4 September, pp. 44-58.
- Patel, V and Kleinman, A (2003): 'Poverty and Common Mental Disorders in Developing Countries'. *Bulletin of the World Health Organization* 81(8): 608-615.
- Singleton N, Bumpstead R, O'Brien M, et. al. (2001): *Psychiatric Morbidity Among Adults Living in Private Households, 2000: The Report of a Survey carried out by Social Survey Division of the Office for National Statistics on behalf of the Department of Health, the Scottish Executive and the National Assembly for Wales*. London: Stationery Office.
- Sinha, K. (2009): 'New Mental Health Programme Finalized', *Times of India*, 11 Feb 2009 (download at http://timesofindia.indiatimes.com/India/New_mental_health_programme_finalised/articleshow/4108096.cms, accessed 24/03/09)
- Tripathi, S K, Dey, D and Hazra, A (2005): *Medicine Prices and Affordability in the State of West Bengal, India: Report of a survey supported by World Health Organization and Health Action International*. (download at http://www.haiweb.org/medicineprices/surveys/2004121W/survey_report.pdf, accessed 24/03/09)
- Van der Geest S, Whyte S R, and Hardon A. (1996): 'The Anthropology of Pharmaceuticals: A Biographical Approach'. *Annual Review of Anthropology* 25: 153-178.
- Vega WA, Kolody B, Aguilar-Gaxiola S, et. al. (1998): 'Lifetime Prevalence of DSM-III-R Psychiatric Disorders Among Urban and Rural Mexican Americans in California'. *Archives of General Psychiatry* 1998(55): 771-778.
- Vega WA, Kolody B, Aguilar-Gaxiola S, et. al. (1999): 'Gaps in Service Utilization by Mexican Americans with Mental Health Problems', *American Journal of Psychiatry* 1999(156): 928-934.
- World Health Organization (2001): *Mental Health: New Understanding, New Hope: The World Health Report 2001*, World Health Organization, Geneva.
- World Health Organization (2008): *mhGAP, Mental Health Gap Action Programme: Scaling Up Care for Mental, Neurological and Substance Use Disorders*, World Health Organization, Geneva