

In this month's *Bulletin*

Biotech for all, but keep the diversity

In an editorial, Feachem (p. 693) sees public-private partnerships as a way of increasing the chances that the biotechnology revolution will be of benefit not only to the rich but also to the less prosperous populations of the world. Direction, however, must be given to the process, so that the respective energies and expertise of both sectors, public and private, are efficiently harnessed to attain their common objectives. Beware, though, of over-management, which could stifle the rich proliferation of ideas and initiatives that characterizes the current partnership scene.

Who does what?

There are now more than 70 innovative international public-private partnerships, according to a recent inventory by the Geneva-based Initiative on Public-Private Partnerships. Following a brief account of their main objectives and their distinctive features — legal status, management structure, participatory scope, and so on — Widdus (pp. 713–720) spells out what each side, private and public, needs to do to enable their partnership arrangements to contribute significantly to reducing the disparity between rich and poor countries in the availability of health tools and, ultimately, in health status.

A bit of push, a lot of pull

How can the international public-sector health community motivate the commercial pharmaceutical industry to invest in the development of drugs and vaccines for the poorer countries of the world? In a review of the options, Webber & Kremer (pp. 735–741) describe a number of “push” mechanisms the public sector might offer its private partners, such as investing in the basic research required and offering tax credits to participating companies, to mention two. A well-devised set of “pull” mechanisms, however, would be a particularly motivating complement to the public-sector contribution: they could include an offer to extend the validity of patents on new or even existing products, and a prior long-term commitment by the public sector to purchase finished products that meet previously agreed specifications.

Putting new life into AIDS vaccine research

In 1999, only US\$ 350 million was spent on AIDS vaccine R&D, of which about two-

thirds came from the US National Institutes of Health. Batson & Ainsworth (pp. 721–727) describe a study commissioned by the World Bank to find out whether and how private industry might be encouraged to invest more heavily in vaccine development in general, but taking AIDS vaccine development as a test case. The findings confirmed the current paucity of industry commitment: in 1988 only about 200 industry researchers were working in this field, for which private funding amounted to between US\$ 50–124 million annually. The main obstacle, the study showed, was scientific uncertainty about the likely outcome of such research, coupled with the magnitude of the financial investment needed not only for large-scale clinical trials but also to build adequate manufacturing capacity to meet the potential demand for such a vaccine in developing countries. Most industry officials interviewed for the study believed a combination of “push” mechanisms (particularly public subsidies for the early R&D work and for building manufacturing capacity) and “pull” mechanisms (such as an assured uptake of the end-product, plus a tiered or differential pricing system for industrialized vs developing countries) would be needed to ensure significant industry participation.

A partnership strategy for WHO

WHO's growing participation in a number of global public-private partnerships is generally regarded as a positive trend. While Buse & Waxman acknowledge the benefits of these partnerships (pp. 748–754), they also highlight certain pitfalls WHO is facing in its interaction with industry. For example, the possibility that WHO's normative functions are subject to commercial pressures and the danger of allowing its traditional concern for the poorest and least commercially “attractive” populations to be influenced by its commitment to partners with necessarily different concerns. To negotiate these pitfalls successfully and to ensure that WHO's involvement in these partnerships reflects its constitutional commitment to equity and public accountability, the authors propose, among other things, that WHO's relations with the private sector be based on clear benchmarks of “good partnership practice”. They also point to the need for better oversight of public-private partnerships, which could be achieved through greater public accountability and through the services of, for example, a “partnership ombudsperson”.

Haemoglobin disorders — a simmering problem

About 270 million people are carriers of the genetic defects underlying sickle-cell anaemia, β -thalassaemia and other inherited haemoglobin disorders. Some 300 000–400 000 babies are born every year with these often fatal haemoglobinopathies. Weatherall (pp. 704–712) notes that, as perinatal and infant mortality from infectious diseases decline in tropical countries, increasing numbers of babies are surviving long enough for inherited haemoglobin disorders to become clinically manifest. Screening and antenatal diagnosis campaigns have reduced the neonatal frequency of β -thalassaemia by 80–100% in a number of Mediterranean countries. Elsewhere, particularly in the developing world, these disorders have been largely neglected. Given the considerable time needed to mount an adequate control programme, the author makes a plea for a start to be made as soon as possible in areas where they are, or are likely to become, a significant public health burden.

A lot of smoke, but no fire

It all began, as Kharabsheh et al. recount (pp. 764–770), on a peaceful September morning in 1998, when the 160 15-year-old tenth-grade students at the Eben-Al Abas school in Amman, Jordan, lined up for a routine tetanus-diphtheria vaccination session. Two students felt faint for a few moments during the session. That evening several other students felt unwell. Next morning, one student fell and cut his lip and was taken to hospital, another felt faint before reaching his classroom, and within the hour a further 20 students were complaining of a variety of vague or mild symptoms. Fear of a disease outbreak prompted a call for an ambulance. Questioning of students cast suspicions on the vaccine. Media coverage plus government alerts spread the news throughout the country. Six days later, nearly 26 000 students had been vaccinated in a dozen districts, 806 had suffered symptoms (none of them serious, most of them vague) and 122 had been hospitalized (most being released within 24 hours). A subsequent government investigation concluded that the initial cases, which may have been linked to the vaccination session, had spiralled through a chain of events, none related to the vaccine itself, into an outbreak of mass psychogenic hysteria. Preventing such uncommon incidents, say the authors, is not easy but raising general awareness of the possibility of their occurrence and improving the skills of health authorities in relating to the media are good first steps. ■