



Research, policy and the private sector: Sir Richard Feachem on malaria

By Richard Feachem and Gabriele Bammer

Sir Richard Feachem led the Global Fund to Fight AIDS, Tuberculosis and Malaria from its inception in 2002 until 2007, just one part of his illustrious career in public health. We were fortunate to host Sir Richard in November for a Development Policy Centre seminar.

Following the event, Professor Gabriele Bammer of the National Centre for Epidemiology and Population Health at ANU interviewed Sir Richard on the role of researchers, policymakers and the private sector in the global malaria response.

The following is a condensed version of their conversation. You can listen to a podcast of Sir Richard's presentation at the ANU and the full recording of the interview [here](#).

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Gabriele: *The malaria story is really a good story. I was wondering if you could tell us the back story to it, particularly how research has been influential in making those changes happen.*

Richard: Well, I think the research dimension to the malaria story is an interesting mixture of good news and less good news. The good news is what you would predict. The malaria research community is quite large and very active. And since Bill and Melinda Gates became seriously committed to malaria around the year 2000, the funding available for malaria research has now increased dramatically.

The malaria research community has made good use of that and expanded the enterprise a lot, varying from fundamental biology and genetics of the malaria parasite and the malaria vector, the anopheles mosquito, right through to more applied areas of vaccine development and drug development, and now, new insecticide development.

So where we are in malaria today is in part at least the result of those research efforts and the fact that we have great drugs. Next year we'll have a vaccine for the first time. And then we'll have better vaccines. And in a number of other areas, we have the products of research to help us do the job.

I think the interesting other side of the coin, which is not so positive, is that if global malaria policy-setting is done by researchers, we'll get the wrong answer.

The research community needs to strongly be a part of a global disease enterprise. It needs to be feeding in great ideas, great insights, products, and analyses to that global effort. But it should not be in charge, because when researchers are in charge, you get a long list of the things we don't know, a long list of the research priorities, and a major statement that we need to be giving more money to answer those unresolved questions. This is not a criticism; I've been a researcher for a big chunk of my life. It's what researchers do. But the

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whole global effort needs to be led by policy makers, strategists, people from the financing institutions, and people who are focused on what we do know and what we can do with existing knowledge and existing technology, and who will aggressively pursue that.

Gabriele: *Can you say more about the public health contribution, particularly the health systems contribution?*

Richard: Malaria research falls into two components — things that happen in laboratories, and things that don't. Things that happen in laboratories and many large field trials are focused around drugs, vaccines, basic immunology and genetics, better insecticides and better understanding of the mosquito, etc.

But outside the lab there are very important avenues for research. For example, spatial analysis, digital mapping, use of all the new technology to actually map cases, households, who's got a bed net and who doesn't, etc. Epidemiology and the greater sophistication in simply measuring malaria, measuring its spatial properties and its clustering and tracking, in real time on an ongoing basis, and things like cell phones and GPS, have contributed a lot.

And then on the health systems side, research has helped contribute to the '*who is going to deliver these services?*' kind of question. Is it going to be the public health care infrastructure? The clinics and hospitals run by the government? Yes, it will be that. But what about the large, private health care infrastructure that exists in most, but not all, of the malaria-endemic countries? That's a good example of a research frontier. We're just waking up to the fact that in many countries, most children with malaria aren't taken by their mothers to a public facility at all. They're taken to a private facility. And that private facility is unregulated and off the map for the government. So, one of the big frontiers is bringing the private providers into the government enterprise.

Gabriele: *You say a lot of really interesting things about the importance of the*

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private sector. Clearly they've had an important role in philanthropy. And you're talking now about the role they play in health systems. Are there other roles for the private sector?

Richard: Yes, definitely. I think when we talk about the private sector in the case of malaria we're looking at a number of different categories of support.

There is the private sector informal small scale as a provider of health care in developing countries.

On a grand international scale, there is the private sector as the engine for new drugs, new vaccines, and discoveries of new tools and technologies. Sumitomo Chemical, the major Japanese chemical company, brought us the insecticide impregnated bednet. That was their technology, now copied by others.

Often there's collaboration between publicly funded labs, such as those in Australian universities, and private companies. Because after the basic discovery phase, bringing a product through development and licensing is a thing that the big private companies typically do better. So that's an important private sector role.

Another role, which has emerged recently in places like Papua New Guinea, is that major private corporations and organisations whose business is not health or malaria, such as the mining and extractive industries, have in some places adopted malaria as a social responsibility cause, with some self-interest.

So a mining company may say: in the area around their mine, there's far too much malaria. It's affecting the work force. It's affecting the families of the work force. And it's affecting all those men, women, and children who work in those communities, which my successful mining operation has a special relationship with and many joint interests. So why don't we as a company expand the medical services, which we probably have, to embrace malaria control and prevention?

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I think that's a model that we can see more of, particularly in countries, like PNG, where the government has struggled to reach remote areas and to provide malaria services to isolated and remote populations.

Gabriele: *I think the perspective that you're putting on the role of the private sector is really very important, because public health often turns its nose up at the private sector. I notice it's also one of the priorities of the group that you lead. Can you say a bit more about what you're doing?*

Richard: Well it's a very interesting piece of colonial history I think. 1960 was the year when more countries became independent and shook off colonialism than any other year. But broadly speaking, between Indian independence in 1947 and about 1970, more than 100 countries became independent.

And at this time of independence, the British National Health Service, the NHS, was sort of the envy of the world. This was a publicly financed, publicly delivered, free at the point of delivery health care nirvana that many countries admired and wanted to emulate. It created a culture across the developing world, particularly in the Anglophone countries but also well beyond, that the model to aspire to was general taxation funding a public monopoly in health care provision.

Many decades later, we see very clearly that it hasn't worked. The ability of governments of low and lower-middle income countries to create anything close to a publicly owned and delivered health care infrastructure that serves most people across big areas, including marginalised and isolated people, is very small.

What we've seen therefore is that the share of publicly provided health care across the developing world has shrunk. Policymakers in the developing world are waking up to that. So there is a wave around the world of governments and advisors to governments saying: let's look at this private sector, to which most of our citizens are going most often when they get ill, and understand it. Let's reach out and have a discussion about how private provision can assist public policy

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goals.

There is a great position for Australia in this debate. Australia is not the UK. Australia has a plural economy in health care provision. So in talking about health sector aid to PNG or to Vietnam or elsewhere, Australia may be at a rather good starting point to say: we don't espouse a public monopoly, so let's talk to you about how we can help you advance a mixed economy in health care.

Sir Richard Feachem is Director of the Global Health Group at UCSF Global Health Sciences, Professor of Global Health at the University of California, San Francisco and the University of California, Berkeley. From 2002 to 2007, Sir Richard served as founding Executive Director of the Global Fund to Fight AIDS, Tuberculosis and Malaria. Gabriele Bammer is a Professor at the National Centre for Epidemiology and Population Health, Research School of Population Health, ANU College of Medicine, Biology and Environment.

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