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Indian J Med Ethics Vol XI (Cumulative Vol XXXIV) No 4 Oct-Dec 2026

COMMENTARY

Three steps forward, one step back: The Draft National Health Research Policy 2026

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Abstract

The Draft National Health Research Policy (NHRP), 2026, marks significant progress in re-organising India's fragmented health research ecosystem. This commentary first commends four features that respond to existing gaps in the research ecosystem — its interdisciplinary approach, built-in transparency provisions, revision of the research assessment framework, and the requirement of informed consent for computational data use. The commentary then recommends improving the policy by increasing participation of the states, naming bodies responsible for listed functions, strengthening benefit-sharing provisions, and anchoring consent procedures within the framework of supported decision-making. Lastly, two areas require further deliberation: revising the research domains to better reflect the envisaged research priorities, and explicitly recognising persons with disabilities both as researchers and research participants. The momentum set by the Draft NHRP must be sustained by timely finalisation of the Policy after accommodating public comments, and early establishment of the named bodies.

Keywords: *health research, research priorities, inclusion, persons with disabilities*

Introduction

On July 6, 2026, the Department of Health Research (DHR) published the Draft National Health Research Policy 2026 (Draft NHRP) [1] for public comments. In 2007, the Indian Council of Medical Research (ICMR) had published a "National Health Research Policy - ICMR", that advocated for setting up the DHR. The DHR, set up in 2007, then published the National Health Research Policy in 2011. More than fifteen years have passed since then, and the scope of health research has expanded in manifold ways in terms of actors, stakeholders, subject matter, and research tools, making this updated version necessary.

The Draft NHRP aims to move India's health research ecosystem from a state of fragmentation towards a coordinated and responsive architecture. It first establishes a National Health Research Agenda to align research effort and investment with national needs. It then sets up a three-pronged governance architecture, with the National Health Research Stewardship Committee for high-level alignment and coordination, the DHR as nodal department, and the ICMR providing scientific and technical leadership.

The Vidhi Centre for Legal Policy submitted comments on the Draft NHRP [2], and this piece draws loosely from that submission to discuss aspects that merit closer attention. Part I of this commentary discusses what the Draft NHRP gets right, analysing four aspects that address current identifiable issues in the research ecosystem. Part II recommends changes to the Draft NHRP to strengthen its objectives and implementation. Part III identifies areas that need further deliberation before finalisation of the Draft NHRP.

I. What the policy gets right

When the DHR published its first attempt at a National Health Research Policy in 2011, reviewers identified multiple structural weaknesses, including an unclear definition of the central term, "health research". The proposed National Health Research Management Forum, responsible for setting the national research agenda, was staffed mostly by politicians and bureaucrats, and its research priorities referenced existing national programmes rather than an independent assessment of the country's needs [3]. The Draft NHRP updates this agenda, resolving some pre-existing gaps while responding to contemporary challenges.

The Draft NHRP's core commitments are to align research priorities, strengthen research infrastructure, and ensure inclusivity and an ethical process built on trust and translation from evidence to policy. Trust comes from community participation, transparency and proportional oversight, and translation requires evidence and innovation to inform policy and practice.

Four areas are specifically worth commending, each addressing a distinct source of collapse in research systems: (i) institutional and disciplinary fragmentation between systems of medicine, (ii) a disconnect between evidence generation and data procurement, (iii) a contradictory conception of merit within the research ecosystem, and (iv) the consent gap for computationally intensive data use.

Interdisciplinary approach

The Draft NHRP 2026 recognises research as a necessarily cross-sectoral undertaking, reflected in its priority-setting methodology. This is in response to the restricted approach that reviewers had previously criticised in the 2011 draft. Clause 3.1.1 (point 9) directs agenda-setting for priorities requiring collaboration across institutions, departments, sectors, disciplines and systems of care. Clause 3.3.3 identifies cross-cutting areas requiring convergence across disciplines and coordinated work across multiple research

types and institutional mandates, and Clause 3.3.3.6 identifies pharmacovigilance for patients receiving care from more than one system of medicine as a priority.

Clause 4.5.1.2 extends this approach beyond agenda-setting, committing the Draft NHRP to interdisciplinary and multisectoral collaborations among government agencies, academic institutions and non-governmental organisations. Together, these provisions treat convergence and coordination as enabling principles running through the policy.

Transparency

The Draft NHRP builds transparency into the research process through connected provisions. Clause 3.2.2 requires the agenda-setting methodology to be publicly justified, and Annexure V requires priority project proposals to disclose data management, data-sharing, and ethics protocols. Clause 4.6.4.1 requires health technology validation findings to be made public to inform procurement, regulatory decisions, and programme inclusion.

This goes beyond a tokenistic recognition of transparency, as it acknowledges that procurement and regulatory decisions should rest on reliable, publicly available evidence, ensuring that the gap between research and its intended outcome is narrowed. Read alongside Clause 6.3.4's requirement for a national coordinating mechanism for health technology assessment, these provisions create a structural link between evidence generation and decision-making at various levels.

Research assessment

Clause 1.7.4 requires assessment to move beyond publication and citation counts to include "publication equivalent" criteria, and Clause 4.2.4.6 provides that individual advancement should not be limited to metrics of personal research output, but should also include administration, project management, ethics review, and research appraisal.

Under Clause 7.5 of the Draft NHRP, the ICMR-Impact of Research and Innovation Scale (ICMR-IRIS) operationalises these alternative criteria. This addresses an endemic issue in the research assessment system. Since 2012, thousands of individuals and organisations, including India's Department of Biotechnology, have signed the San Francisco Declaration on Research Assessment, which emphasised that journal-based metrics should not be used as a surrogate to measure the quality of an individual scientist's research and contributions, especially in hiring, promotion and funding decisions [4]. Treating publication as the sole measure of merit risks unoriginal, low-rigour output, reduces research to a checkbox exercise and risks genuine contributors falling through the cracks. By enabling a holistic assessment process, the policy supports recognition and advancement of motivated, impactful researchers.

The ICMR-IRIS tool could be strengthened by calibrating for different career stages, reflecting the differing access, resources, and opportunities available to researchers at different points in their career. For example, an early-career researcher is far less likely to hold a patent compared to a senior researcher with an established lab and funding. A rationalisation of the weightage given to different categories would also help ensure that the tool serves its purpose of a proportional and holistic assessment. For instance, ICMR-IRIS grants ten publication-equivalents for research that has led to policy changes at the national or international levels, but twenty for commercialised health technologies used at scale. This is difficult to justify, since policy-influencing research is directly tied to the public purpose that the Draft NHRP invokes as a guiding value.

Consent for computational use

Clause 5.6.2 requires that when health research is used to train or develop artificial intelligence and other computational tools, the consent process must communicate anticipated use and allow participant choice. This explicit requirement of informed consent is all the more important, given that the Digital Personal Data Protection Act, 2023 (DPDP Act) exempts data processing carried out for research, archiving or statistical purposes from most of the Act's obligations [5]. Since the Act does not clearly define "research", the application to technological research is ambiguous. Given this lack of clarity in the DPDP Act, the protection and transparency required under the policy serve as additional safeguards.

It is currently unclear whether this disclosure would require naming specific tools or models or a description of the categories of computational use. This clause in the Draft NHRP could be strengthened by specifying the minimum disclosure required in terms of "anticipated use".

II. What changes would benefit the NHRP generally?

The states should be a greater part of the NHRP

In line with the national objective of cooperative federalism, it is imperative that all national policies must actively involve the states in their action plans. It is commendable that the Draft NHRP accounts for autonomy for the states to determine their specific research needs, based on their population health needs and service delivery challenges. It urges the Central government to extend technical guidance to the states to develop dedicated research financing mechanisms. However, this is not nearly enough to reflect the vital role the states play in supporting health research systems.

Noticeably, the role of the states in the development of the National Research Agenda, and a mention of the states in the Policy overall, is mostly limited to Annexure III. Only a few references are made to the states' responsibilities and the importance of their inputs in developing national priorities in the main text of the Draft NHRP. For instance, the functions of the Committee, listed under sub-clause 2.1.1, do not refer to consolidation of state inputs. Clause 2.3.3.3 of the Draft

NHRP states that "Advisory and review mechanisms at national and institutional levels shall work in a complementary manner, with appropriate coordination and role clarity". This should have included advisory and review mechanisms at the state level as well, instead of limiting it to national and institutional levels.

Accordingly, the Draft NHRP must acknowledge state-level planning and state contributions to the national priorities and the agenda within the main text, instead of limiting them to an Annexure. This is critical for the effective design and operationalisation of the National Health Research Agenda.

All functions within the NHRP should have the responsible bodies listed

The Draft NHRP recognises that specialised bodies have to be established that understand the needs of the country's health research infrastructure, while designing the National Agenda. Accordingly, the Policy sets up different bodies, from the National Health Research Stewardship Committee to the National Research Integrity Office, and Annexure II further lists the responsibilities of different national departments, councils, and institutions across the health research ecosystem.

However, later in the Policy document, fewer responsible bodies are identified, especially in the context of preparing guidance and maintaining departmental oversight. For instance, clause 6.3.4 of the Draft NHRP states that the health technology assessment function would be supported by a network of resource centres, and that "a national coordinating mechanism" shall set standards and support capacity-building across this network. There is no clarity as to who would design and maintain this national coordinating mechanism, even when this is presumably a vital part of ensuring that health technologies are well-developed before being included in clinical practice or public programmes. It is thus necessary that the Policy consistently identifies the responsible body for all functions referenced.

Benefit-sharing must be given greater attention as part of health research

The Draft NHRP does refer to community well-being and public benefit throughout its main text, though it does not define it or provide illustrations of what such benefits could look like. Clause 5.6.4 does mention that when data is derived from indigenous communities, research shall include benefit-sharing provisions. However, it is unclear why it does not extend to other vulnerable and marginalised populations as well. Annexure V lists "equity considerations" as a proposal requirement for all National Health Research Priority Projects, but it does not clarify what the term means.

It is critical that health research projects actively give back to the population groups they rely on for outcomes that have wide-ranging public benefits. The Draft NHRP must expressly require, including in Annexure V, that all research projects that rely on research subjects from indigenous, vulnerable, or marginalised groups have benefit-sharing provisions. The Draft NHRP should also acknowledge the necessity for Ethics Committees and Review Boards to be trained to determine the appropriateness of proposed benefit-sharing arrangements [6].

Supported decision-making should be recognised in research consent processes

Consent has traditionally been treated as the threshold question — either a person has the capacity to provide consent for research, or they lack capacity, in which case, someone else steps in to provide consent. The Draft NHRP moves slightly beyond this conception. Clause 5.2.8 requires that consent processes be adapted to a participant's vulnerability, accounting for context. However, there is no explanation as to what is required in adapting the process, much of which would depend on the vulnerabilities that are identified.

Supported decision-making, a model already recognised in Section 13 of the Rights of Persons with Disabilities Act, 2016, provides an alternative to the binary view of capacity. It allows for persons to be supported in exercising their capacity, rather than having capacity entirely displaced and shifted to another person. Though framed for persons with disabilities, including those with intellectual and developmental disabilities, supported decision-making also extends to others whose capacity may be impaired or fluctuating, such as elderly participants with fluctuating lucidity, or first-time research participants unfamiliar with medical terminology.

Rephrasing Anchoring Clause 5.2.8 and anchoring it explicitly in supported decision-making would ensure that equity, envisioned in the Policy's objective, is extended to every step of the process.

III. Areas that need further consideration

In addition to certain improvements to the Draft NHRP as a whole, certain areas would benefit from further deliberation and research. In particular, two aspects need attention: revisiting research domains and the corresponding research prospects, and centring persons with disabilities within the health research ecosystem.

Domains of research should be recategorised to reflect research prospects better

In its domains of research, the Policy lists a diverse range of health challenges — vector-borne diseases, mental health, maternal and neonatal mortality, primary healthcare and emergency care. It then highlights emerging areas within healthcare systems, such as digital health, artificial intelligence, obesity, and climate change. In another paragraph, it emphasises areas that need more attention relative to their significance, including ageing, disability, nursing, and socio-behavioural interventions. In the final paragraph of the section, it notes that research shall address the "full spectrum of prevention and early detection to

treatment, rehabilitation, and long-term care" (Clauses 3.3.1.1-3.3.1.4). However, a plain reading shows that this referenced spectrum is fundamentally incompatible with the highlighted domains.

Activities such as prevention, detection, and treatment are not suitable for systems altogether, such as primary healthcare, artificial intelligence, and nursing. Non-communicable diseases and health conditions, like obesity, need more focus on morbidity, risk-factor surveillance and promotion of health-seeking behaviour. Addressing One Health concerns, such as the health impacts of climate change, require identification of different research priorities that are more cross-cutting than traditional health research.

Accordingly, the Policy must devote adequate space to illustrate different spectrums of health research that would be necessary to explore different categories of priorities. The domains of research must be revisited, and the categories of different priorities need to be redrawn, such as whole systems (primary healthcare), infectious diseases (tuberculosis), conditions that are risk factors for non-communicable diseases (obesity, health impacts of climate change), technological developments that may be systemically or individually adopted (artificial intelligence), and so on.

NHRP should account for persons with disabilities as persons conducting research as well as persons being participants in research

Public comments on the Draft NHRP have noted that certain vulnerable and marginalised populations have been omitted from the Draft NHRP, including sexual minorities, sex workers, persons with reduced autonomy, and terminally ill patients [7]. Even when the Draft NHRP acknowledges vulnerable groups, like persons with disabilities, the recognition is limited and perfunctory. Disability is named explicitly only in two places across the Draft NHRP — once as a research domain needing more attention under Clause 3.3.1.4, and once for additional safeguards needed during ethics review for vulnerable participants.

The superficial acknowledgment of persons with disabilities is reflected in the policy's procedural provisions. Clause 3.2.5, meant to ensure public and patient participation while setting research priorities, does not require offering Easy Read or plain language materials. Accessibility requirements are similarly absent from the Draft NHRP's infrastructure and technology assessment standards. The Health Technology Assessment criteria in Clause 6.3 do not ask whether a device can be used independently by someone with a visual or hearing impairment, or with limited manual dexterity.

The Draft NHRP does not recognise that persons with disabilities also occupy the other side of research as principal investigators, doctoral candidates, and similar actors. Clause 4.2 makes no reference to the inclusion of persons with disabilities within the research workforce. No accessibility standards are set for research sites such as laboratories and trial sites.

There is a need for the Draft NHRP to explicitly view people with disabilities as both participants in research who should be protected from exploitation, and persons shaping how research is conducted and produced. Addressing this is necessary to ensure that the Draft NHRP's stated commitment to equity extends to persons with disabilities in practice.

Conclusion

It is commendable that the Union Government has recognised the importance of valuing health research as an ecosystem, and the Draft NHRP does reflect a holistic understanding of the research infrastructure accordingly. The areas needing improvement highlighted above can help clarify ambiguities, and make the Draft NHRP more inclusive and responsive.

This momentum built by the Draft NHRP should be sustained by accommodating public comments, finalising the Policy within reasonable timelines, and commencing the establishment of the national bodies mentioned in the Policy. Feedback loops amongst governments, practitioners and academicians, institutions and companies must be built effectively to develop and operationalise the National Health Research Agenda. The final NHRP must support a robust Indian research ecosystem to be able to develop solutions to long-standing public health and healthcare challenges.

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Conflict of Interest: None declared **Funding:** None

To cite: Padhy R, Mody S, Mehta D. Three steps forward, one step back: The Draft National Health Research Policy 2026. *Indian J Med Ethics.* 2026 Oct-Dec; 11(4) NS:318-322. DOI:10.20529/IJME.2026.067

Submission received: September 26, 2026

Submission accepted: October 27, 2026

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The FMES is supported by occasional grants from philanthropists and subscriptions to the journal.

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