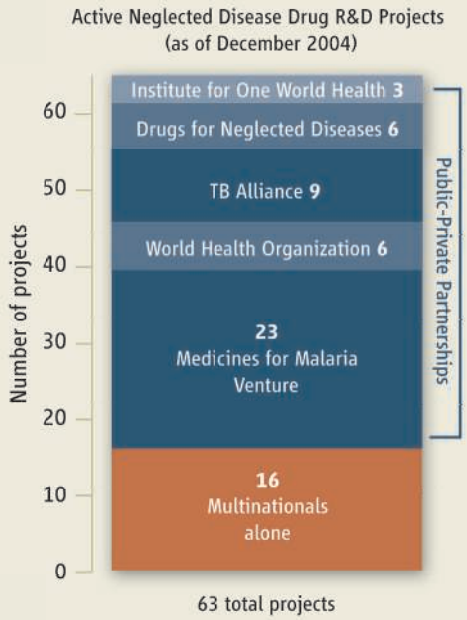
Public-Private Partnerships Proliferate

The label "neglected diseases" packs a rhetorical wallop, as it conjures up needy causes that the world callously has ignored. But the phrase is losing some of its punch when it comes to malaria, tuberculosis, Chagas, dengue, visceral leishmaniasis, and African trypanosomiasis. Although profit-minded pharmaceutical companies have long shied away from research and development on drugs against maladies that mainly afflict the poor, 63 drug projects now under way are targeting these very diseases. As Mary Moran wrote in the September 2005 issue of *PLoS Medicine*, "The landscape of neglected-disease drug development has changed dramatically during the past five years."

Moran heads the Pharmaceutical R&D Project at the London School of Economics and Political Science. In its recent analysis of drug-development projects for neglected diseases (it did not analyze vaccines or diagnostics), Moran's team credited a raft of new "public-private partnerships" (PPPs)—80% of which are funded through philanthropies—for the surge in new efforts.

Pioneered by the Rockefeller Foundation and later by the Bill and Melinda Gates Foundation, PPPs link big pharmaceutical companies or smaller biotechs with academics, nongovernmental organizations, and multilateral groups such as the World Health Organization. Ten years ago, not a single PPP for global health existed. Today, there are nearly 100 of them, in the most liberal definition, with a combined war chest of more than $1 billion. "It's a seismic change," says Seth Berkley, head of the International AIDS Vaccine Initiative, which, at 10 years of age, is the granddaddy of PPPs for global health.



Business as unusual. PPPs account for nearly 75% of R&D projects under way to develop drugs to treat neglected diseases.

Moran and her co-workers predict that as many as nine products now in development will come to market in the next 5 years. In each case, the companies have agreed to sell any resultant drugs to poor governments at deep discounts or no profit. Moran's group further notes that between 1975 and 2000, the pharmaceutical industry developed a meager 13 new drugs for neglected diseases—and because of their high prices, only one was widely used.

Companies that enter into PPPs have little prospect of making money on the drugs they develop, but Moran notes that they face relatively limited financial risk because their partners typically pay for the most expensive part of the process: staging large, clinical trials. This "no profit–no loss" business model does offer big pharma benefits: a good public image and an introduction to developing-country markets and researchers who might help them elsewhere.

Although the entry of big pharma into this field is welcome—and, some say, long overdue—the problem is by no means solved, cautions Peter Hotez of George Washington University in Washington, D.C. In an article in the November 2005 issue of *PLoS Medicine*, he and his co-authors point out that many diseases remain neglected. "When people speak of global health, the first thing you hear about is HIV/AIDS, malaria, TB, and you're liable to think that's all there is," says Hotez, who works on hookworm vaccines. Hookworm, schistosomiasis, leprosy, and 10 other neglected tropical diseases "affect at least as many poor people as the big three," they write. And they contend that for a mere 40 cents per person a year, four existing drugs could be used to quickly reduce the harm caused by seven of these scourges. **–J.C.**

SOURCE: PHARMACEUTICAL R&D POLICY PROJECT

and Mozambique (see graphic). The illustrations could have spotlighted just as aptly the architecture of aid for tuberculosis, malaria, and other diseases that all have a plethora of eager new players trying to help.

The cartoons depict a spaghettilike squiggle of lines connecting dozens of bubbles that represent UNAIDS, WHO's 3 by 5 program (which failed to reach its goal of having 3 million people on treatment by the end of 2005), UNICEF, PEPFAR, the Global Fund, the World Bank's MAP, and a variety of other donors, local ministries, and NGOs. The overall effect is a comical mess, but the problem is anything but. "We were stepping on each other's toes, and in some countries it was destructive," says Debrework Zewdie, who heads MAP and also sits on the board of the Global Fund. "Imagine the amount of time that countries spend catering to the different donors rather than fighting epidemics."

The UNAIDS report described a potential solution. In April 2004, the various stakeholders met in Washington, D.C., for a Consultation on Harmonization of International AIDS Funding and agreed to try to quell confusion by instituting a principle called "the three ones." It calls on each country to have one HIV/AIDS budget, one national AIDS coordinating committee, and one national monitoring and evaluation system that can report the same data to each donor.

As a follow-up to the D.C. consultation, UNAIDS formed a Global Task Team to analyze the "institutional architecture" that connects the various stakeholders in HIV/AIDS. Among the team's sweeping recommendations: establish a joint U.N.–Global Fund problem-solving team to address bottlenecks and develop a scorecard to rate performances of donors and recipients alike. "We're trying to bring some order into the universe," explains UNAIDS Director Piot.

Others are beginning to ask similar "architectural" questions about the broader universe of global health. In the November issue of *Nature Reviews Microbiology*, former GAVI head Godal argues for a more "holistic" approach that embraces the differences between bilateral, multilateral, and targeted approaches such as GAVI—rather than fighting about which one works best. "We need a summit of key players and a continuous kind of work plan to address issues in a systematic way and not on an ad hoc basis," says Godal.

If there's one universal, time-tested truth in the global battle against infectious diseases, it is this: easier said than done. For decades, rich countries have attempted to help poor ones, and poor ones have struggled to help themselves. Yet preventable, treatable, and even curable illnesses have continued to gain ground and cause massive suffering. The revolution that is sweeping through the global health effort has clearly brought more money, tools, creative ideas, and momentum than ever before. But the goal—narrowing the gap between aspirations and actions—remains a staggering challenge, and what already has become evident to many of the new and old players alike is that they have to monitor progress more vigorously, make midcourse corrections more quickly, and work together more effectively. Because at the end of the day, the question is not simply whether this revolution has done some good, but whether, as Jimmy Carter asked of the Gates Foundation, it has fully exploited all the remarkable possibilities. **–JON COHEN**