

3. The caregiver's perspective: The secondary debate in the wake of this process is whether the concerns and rights of caregivers of people with mental illness are adequately addressed in the draft proposal. This is important given that, in Indian society, the bulk of caregiving happens in the domestic space, and Indian society places as much value on the family unit as on personal autonomy. Legislation must reflect people's socio-cultural concerns, so the importance of this cannot be overstressed.

4. The law/policy debate: The final issue about which we need to think is how we visualise legislation as being directive of policy. As access to facilities for mental healthcare is introduced into the legislative process, this change from a "lean" mental health law probably needs some thought. It may be a tool to bring about change, but we need to give more consideration to this mode of policy planning.

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Making can-do into must-do; the way forward to health and wealth?

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The Commission on Social Determinants of Health headed by Prof Sir Michael Marmot set an ambitious agenda to close the health gap between the rich and the poor in a generation (1). Constituted by the World Health Organization in 2005, the Commission submitted its report in 2008 and, in accordance with its recommendations, July 2010 saw the Economic and Social Council of the United Nations, supported by the World Health Organisation, pass resolutions for the adoption of issues related to health equity as a core global development goal (2). These efforts are key to the achievement of the Millennium Development Goals, a set of eight poverty alleviation goals set by the UN at the Millennium Summit in 2000, scheduled to be achieved by 2015 (3). Decision makers, activists, aid organisations and governments have been working towards these goals, and the levels of progress seem directly linked to the attention paid to social determinants of health by each country.

In this context, the Commission's remit is appropriate, if perhaps utopian, given the widening development gap in many parts of the world. The Commission, in its report, discussed how social conditions influence the access to and availability of

healthcare, resulting in differences in measurable, vital, event outcomes. For example, life expectancy is a reflection of per capita Gross Domestic Product with the difference between two Asian countries, Bangladesh and Japan, being 20 years. However, these differences operate on both a macro- and a micro-scale. Incredibly, in Glasgow, Scotland, the difference in life expectancy at birth between men in affluent and deprived suburbs is 28 years. The same story holds good for deaths in children under the age of 5 where the difference between the rates of deaths between the richest and poorest communities is 300% (4).

As the world changes with globalisation, in economics as in health, inequalities are growing. In the rest of the world, infant mortality has fallen to a third of what it used to be in 1970; while in Sub-Saharan Africa, infant mortality rates are those that the rest of the world had in 1970. So what really determines who lives and how long they live? These are the social determinants of health: age, gender, race, education and occupation and the conditions in which people are born, grow, live, work and age. These can also be defined as power, income and access to goods and services. The social determinants of

health determine stratification of access to healthcare, increase exposure and vulnerability and magnify the social, economic and health consequences of illness for disadvantaged people (1). It is not enough to treat people, if they have to go back to the conditions that made them ill in the first place.

What can be done?

The improvements in healthcare in the more developed parts of the world have taken generations to achieve, even though disparities do still exist by social strata. The Commission's report suggests that, to remedy the situation, we need to bring in an inter-sectorial approach to i) improve daily living conditions, ii) get governments to commit to health equity by examining issues of access and resources and iii) build systems to monitor equity and promote training and activities to build awareness for all stakeholders and the public.

These are no easy tasks. A comprehensive approach to early childhood initiatives for child survival and education requires commitment at the highest level. The Commission not only suggests this as a necessity, but also advocates the inclusion of packages to promote physical, social and cognitive development. Barriers for children, particularly girls, to obtaining primary school education and to staying in school need to be identified and addressed. Particularly in urban areas, environments need to be developed keeping in mind affordable housing, provision of water and sanitation, electricity and paved roads as a minimum for all social classes. Beyond the basics, promotion of healthy behaviours requires attention to transport, access to healthy food, and control of unhealthy foods and alcohol. In rural areas, addressing policies that lead to exclusion, resulting in landlessness and displacement, requires investment in rural infrastructure and policies that support migrants. In both urban and rural settings, safe and secure employment with good working conditions can help alleviate poverty, reduce social inequities and exposure to hazards, enhancing healthy living. These needs are the bedrock of a healthy society and if we continue to permit the widening of the social equity gap, we will be moving backwards rather than to a better future.

Policies and schemes are needed to provide a basic standard of living below which no person should have to fall due to circumstances beyond their control. These should not be considered support systems that promote a parasitic culture, but can be mechanisms to reduce poverty and promote the economic development of societies. Healthcare systems need to be developed, that are based on principles of equity and aimed at the prevention of disease and the promotion of health. This requires quality primary healthcare services, which ensure universal access without limitations imposed by the ability to pay. These may seem to be unachievable goals in a short time frame, but a healthy workforce leads to increased productivity, and this needs to be emphasised to governments, to promote buy-in from policymakers.

The second major issue is the unequal distribution of access and resources. Again, this requires support from the highest

level of government and coherent action to ensure public finance for equity by developing a framework of action to address the social determinants of health. The state must provide basic services essential to health, such as water and sanitation, and work towards redressing gender biases and increasing universal coverage of health and social programmes.

All the evidence generated so far tells us that health-related initiatives are unlikely to be sustainable unless social and societal issues are addressed. However, these need evidence for action and it is clear that countries lacking basic data on morbidity and mortality by socioeconomic indicators cannot move forward in the provision of health-related interventions. Take the example of a country that does not have basic systems to register births and deaths-this country will not be able to have any estimates for child survival or any form of developmental outcomes. Unfortunately, most health research funding is focused on biomedical research and data related to health at the national scale come from economic research, which tends to ignore the social determinants of health.

Policies are determined by three key features: evidence, political will and institutional capacity. Stakeholders and policy makers need to understand what affects population health and what determines the gradient of equitable access.

What has been done?

Does all this seem impossible? From around the world, there are dozens of examples showing that targeted action does work. Brazil's national programme of food and nutrition assures all citizens of permanent access to sufficient amounts of basic quality foods without compromising other basic needs. Implemented in alignment with the family health programme, it was possible for Brazil to promote exclusive breast feeding until six months of age, and regulate media advertisements for children's food. SEWA in India is a trade union of poor self-employed women. They needed childcare which would allow them to work while keeping their children safe. Working with the government, they have established 100 childcare centres looking after children 0-6 years old. Teachers hold regular meetings with mothers to discuss the child's development, nutrition and education. This has resulted in improved physical growth and in all children starting primary school and the majority carrying on to high school (5). Another example is that for equivalent work, women generally earn less than men which has important consequences for poverty levels, such as among children of single mothers. In Quebec, trade unions have committed themselves to "the equal pay for work of equal value" struggle (1). These are important actions to tackle unjust situations and demonstrate that committed integrated actions do work.

Is a change possible in India?

Recently, researchers at Oxford created the Multidimensional Poverty Index (MPI), which complements the traditional focus on income to reflect the fact that the lives of people living in poverty are affected by more than just their income. This index,

which reports acute poverty in 104 developing countries, shows that India ranks below Bangladesh, and that India has 845 million MPI poor people, more than 26 sub-Saharan African nations put together. This is not surprising, given that one in five households does not have a single person with primary school education, one in four households has had a child die, two in five households have malnourished children or adults, one in eight has no access to clean drinking water and one in two has no access to its own sanitation facility (6). In this context, what trickle-down effect can we claim for our globalising and growing economy?

As described in the Commission's extensive review, without remedying social determinants there can be no chance of sustainably improving healthcare. Action is needed now and from multiple players -- the WHO, other multilateral agencies, national and local governments, civil society, the private sector, and research institutions studying economics, health and development. The National Rural and Urban Health Missions are evidence of commitment, but words need to be supported by deeds. Transparency and action are needed across various fields, not just in health.

Reducing health inequities is, for the Commission on Social Determinants of Health, an ethical imperative. There are two possibilities - the first being that we do not change and things

stay the way they are. The second is that we try to change things and make opportunities for health and development in a universal social support framework giving everyone equal access and care and that way we could go far. As stated in the report, "it is the right thing to do, and now is the right time to do it"

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The Health Impact Fund: a potential solution to inequity in global drug access

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Abstract

Global health inequities persist despite significant increases in funding and a growing number of global health initiatives. Especially vulnerable to disease, the poor majority of the world's population currently cannot afford advanced medicines, and the diseases confined to the poor receive little attention from pharmaceutical research. As a complement to the existing intellectual property regime, we have proposed the Health Impact Fund (HIF) as a mechanism that would create incentives for the development and optimal promotion of new high-impact medicines sold at the cost of manufacture. In this article, we outline the HIF and its ethical significance.

Background

Although global development assistance for health has increased greatly in recent years (1), large rich-poor health gaps remain within and among countries, even though the number of global health initiatives and the number of interested international and local stakeholders continue to rise (2). Consequently, there have been calls for improved matching of funding and resources from global health initiatives to local needs (3). In addition, better health impact assessment is required within health systems so that changes can be properly measured. Impact assessment is needed alongside effective interventions and treatments and capacity building, in order to realise sustainable improvements in health (4). Discrete,