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Comments on the National Health Research Policy

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Health research is an important component of the process for reaching the goal of Health for All expressed in the Alma Ata Declaration. Today, 33 years after the Declaration, the goal is best expressed in terms of health systems that can provide universal access to comprehensive healthcare as well as action on social determinants of health to reduce the burden of disease and promote good health (1). The goals of health research would be:

- to better understand the causes of disease and the determinants and factors contributing to both good and ill health, including the immediate, biomedical factors and the larger social and environmental determinants of disease;
- to develop drugs, vaccines, diagnostics, prosthetics and other technologies for preventing disease, promoting good health and for curative, palliative and rehabilitative care; and
- to contribute to developing health programmes and health systems that use resources efficiently, are effective in reducing the disease burden and relieving suffering, and allow greater autonomy to communities, families and individuals in decision making on health.

The first two goals require considerable inputs from basic sciences and the third requires inputs from social and management sciences and all of them require adequate knowledge generation capacity in the health sciences. A National Health Research Policy would be a useful instrument to promote health research in order to achieve the goals of Health for All (2). The current national health research policy draft is an important development in this direction. However, more clarity and focus are needed before this document can become a guide to action.

Health systems research and health research systems

There is a disturbing trend in the draft document to use "health systems research" and "health research systems" side by side, without adequately differentiating between these as two entirely different concepts. Health systems research is an important and much neglected dimension of health research systems, and there is an urgent need to develop this area in India. The organisation I work in is devoted entirely to health systems research, and for that reason, also, I would emphasise this component. Still, in terms of investment, health systems research is only a part of health research systems. It may attract only a small part of the total funds that flow into health research (3). A health research policy document should not lose sight of the larger area of biomedical research that it must guide. If, on the other hand, the aim is to have a policy for accelerating and giving direction to research in health systems, a health systems research policy would be welcomed, but it should not be equated with the whole of health research.

India's position in the research world

Biomedical research into disease, its causation and its treatment is not nation-specific. True, there are national priorities, but in very limited areas. Research into cancer, or cardiovascular disease, or diabetes and other metabolic diseases is part of one seamless international effort, and any health research policy in India must ensure that India aspires to be a leading contributor to such research. It is not about winning Nobel Prizes, though our failure to appear in the list of Nobel laureates need not be dismissed out of hand.

As we move, either unwisely or due to a lack of options, from process patents to product patents, we can renegotiate our position - and, indeed, the overall interests of developing nations for generic drugs and new drugs on affordable costs - only if we are in a position to contest the generation of new knowledge itself (4). Today our strength is in reverse engineering and in the Indian drug industry's ability to manufacture any molecule at very affordable costs. But the

new molecule itself comes from the frontlines of international research, where we are a minor player.

Issues the policy must address

As new drugs are less and less likely to have large markets, they are likely to be priced higher and higher (5). For example, a new antibiotic would have to have very restricted use, so that resistance to the drug does not develop early. But such restricted use makes research and development of such a drug a bad investment for the industry. So, unless the public sector makes an advance marketing commitment to buy the drug or underwrite its costs, it would not be worth developing and bringing to the market (6). As a result there are almost no new antibiotics under development. It will be publicly funded, not commercially driven, research that closes the gap and brings out new molecules. Commercial research will increasingly focus on pre-market introduction steps rather than the whole process. Though such a trend is most clearly visible in the development of antibiotics, it may soon be a problem for all drugs and most areas of technology development. The paradox is that patenting was justified as necessary to stimulate new research and develop new products, but there is no clear evidence that it will do this, and publicly financed research continues to have a central place (7).

The health research policy must address this and also have a vision that in a 10-year period, India catches up with the best in such research in the US, Japan and Europe, either on its own or as a consortium of similarly positioned developing nations with similar capability - Brazil. China, South Africa, to name a few.

Such a vision is missing in the policy draft, which sees a developing nation's role only in translational research and health programme design. Without meaning to do so, it may be accepting as inevitable the current division of labour between nations on knowledge generation, and settling for a third world place in this division.

It may be noted that during the period of India's struggle for independence we won India's only Nobel Prize in science. And in many areas of science, including medicine, we could have competed as equals with many nations. At that time, indigenous scientific capacity was seen as a necessary ingredient for sovereignty. This vision needs to find expression in the policy document, appropriately modified for a globalised world, where the search for knowledge is still truly universal but its successes are patented by the powerful.

The knowledge generation process in health systems research

In health systems research the challenge is to articulate research questions in a manner that will help administrators and the political leadership make evidence-based decisions. The challenge is also about the decision making process itself. One concern that the policy document articulates is how, even today, knowledge generated indigenously needs endorsement and packaging by international agencies for it to be legitimised and adopted as part of a national health programme; in the absence of such support, many good schemes and models struggle to find space, however robust the evidence base and even if the planning commission and key policy makers approve it. One example is the controversy in the choice between the IMNCI model (Integrated management of newborn and childhood illness) promoted by UNICEF and WHO as the global standard which draws significantly on the experiences from India, and the HBNCC model (home-based newborn care model) for training community level health workers which is the leading Indian model in this area.

Often innovations in health systems are from within the implementing agencies themselves, with few inputs from academic institutions or even technical support agencies. There is however an increasing amount of public health research that appears in the form of reports and almost one third of these consist of evaluation studies (8). Evaluation studies tend to be cross-sectional and descriptive, and often conclude with generic observations already known to programme implementers. There is also an increasing concern that health systems evaluation does not lend itself to quasi-experimental designs, and there is a need to factor in contextual and subjective factors more innovatively. Evaluators often lament the lack of seriousness given to their reports, seldom recognising that part of the reason is their failure to factor in contexts and provide the evidence base for recommendations (9).

Given the limitations of evaluation and technical support by academic institutions, programme implementers also tend to move to evaluation agencies that will simply do a sample survey for a client-driven evaluation design. Because of this, they will be polite about findings which reflect poorly on the programme; academic departments are unlikely to be so polite. Though such client-driven evaluations are helpful as a programme audit, they seldom contribute to new knowledge or new programme designs or even much problem solving. Much of health systems research happens in a sector called "technical assistance" (TA) where agencies are "procured" by a web of procedures and financed by development partners (bilateral or multilateral funding agencies). The agencies so procured are referred to as TA agencies or TSP (technical support partners). Though they might include academic bodies, in the main these are consultancy agencies. In practice these agencies contribute significantly, but whether this is adequate, and whether there are institutional limitations of such agencies needs to be examined.

Another potential source of health systems research, which had the greatest potential to combine basic biomedical research with health programme development and health systems research, is the network of research institutions financed by the Indian Council of Medical Research (ICMR) and the Centre of Scientific and Industrial Research (CSIR) (10). Historically, some major frontline achievements have emerged from some of these institutions. But what has happened to them now, and why? How will the draft national health research policy contribute to revitalising them?

No analysis of systemic constraints

The problem with the draft national health research policy is that, to the extent it deals with health systems research, it is not based on any analysis of the constraints that health systems research faces. It is not even based on an understanding of the sources of creativity that led to such successful innovations as we are able to find. There is some descriptive understanding of constraints, like the lack of research in medical colleges, but nowhere is there an indication of the direction of reform that would address such a gap, or the reasons for this state of affairs. The proposal of a national forum, with the minister in the chair and the department secretary as its secretary, is neither here nor there; it is an appearance of movement devoid of any real content. It may help, or it may not. Unless the new body has a programme of action or direction which is different from the existing bodies, and unless we are clear as to why the current structures cannot undertake this direction, it is not helpful to create one more structure

What a national research policy should do

I submit that a national health research policy needs to articulate three distinct but inter-related institutional frameworks: the institutional framework required for developing basic medical research capacity such that it would bring us on par with the best in the world; the institutional framework for health systems and health programme development; and the institutional framework and organisational processes that must be put in place to enable evidence-based decision making in public health.

The policy would need to indicate what is expected, in each of these three areas, of the university system, medical colleges, research institutions of the ICMR and CSIR, public health academic institutions and agencies, the technical support institutions of the government, the departments of health, and the research units of the pharmaceuticals and health industries. It would also need to explain how these varied institutions must be shaped and inter-linked to make them productive and effective as centres of health research and innovation. Further, it must articulate an approach to human resources generation to attain the goals of health research. It must understand the forces that shape technology, and address the need to shape the development of technology and health systems in a direction that ensures equity and greater participation and control by people and communities over their lives and health. It must indicate how concerns of sovereignty and a pro-people orientation in decision making would be safeguarded, and undue influence by national or international vested interests would be prevented. The policy must also examine and draw upon institutional and organisational models of relevance to us from other nations for these different functions.

The intention to build a national health research policy is most welcome, but it does seem that there is much more work to be done to develop a policy that would be a guide to action.

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