News from here and there

A new era in pharmacovigilance

A peripheral pharmacovigilance centre is slated to open by May 2010 at the Gauhati Medical College and Hospital, Guwahati. Under the National Pharmacovigilance Programme (NPP), set up by the Ministry of Health and Family Welfare, Government of India in November 2004, the initiative was taken to start pharmacovigilance in several parts of the country. The Gauhati Medical College was one of the sites identified for the provision of training in the discipline. During 2005, only one designated faculty was provided training. Now, however, the NPP has decided to train several faculties, with a provision for the formation of a pharmacovigilance committee in every centre. This committee shall be constituted of members from clinical disciplines and pharmacology.

The Gauhati Medical College and Hospital has been taken up in the first phase as one of the 25 peripheral pharmacovigilance centres that are being set up across the country. The NPP also plans to bring another 200 medical colleges into its voluntary reporting ambit by 2012. Towards this end, the Department of Pharmacology, Gauhati Medical College, in association with the National Institute of Pharmaceutical Education and Research, Guwahati, organized a day-long national symposium on 17 March 2010. 'No drug is safe unless there is safe application,' emphasized Dr S. K. Tripathi, Head of Clinical and Experimental Pharmacology, School of Tropical Medicine, Kolkata. The programme, attended by over 150 delegates from all over the country, was aimed at sensitizing healthcare personnel to the felt need for monitoring and reporting adverse events, particularly in the north-east of India.

SIBASISH DEY, *Guwahati, Assam*

Canada steps up the ante in neglected diseases

According to WHO, a major proportion of people in the world—over 1 billion people—suffer from one or more neglected tropical diseases. Yet, as per the Drugs for Neglected Diseases Initiative, only 1.3% of new drugs approved between 1975 and 2004 were developed specifically for tropical diseases and tuberculosis. The Neglected Global Diseases Initiative (NGDI) at the University of British Columbia (UBC)—the first of its kind at a Canadian university—aims to play a strategic role in developing drugs for neglected diseases.

The mission of the NGDI is to develop drugs for neglected global diseases in partnership with university researchers and industry partners, and to ensure delivery of these to those in need in the developing world. One of the first drugs to be licensed as a result of this initiative is an oral formulation of the antifungal drug, amphotericin B, developed by Dr Kishore Wasan, a distinguished university scholar and professor at the UBC Faculty of Pharmaceutical Sciences, for visceral leishmaniasis—a common tropical disease in the developing world.

Dr Wasan is also organizing a Neglected Global Diseases workshop to bring together eminent scientists from UBC who work in the area of neglected global diseases that are prevalent in developing countries. The First Annual Neglected Global Diseases Symposium will be hosted by UBC in September 2010. Some of the topics under discussion at the symposium will be leishmaniasis, dengue fever and vaccine development work by associates within the UBC Neglected Global Diseases Initiative.

The Consortium for Parasitic Drug Development, a Bill and Melinda Gates Foundation grantee, has announced an initial funding of more than US$ 180 000 to assist Professor Wasan in optimizing amphotericin B for use in tropical conditions.

MEENAKSHI KASHYAP, *Vancouver, Canada*

US enacts new healthcare law

In March 2010, the US government passed a new healthcare bill—the Patient Protection and Affordable Care Act (PPAC). The bill was passed in a polarized House of Representatives, without any Republican votes, and was signed into law by President Obama on 23 March 2010. The PPAC includes immediate and time-delayed improvements in the affordability of healthcare coverage for the American people, with a strong focus on preventive services. The actual bill has several components: it amends the Public Health Service Act; creates refundable tax credits to help defray the cost of health premiums; institutes reforms for the health insurance market; establishes health benefits exchanges; provides for small business tax credits; establishes penalties for failure to obtain minimal essential healthcare coverage; expands Medicaid eligibility and prescription drug coverage; funds health education and research, outreach campaigns and task forces; and establishes a national healthcare workforce commission to study workforce resources and align them with national needs.

The main thrust of the bill is to provide so-called universal coverage. Under the provisions of the bill, the uninsured and self-employed would be able to purchase insurance through state-based exchanges, with subsidies available to low-income individuals and families (up to four times the poverty level, which is currently defined as an annual income of less than US$ 22 050 for a family of four). Funding will be made available to states to establish exchanges within a year of enactment and until 1 January 2015. Separate exchanges would be created for small businesses to purchase coverage, effective from 2014. Eligible buyers will receive premium credits and there will be a cap for how much they have to contribute to their premiums on a sliding scale. By 2014, everyone must have health insurance (either employer-sponsored, subsidized or self-purchased) or face an annual fine of $695. Illegal immigrants will not be allowed to buy health insurance in the exchanges, even if they pay completely with their own money. Starting at 6 months after enactment, insurance companies can no longer deny coverage

to children on the basis of a pre-existing medical condition; in 2014, coverage cannot be denied to anyone (child or adult). Coverage cannot be rescinded, except in cases of fraud or misrepresentation. Preventive services and recommended immunizations must be covered under all healthcare plans. Further, unmarried dependants can be covered under parents' plans until 26 years of age.

The congressional budget office (CBO) estimates that the bill would provide coverage to 32 million uninsured people, but still leave 23 million uninsured in 2019. The new costs, according to the budget office, would be more than offset by savings in Medicare and by new taxes and fees, including a tax on high-end ('Cadillac') health plans, a tax on the investment income of the most affluent Americans and also a tax on tanning services! The CBO's cost estimates show that the bill would reduce federal budget deficits by US$ 143 billion in the next 10 years. Although the liberals (read Democrats) argue that social insurance for health will unite the entire population into a single 'risk pool' and benefit everyone in the long term (wherein the healthier young will contribute relatively more than they use, thus paying for older and sicker individuals), the conservatives (read Republicans) have berated the bill. The latter argue that it will lead to unaffordable levels of national debt, leave states with expensive new obligations, weaken Medicare and increase the socialization of government. Interestingly, Associated Press has noted that although President Obama promised to put the full weight of his office behind the marketing of the healthcare bill once it became law, the subject has hardly left his lips since 1 April 2010.

HARESH MANI, *Hershey, USA*

Science writer of Indian origin wins landmark libel battle in the UK

The recent conclusion of a landmark libel case in the UK may make it easier for people to criticize contentious scientific claims. The controversy began after an article titled 'Beware the spinal trap' by a popular science writer, Dr Simon Singh, was published in *The Guardian* in April 2008, alleging that the British Chiropractic Association (BCA) promoted 'bogus treatments' for some childhood conditions, such as asthma, colic and earache. He was promptly sued for libel by the BCA after he refused to retract the article or apologize, maintaining the view that these claims were not backed up by robust scientific evidence. In May 2009, the High Court ruled that Dr Singh's claims amounted to allegations of fact rather than comment, meaning that he could not use a defence of fair comment. This ruling would have made it difficult for any scientist or journalist to question scientific claims made by organizations or companies without risking costly defamation lawsuits. Dr Singh appealed against the ruling and in a landmark judgment on 1 April 2010, the appeal court overturned the previous ruling. In a scathing judgment, the appeal court said that scientific controversies should be settled by scientific debate rather than litigation. The judges criticized the BCA's taking speedy recourse to legal action rather than taking up the offer of a right to reply to the original newspaper article. Following this ruling, the BCA withdrew its case against Dr Singh in what has been widely hailed as a major victory for free speech and a major step towards libel law reform in the UK. Dr Singh told BBC news that when scientists, science writers and activists were threatened with libel suits, the people who lost out were the general public as they did not get to find out the real truth. The costs of fighting this legal battle have cost him over £200 000 and he is likely to recover only 70% of the cost from the BCA. He said his bill for a clear victory could be £60 000, which explained why people did not fight libel cases: even if they won the case, they lost financially. Dr Singh, whose parents emigrated from Punjab to Britain, holds a PhD in particle physics from Cambridge University and has received the MBE honour for services to science education and communication.

DHEERAJ RAI, *Bristol, UK*

Access to Cochrane Library in India extended till 2013

Free access to the Cochrane Library in India has been made available online for the next 3 years (2010–13) through the purchase of a national subscription by the Indian Council for Medical Research (ICMR). The Cochrane Library is a collection of databases of evidence which can be used to inform decision-making in healthcare and is run by Wiley–Blackwell, the scientific, technical, medical and scholarly publishing business of John Wiley.

The original national subscription which offered free online access to the library in India was operating from 2007 and had lapsed for a short period. Advocacy regarding the utility of the library, especially by the South Asia Cochrane Network based at Christian Medical College (CMC), Vellore, has led to a 3-year renewal of funding by the ICMR.

Data presented at a symposium in Vellore in January 2010 showed that there was an article downloaded from the Cochrane Library every 7 minutes in India in 2008; the total full-text download from the library in India in 2008 was 70 090. This made India one of the top 10 countries in Asia accessing the library.

With the number of internet users, including healthcare providers, policy-makers and consumers, increasing in India, access to the Cochrane Library could help promote a culture of evidence-based decision-making. The library is unique in offering information to anyone who can access the internet.

A press release from the publishers of the library quoted Professor Prathap Tharyan from the Professor B.V. Moses and ICMR Centre for Advanced Research and Training in Evidence-Informed Healthcare at the CMC, Vellore as stating that the resources in The Cochrane Library had the potential of bringing evidence-based medicine to the forefront of medical practice in India. He said an increasing number of Indian researchers had been contributing to Cochrane reviews in the past years, and an increasing number of people from all walks of life in India were using the library. He hoped that this trend would help raise the quality of research and health outcomes in India.

ANANT BHAN, *Pune, Maharashtra*