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RECOMMENDATIONS ON THE DRAFT

National Health Research Policy 2026

Public Consultation Submission to the Department of Health Research, Ministry of Health and Family Welfare

We shall learn from the COVID vaccine development model.

Core position. The Policy must move from broad intent to a lean, mission-led and milestone-based measurable system: collaborative like the COVID-19 vaccine effort, driven by Indian health problems, adequately funded, continuously open to ideas, and accountable for translation into products, programmes, practice and population outcomes.

1. Make translational research the overarching principle. Every mission, grant and institution should define the Indian problem being solved, measurable outputs, timelines, pathway to adoption and expected public benefit. Priority must shift from academic publication alone to prevention, diagnosis, treatment, products, policies and scalable service-delivery solutions. Primary and secondary prevention, such as preventing diabetes progression to CKD and hypertension progression to CVD, must receive explicit funding. ***"If it is not quantifiable, it is not being achieved."***

2. Specify granular national priorities and establish mission-mode institutions outside Delhi

The Policy should clearly identify the following as priority areas for focused, adequately funded national research:

- Brain and neuroscience research
- Improvement in Healthy Life Expectancy (HALE)
- Sexual and reproductive health
- Tuberculosis and malaria
- Cancer research
- Genomics
- Precision, personalised and predictive health
- Biomarker discovery, validation and translation
- Wearable health technologies and remote-monitoring devices
- Implantable medical devices
- Artificial organs and organ-replacement technologies
- Digital de-addiction and the health effects of excessive technology use
- Cognitive behavioural therapy and development of validated psychometric tools
- High-altitude and hard-terrain health research for defence personnel, including those serving in Siachen and similar environments
- Multi-pathic and integrative health research

- **Assistive technologies** *(reference may be made to successful models supported through the U.S.–India Science and Technology Endowment Fund)*

A separate National Biomarkers Mission should be established, along with dedicated national institutes for:

- Brain and neuroscience research
- Precision, personalised and predictive health
- Wearable, implantable and artificial-organ technologies

These institutions should be located across different States rather than concentrated in Delhi. Their leadership, fellowships and scientific positions should prioritise active, high-performing and younger investigators and should not become post-retirement placements.

3. Decentralise research funding to high-need States and non-capital institutions

A larger, ring-fenced share of national health-research funding should be directed to Uttar Pradesh, Bihar, Madhya Pradesh, Rajasthan, Jharkhand and Chhattisgarh, which together account for approximately 42% of India's population and nearly 56% of its annual population increase. Funding allocation should follow transparent criteria based on population size, disease burden, health-system gaps and research capacity needs. Grants should reach district institutions, medical colleges and health facilities outside State capitals. Selection criteria, shortlisted proposals and reasons for award should be placed in the public domain so that funding follows merit, need and potential impact—not proximity to power.

"Please do not think that anyone sitting in Delhi knows everything."

4. Build a national culture of data around India's diverse gene pool. Research policy must first create reliable, interoperable and usable data systems across public and private healthcare. India's diverse gene pool should become a strategic research strength; products intended for Indian use should undergo adequate research and validation in Indian populations and settings. Institutions using the title 'research centre' should publicly report studies, datasets, outputs, translation and impact. ***"We have no culture of data. How can we have credible research?"***

5. Rationalise governance before creating another committee

Conduct a zero-based review of the overlapping mandates of DHR, ICMR, NHSRC, NIHFW, CDRI and other health-research bodies, and merge or discontinue duplicative functions before creating any additional governance layer. Between NIHFW and NHSRC, only one institution should continue, based on a transparent assessment of mandate, performance, relevance and value for public expenditure.

Research stewardship should rest with empowered, enduring institutions with clearly defined execution authority, not advisory committees that add administrative overhead without accountability for outcomes. Except for ICMR, national health-research and allied institutions should be progressively relocated outside Delhi and distributed across different States to decentralise expertise, strengthen regional research ecosystems and reduce excessive concentration of authority and resources in the national capital.

ICMR should be broadened and renamed the Indian Council of Health Research, with clinical research treated as one component of a wider mandate covering public health, health systems, implementation research, behavioural sciences, digital health and allied health research.

6. Establish National Health Research Accounts every two years. DHR should publish biennial National Health Research Accounts showing actual allocation, release and expenditure by Union department, State, funding source, institution type, geography, disease area and research category, including basic, clinical, public-health, health-systems, implementation, digital and translational research. This will show where money is going, expose neglected areas and permit evidence-based reallocation.

7. Make grants rolling, time-bound and large enough to produce meaningful results. Research proposals should be accepted on a rolling basis and reviewed every month. Final decisions should be issued within a maximum of 24 weeks, with published timelines for each stage and automatic escalation of delays. Serious mission-oriented grants should ordinarily range from ₹2.5 crore to ₹25 crore, with defined two-, three- or five-year terms, except justified longitudinal studies. Collaborative government–industry–academic funding should be encouraged. ***"If we want world-class research, we must spend world-class money also."***

8. Replace 'Medical Science PhDs' with translational 'Health Sciences PhDs'. The indicator should be 'Health Sciences or Health Research PhD completions per million population' and include public health, nursing, dentistry, pharmacy, allied health, epidemiology, biostatistics, health economics, behavioural sciences, biomedical engineering, genomics and health data science. PhDs should be predominantly translational, adequately remunerated and open through rolling applications rather than a once-a-year entrance cycle. Selection should be based on the quality of the problem, proposal, guide and institutional capability. At least 50% should be pursued with industry or implementation partners through co-funding and real-world translation commitments. The policy should also track active full-time-equivalent health researchers, not degrees alone.

9. Create formal cadres for research-support professionals; remove avoidable overhead structures. Establish recognised cadres, competency standards, pay bands and career progression for research nurses, coordinators, biostatisticians, data managers, laboratory scientists, field investigators, regulatory specialists, research software engineers and grant managers. The blanket requirement for a separate Research Administration and Finance Unit in every institution should be removed. Technology-enabled shared services and regional support hubs should be used instead, so that scarce research funds are not consumed by duplicative administrative overheads. ***"Research should be treated as an asset, not an administrative parking lot."***

10. Establish a National Health Research Registry beyond clinical trials. India needs a public registry covering all significant health research, not only clinical trials registered in CTRI. It should include public health, epidemiology, health systems, implementation, behavioural, nursing, allied health, dental, diagnostic, digital-health and technology-validation studies, linked to funding, ethics status, protocols, completion, results, datasets, publications and policy or programme uptake. This will reduce duplication, reveal evidence gaps and make publicly funded research visible and accountable.

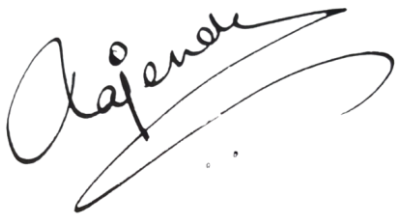
11. Create a dedicated Health AI Registry module and full-lifecycle AI safeguards. The National Health Research Registry should contain a dedicated Health AI module listing intended use, target population, datasets, model version, validation sites, performance, regulatory status and deployment. Prospective Algorithm-Change Protocols should be mandatory for adaptive or retrained systems, specifying permitted changes, revalidation, version control and rollback. Post-deployment surveillance must track performance drift, subgroup deterioration, false outputs, clinician overrides, hallucinations, cyber incidents and adverse events. Independent AI and digital-health validation centres should test tools across Indian populations and care settings. Ethics committees, regulators, procurement officials and investigators must receive specialised AI training so that unsafe tools are stopped without blocking credible innovation.

12. Replace duplicative committee approvals with strict, risk-based ethical governance. The Policy should not create additional layers of ethics committees. It should establish clear national ethical guidelines, standard templates, self-certification and audit for low-risk research, and independent, time-bound review for high-risk human research. Non-compliance should trigger suspension, exclusion from funding and institutional accountability. This preserves participant protection while preventing routine approvals from becoming delay points. ***"Committees are sure-shot ways to delay the research."***

India should draw from the mission-oriented autonomy of its space and science-and-technology programmes: scientific leadership, adequate financing, time-bound decisions and freedom from routine administrative interference.

"Bureaucrats should not be appointed to lead, supervise or control research institutions or research-based departments at any level. Research must remain outside routine bureaucratic oversight and be led exclusively by career scientists, researchers and academicians with demonstrated domain expertise. Administrative systems should facilitate research; not determine its scientific direction."

"Research should be treated as a national investment—not as an expenditure. It must add to the global repository of knowledge while serving the strategic, scientific and health needs of the nation."



Dr. Rajendra Pratap Gupta
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