

A Critique of the Draft National Health Research Policy 2011

UPENDRA BHOJANI, N S PRASHANTH, NARAYANAN DEVADASAN

The newly created Department of Health Research of the central health ministry has formulated the draft National Health Research Policy 2011, improving upon the 2010 version. A critical examination of the contents from a health researcher-practitioner's perspective shows a number of shortcomings: a lack of clarity in the terminology, a simplistic interpretation of equity, and a lack of alignment of local research priorities with national health programmes.

Considering the number of academic institutions in the country, India's contribution to health research remains poor. In 2007, the number of original research papers from India indexed in a widely used health-related bibliographic database¹ constituted only 1.64% of global health research outputs (Dandona et al 2009). Dandona and colleagues (Dandona et al 2009; Dandona et al 2011) highlight the poor quality of health research and misplaced priorities; more research outputs on basic and clinical research, compared to public health research. They call for a national policy to enhance relevant health research in order to achieve health-care for all. A similar proposition was made by the Planning Commission (Planning Commission 2006). The forthcoming World Health Report (2012) also has its theme, "No Health without Research" (Pang and Terry 2011).

Responding to this need, the newly created department of health research (DHR) of the health ministry formulated a draft National Health Research Policy (NHRP) first in March 2010 (henceforth referred to as "earlier draft") (Department of Health Research 2010). This was subsequently finalised in February 2011 and has been placed in the public domain for feedback (henceforth referred to as "draft") (Department of Health Research 2011).²

We welcome this initiative of the DHR towards formulating the NHRP. The final draft provides a vision for health research in India and acknowledges various stakeholders in health research. The draft also provides objectives, proposes new institutions to steer health research at national level and identifies the underlying values for such a policy. Given that health is a complex social issue and health research is being carried out by a number of individuals/institutions across sectors and disciplines in a fragmented manner, the systems approach put forward by the draft NHRP is in itself a commendable move.

Kurian (2011) in his reflection on the earlier draft highlighted the gross plagiarism, poor writing, and lack of coherence in this important policy document and made a case for serious redrafting. We find that some of his observations remain valid even as far as the final draft is considered. In this paper, we would like to critically examine the policy contents of the final draft to highlight some of the major concerns from a health researcher-practitioner's perspective, that need to be addressed before turning this draft into a policy.

Lack of Clarity

The draft uses many terms often without clearly defining them, the most important being the term health research, the principal subject of this policy. Unlike the earlier draft that failed to define health research, this draft begins by defining health research as a comparatively new concept and distinguishes it from medical research. According to the draft, health research "goes beyond illness to include the research into various determinants of illness as well as health" and is therefore a "systematic generation of knowledge that can be used to promote, restore, maintain and/or protect health of individuals and populations" (Department of Health Research 2011:4). However it is not clear whether health research, as defined by the draft, subsumes medical research. This is because, the draft makes simultaneous use of both the terms, e.g, some of the functions of National Health Research Management Forum are "to review biomedical and health research management..." and "...to develop human resources for biomedical and health research" (Department of Health Research 2011: 12). Furthermore, DHR also does the same while describing its mandate, e.g, "...basic, applied and clinical research including clinical trials and operational research in areas related to medical, health, biomedical and medical profession..."³ It is unclear whether and how the policy (or the DHR) actually distinguishes between biomedical research and health research. We suggest that such a policy document should clearly define health acknowledging both biomedical and social determinants. Subsequently, the scope of health research can be expanded

Upendra Bhojani (upendra@iphindia.org), N S Prashanth (prashanthns@iphindia.org) and Narayanan Devadasan (deva@iphindia.org) are at the Institute of Public Health, Bengaluru.

beyond merely medical research to include areas such as social determinants of health, quality of and access to health-care, management of health systems, health policies and governance.

Similarly the draft defines a health research system mainly by the activities of such an institution (i.e., planning, coordinating, monitoring, managing and promoting research) but lacks clarity in its scope and contents. The World Health Organisation (WHO) defines health research system as “the people, institutions, and activities whose primary purpose is to generate high quality knowledge that can be used to promote, restore and/or maintain the health status of population” (Sadana and Pang 2004). It further clarifies that though the concept of health research system overlaps to a certain extent with health systems and other research systems, it is important to clarify the scope of national health research system and what it entails at a particular point in time (ibid: 4). Such clarity is essential in case we expect such a system to provide effective governance and leadership and for evaluation of the health research systems.

Another example is an ambiguous use of the term private. Though the draft refers several times to private sector players in health research, often a very simplistic use of the term to denote anything that is not owned by the government is observed by lumping together a wide variety of non-state actors. To quote,

The private sector, pharmaceutical industry, biotechnology and biomedical technology oriented industries, private educational institutions, hospitals and nursing homes, research foundations and institutions, private practitioners, NGOs and CBOS working on a not-for-profit basis, etc. are now major stakeholders in healthcare research and delivery. The National Health Research System (NHRS) recognises their important role in health research and shall foster their participation in the system as partners (Department of Health Research 2011: 9).

These private players represent diverse interests, approaches and capacity for health research. They have varying governance structures and varying degrees of transparency; the accessibility and utility of their work towards the public goals of health research is very different. The study of health research outputs from India

from 2002 to 2007 clearly shows that research outputs even among private players is varied not only in terms of quantity but also the type of research represented (Dandona et al 2009). In 2007, not-for-profit non-governmental organisations (NGOs) published more than 10% of research papers on public health compared to no outputs in this category by private-for-profit organisations, while papers published on basic science research by private-for-profit organisations were three times that by not-for-profit non-governmental organisations (Dandona et al 2011). Vested interests leading to bias in research funded or conducted by industry are well-documented (Bourgeois et al 2010). Under these circumstances, it is absurd to lump all these private actors (especially for-profit and not-for-profit) together merely as being non-state and reflects a poor understanding of private sector. This is especially grave considering that the draft proposes incentives for private actors including, (1) Provision of tax and other incentives by government to private sector for setting aside research funds, (2) Capacity building for research in private sector, (3) Collaboration with and participation of private players in NHRS as partners, and (4) Right to access to research outcomes by all stakeholders.

The draft uses the term “health system research” (HSR), a widely used term in literature, while describing the operating principles of NHRS but does not define it. It is not clear whether the draft uses this term to refer to a specific method of doing health research⁴ (as widely endorsed at the recently concluded WHO Global Symposium on Health Systems Research⁵) or just interchangeably with the term, health research system. For example, while describing functions of NHRS, under the sub-heading of responsiveness, the term HSR appears to mean a particular research discipline, i.e., “Current and emerging issues such as...Health system research, Health Economics, Behavioural and Social issues...” (Department of Health Research 2011: 8). In the same section, under the subheading of “Monitor and Evaluate Impact of Health Research”, this term appears to be used interchangeably with the health research system, e.g., “Indicators will be developed to monitor

the development and effectiveness of the health research system...Direct indicators of National Development, would serve as indirect indicators of the efficacy of the Health System research as a vehicle of development” (Department of Health Research 2011: 10).

The draft repeatedly mentions the importance of equity in health research highlighting equity as one of its values. However, in translating equity into health research priorities, it applies a very limited interpretation of whose problems/concerns need to be researched and not on other important aspects like funding as well as dissemination of and access to research findings/outcomes. The draft interprets equity as the need to focus on health problems of socially underprivileged groups (tribals, women, other marginalised groups) and population living in hard-to-reach areas. While such an explicit focus on the vulnerable population is desirable and commendable, such a simplistic interpretation of equity is far from the contemporary broader meaning and tends to ignore inequities that exist throughout entire socio-economic gradient and along multiple dimensions (Sen 2002).

Centralised Bureaucracy?

The National Health Research Management Forum (NHRMF) is proposed as an overarching body at the national level that is expected to steer health research in the country. It is also expected to make annual and five-year national research plans. Ironically it appears that nearly half of the members of the NHRMF will be politicians and bureaucrats including those who will occupy the posts of chair, vice-chair and member secretary. In fact increasing the number of technical experts as members of NHRMF from a maximum of three in the earlier draft to 10 in the new version is welcome. Though political commitment is desirable in such processes, a NHRMF

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dominated by politicians and bureaucrats will go against the recommendations of the National Commission on Macroeconomics and Health in 2004; the need for de-bureaucratisation of procedures to enhance research culture and engagement/retention of researchers (Ministry of Health and Family Welfare 2005b).

Furthermore, the draft proposes that the research agenda/plan for NHRP would be developed by the NHRMF, assisted by expert-led working groups but fails to even outline as to how such a national body, given the lack of any proposal for state/district level bodies or at least alignment with existing state/district level bodies, will define, translate and realise our country's diverse health research needs. The challenges of aligning local research priorities with identified national goals are well known; Nuyens (2007) in his review of research experiences of low- and middle-income countries highlights the need for transparent, participatory and iterative nature of national health research priority setting processes to maintain its relevance for sub-national levels. The National Rural Health Mission (NRHM), cited often in the draft, advocates a decentralised approach in health planning where village health plans (prepared by representatives from the community and local government as well as health workers) feed into the taluka/block health plans and so on to the state health plan (Ministry of Health and Family Welfare 2005a). While such elaborate planning processes are being painstakingly put in place by the NRHM, the draft conveniently neglects such processes and naively proposes to set such priorities centrally through a politico-bureaucratic body.

The current proposition of the NHRMF also neglects many existing relevant national and state bodies (e.g., national and state health system resource centres, national and state institutes of health and family welfare, and the several institutions of national importance).

One of the major thrusts in the document is the development of a national health research plan. Although the proposition of such a plan itself is useful, NHRP's research priorities primarily revolve around addressing research needs of national health programmes, e.g., "Identify priorities for effective and ethical health research to

enable the achievement of the objectives of NHP 2002, NRHM, Bharat Nirman and National Food Security Act as well as global commitments such as MDG and IHR..." (Department of Health Research 2011: 5). Although it is important for such national efforts to coordinate with existing programmes, it is a wasted opportunity if a policy merely caters to the national health programmes rather than comprehensively considering the health problems in the country, e.g., scarcity of human resources, access to affordable medicines, role of private sector, universal health coverage.

Standards of Ethics in Research

The draft proposes to improve ethical guidelines in India and their harmonisation with international standards. While the international standards for clinical and biomedical research are quite universal, there is still a raging debate on such a universal standard for health research in general. We suggest caution in adopting international ethical standards for health research in India. The prevailing international standards have largely been developed with regard to biomedical research and its universalism may not be relevant to all the forms of health research, especially in the case of health system research, an identified research priority in India (Prashanth et al 2011; Ministry of Health and Family Welfare 2005b).

The objectives of the NHRP abruptly bring in concepts that are not deliberated upon in the introduction segment and often without any supporting evidence. One example is the proposition for PPP (presumably public-private partnership) without mentioning the purpose or context and without defining the nature of the private partner/s. Another objective highlights the need to assess cost-effectiveness and cost-benefits of health interventions. Though these are relevant concepts, we find it strange that the NHRP needs to explicitly mention such concepts as a separate objective without situating them within broader general objectives. On the contrary, important and broader issues of ethics, quality and regulations in health research, which are highlighted in the introduction, are missing in the objectives except for a passing use of "ethical" as an adjective for research in one of them.

Finally, the 10-point action programme proposed by the draft NHRP is not in coherence with issues discussed in the earlier sections. For example, none of these action points address financing aspects of health research. Also after reading a draft policy that seeks to bring in greater focus on health system research, it is strange to see that the action programme makes no mention of this, while in turn mentioning the need to promote other specific types of health research such as basic and fundamental as well as translational research. The Planning Commission's working group report explicitly mentions the need to promote health system research in India (Planning Commission 2006). Translational research as described by the draft NHRP and as often conceived as a concept is mainly about translating outcomes of basic laboratory-based sciences to clinical application (Pearson 2008). We suggest a broader interpretation of this to include the study of translation of proven interventions and policies into health systems.

Conclusions

We welcome the government's initiative to formulate the NHRP. Given our tremendous progress on the economic front contrasting with our dismal progress in the social sector, perhaps a bold policy that promotes relevant and much-needed research is indeed the need of the hour. However the current draft needs significant revision to improve its coherence. While the draft identifies several values, we find that the rest of the draft does not incorporate them. Similarly, the draft lacks consistency across the objectives, strategies and action plan (what the draft calls programme) proposed.

In summary, the draft needs significant revision to improve its coherence and clarity on terminology used; there is also a need to root its proposals within decentralisation and participatory principles among others. We hope that issues highlighted in our paper will generate further discourse on the contents of the draft NHRP in order to improve it before it gets adopted as policy.

NOTES

- 1 Study used PubMed (<http://www.ncbi.nlm.nih.gov/pubmed/>) database, a service of US national

library of medicine containing online archive of more than 20 million citations on health literature, and considered only original research outputs having an Indian as the first author.

- 2 On 4 April 2011, *The Hindu* reported that the policy has been finalised. However, we note that the same draft that we have used for this critique is still available unchanged on the ICMR website. There has not yet been any official announcement of the adoption of this policy.
- 3 "Mandate" Department of Health Research viewed on 15 March 2011 at <http://www.dhr.gov.in/madate.htm>
- 4 Health system research is a well-defined method of health research that uses system approach. For details see work of Grodos and Mercenier at <http://www.itg.be/itg/GeneralSite/default.aspx?WPID=391&L=e&miid=>
- 5 First Global Symposium on Health Systems research was organised in Montreux, Switzerland in November 2010 to bring together various stakeholders to discuss universal health coverage especially in low- and middle-income countries. See <http://www.hsr-symposium.org/>

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