



The Indian Medical Association's role in federal and state policy processes in India: a scoping review

Alessia Montecalvo¹, Veena Sriram ^{1,2*}, Kiran Kumbhar³, Vikash Ranjan Keshri ^{4,5}

¹School of Public Policy and Global Affairs, University of British Columbia, C.K. Choi Building, 251-1855 West Mall, Vancouver, B.C., V6T 1Z2, Canada

²School of Population and Public Health, University of British Columbia, 2206 East Mall, Vancouver, BC, V6T 1Z3, Canada

³Center for the Advanced Study of India, University of Pennsylvania, 133 South 36th Street, Suite 230, Philadelphia, PA, 19104-6215, United States

⁴Jindal School of Public Health and Human Development, O.P. Jindal Global University, Sonipat Narela Road, Near Jagdishpur Village, Sonipat, Haryana, 131001, India

⁵School of Population Health, University of New South Wales, Building C29 HTH Level 5, Sydney, NSW, 2052, Australia

*Corresponding author. School of Public Policy and Global Affairs, School of Population and Public Health, University of British Columbia, 2206 East Mall, Vancouver, BC, V6T 1Z3, Canada. E-mail: veena.sriram@ubc.ca

Abstract

Physician associations play a significant role in shaping health policy at national and subnational levels. However, the influence of such associations in low- and middle-income countries has not been synthesized or assessed. The Indian Medical Association (IMA), one of the largest physician associations in the world, has a long history of policy engagement at national and state levels across multiple issues. This review aims to assess—for the first time—the empirical literature available on the IMA as a political actor. Adopting a scoping review methodology, the paper sought to identify the policy stances, strategies, and influence of the IMA over India's health policy. Nine health, social science, and policy research databases were searched for English-language studies published between 1974 and 2024. Reviewing 37 papers, it finds that the IMA has been active in seven main policy domains: violence against doctors; regulation of the private healthcare sector; restriction of traditional medicine; professional authority or autonomy for physicians; publicly funded health insurance; medical ethics; and partnership in public health programmes. It has been reactive against new legislation, reform or regulation in all domains except for violence against doctors. Through interrelated interior and exterior strategies, the organization has been successful in influencing, stalling or limiting legislation. While the IMA holds influence through the size of its membership and its embeddedness in health administration and corporate interests, the tactics of the organization often lack coherence and consistency. Situating these findings in the broader landscape of health governance, our review contributes further evidence for the need to develop more inclusive and transparent pathways for participation in decision-making.

Keywords Indian Medical Association, India, health policy, physician associations, lobbying

Key MESSAGES

- The Indian Medical Association is an influential actor in India's health policy processes, though a clear understanding of its policy stances, engagement strategies, and effect on policy has not yet been assessed.
- IMA policy stances are narrowly based in conserving the dominance and ideology of biomedicine and in protecting the interests of private practice, making it resistant to state reforms and seek to weaken regulatory legislation, expansion of traditional medicine, and affordable health insurance rates.
- Through both interior and exterior engagement strategies, high organizational capacity, and wide membership, the

Indian Medical Association is able to influence, often stalling or limiting, reforms to health policy.

- The degree of influence of the Indian Medical Association over health policy in India suggests a need for more inclusive and equitable representation in decision-making.

Introduction

Doctors' associations play a significant role in shaping health policy across administrative levels in countries across the world, through their symbolic power, access to political power, and collective strength. Much of the existing scholarship on physician associations has emerged from high-income countries

Accepted: 29 April 2026

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(HICs), in particular, the United States (Starr 1982, Brophy 2019, Laugesen 2019). This literature fails to capture unique factors that shape policy processes in low- and middle-income countries, including (post)colonial histories, interactions between biomedical and traditional systems of medicine, professional power in the context of socioeconomic disparities, and influences of gender, ethnicity, religion, and caste (Koon 2021, Brophy and Sriram 2021a, Kumbhar 2024). An emerging body of scholarship has however begun to broaden our understanding of these organizations as political actors in LMICs—the role of associations in mobilizing the profession to participate in collective action strategies (Irimu et al. 2018), the political connections between association members and political parties (Wood 2013), and the role of individualized leadership and elite networks (Sriram et al. 2018, Keshri et al. 2024). This is a pressing area for research given the changing role of medical associations under new health sector reform, where decentralization of health systems and marketization of health care are affecting the place and activities of associations (Brophy and Sriram 2021b).

Professional medical associations (PMAs) refer to representative health worker organizations defined by their occupational group (e.g. physicians, nurses), taking interest-oriented action on health workforce policy, health systems governance and management and health sector reform (Sriram et al. 2023). Tactics and interests of PMAs are mediated by historical, social, political, and labour contexts. PMAs in postcolonial states tend to bear the standards of practice and regulation instituted under colonial administration (Johnson 1972). Recent literature suggests that associations may employ strategies to call attention to under-resourced state health services, such as in Kenya (Koon 2021), while in state-dominated health systems, like China's, PMAs may lack professional autonomy and political strength to make demands (Cao 2011).

Healthcare in India has historically been characterized by medical pluralism. Western biomedicine system came to India through the British East India Company's Indian Medical Service (IMS) in 1764 (Ruddock and Chakrabarti 2022). The state push for professional standards delegitimized traditional health systems, and the 1912 Medical Registration Act excluded traditional practitioners from formal medical licence (Jeffery 1979, Ruddock and Chakrabarti 2022). Poor budgetary allocations and human resource shortages in the early years of Independence compromised the quality of public health institutions down by the 1970s. Through the 1980s and 1990s, buoyed by a neo-liberal economic push, the private sector in health, particularly large corporate hospitals and nursing homes, grew exponentially without adequate regulation, deepening the gap in accessible, affordable care which persists today (Baru 2018). Despite attempted policy interventions, successive governments have failed to effectively prioritize and fund public health systems or regulate private services (Selvaraj et al. 2022).

The Indian Medical Association (IMA), a representative, voluntary organization of doctors in India, was formed in 1928 and has since served as the primary conduit for the interests of India's biomedical or allopathic' ('Allopathic' practice refers to the system of Western biomedicine, that is, practice qualified by Western medical education. While the term is largely outdated in the global medical community, it continues to be used colloquially and academically in India, particularly by the IMA, to distinguish Western medicine from traditional medicine (i.e.

AYUSH).) physicians (Indian Medical Association 2020). Despite its long history and presence, the association has not been a subject of substantial research. The IMA has actively shaped and influenced policy at the national- and state-level, forging public perceptions around the medical profession, advocating for professional autonomy and protection and the role of the physician in health service delivery, and sustaining the centrality of Western biomedical ideology amongst the medical community. Moreover, in the context of increasing privatization and marketization of health care in India and failures of government bodies to develop robust legal and administrative systems to regulate health markets, medical professional groups have entrenched a stand defending their interests as clinician-entrepreneurs (Nagral 2012). Despite widespread recognition of the IMA's influence in this sphere, little empirical research has explored in detail the role of the association in health policy processes in India.

This lacuna in health policy analysis scholarship is important to address for several reasons. The first is the size and scale of the Indian Medical Association. The IMA is among the largest physician associations in the world, if not the largest, with over 330 000 members and local branches in 34 states and territories (Indian Medical Association 2020). This has made its imprint on health policy processes throughout the country impossible to ignore. Exploring these questions in an Indian context will shed important light on the politics of domestic healthcare and public health policy in other contexts, an area of growing importance given global prioritization of universal health coverage (Ho et al. 2024). Second, the IMA's stated objectives are promoting and advancing medical and allied sciences in their different branches, improving public health and medical education in India, developing standards for ethical practice, and advocating for the interests of the medical profession. Similar to other professional associations, however, the IMA's policy objectives are arguably more complex than their stated intentions. For instance, the American Medical Association has pursued policies for physician reimbursement and commercial activities to secure consistent revenue for the association, expand its membership, and reinforce its historical position (Laugesen 2019). Third and finally, PMA's positions and approaches in some contexts and approaches are often at odds with health policy goals as expressed by government and civil society at state and national levels (Laugesen 2019), but these patterns have not been well investigated in many contexts, including India.

The aim of this scoping review is to comprehensively synthesize and analyse existing scholarship on the Indian Medical Association's role in policy processes. Specifically, we conducted a scoping review of empirical studies and commentaries published between 1974 and 2024, which discuss or mention the role of the IMA in health policy. Through this review, we identify the association's overarching policy stances, engagement strategies, and degree of influence over health policymaking.

Methods

The study followed a scoping review design (Arksey and O'Malley 2005). The search strategy focused on published, peer-reviewed studies explicitly discussing the Indian Medical Association as a policy actor in India. We used the definition of 'policy actor' from Howlett, describing governmental and non-governmental

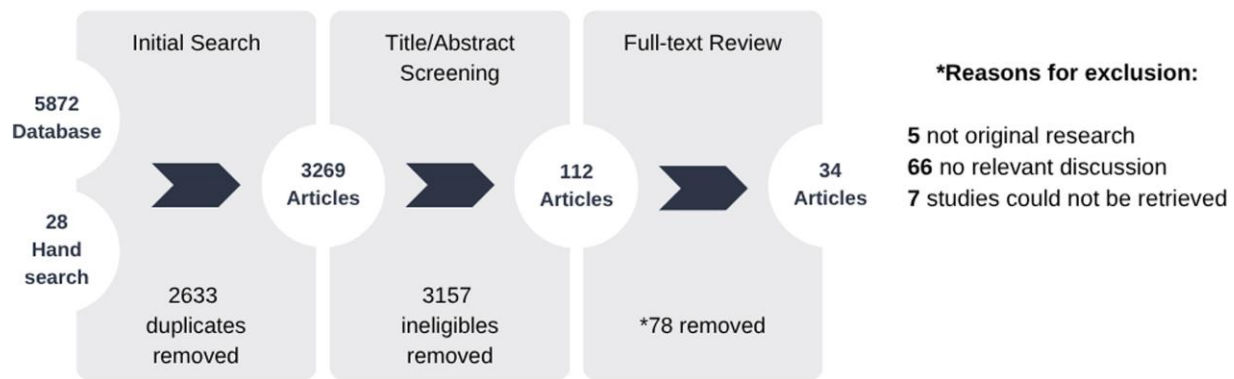


Figure 1 Flowchart diagram of scoping review methods. Figure demonstrating the scoping review paper identification process. Diagram states number of papers gathered in initial search, number of papers selected for title/abstract screening, and number of papers selected for full-text review. Reasons for exclusion are given, with number excluded for each region.

individuals or groups interacting in 'different 'arenas' and decision making...in multiple 'rounds' or phases in which individual decisions in each round accrete to generate a final result' (2011, 659). While the search surveyed studies that reference the IMA and policy activities, the strategy focused on original research that included substantive analysis and discussion of the IMA in health policy processes.

The search strategy included eight electronic databases for social science and medicine publications: Ovid Medline, PubMed, Scopus, Web of Science, ProQuest/PAIS Index, CABI Digital Library, Policy Commons, and Global Index Medicus. The search was conducted using two concepts: the Indian Medical Association and health policy, associated with 11 keywords. Searches included the term 'Indian Medical Association' AND 'policy' OR 'politics' OR 'regulation' OR 'reform' OR 'lobby' OR 'workforce' OR 'advocacy' OR 'influence' OR 'interest' OR 'protest' OR 'strike'. Publication date was limited between 1974 and 2024. This period was chosen to reflect major health policy shifts, such as privatization, from the 1970s onwards. Only English-language publications were included. Commentaries were considered for inclusion depending on the relevance and quality of analysis. News articles were excluded from the review. Some papers identified met the inclusion criteria but had to be excluded from the review as full texts could not be retrieved.

Figure 1 presents the results of the search strategy. Five thousand eight hundred and seventy-one studies and commentaries were imported to Covidence for screening from the above databases. Of those, 2631 studies were removed as duplicates. The remaining 3240 studies were screened by title and abstract by one reviewer (A.M.). Three thousand one hundred and fifty six studies were identified as unrelated, and the remaining 84 studies moved to full-text review. Excluded papers included medical studies by the *Journal of the Indian Medical Association* or studies which cited the journal, news stories, and studies in which the IMA was referenced solely in policy recommendations or as an implementing body rather than a political organization. Papers appearing to be empirical studies of the IMA's engagement in policy processes were included. An additional 28 studies identified through a hand search in Google Scholar were also imported and moved to full-text review (A.M.). Full-text review of the 112 studies was conducted by two authors (V.S. and A.M.), with the studies split evenly between them. Seventy three studies were

excluded at this stage if they did not discuss the IMA as a policy actor or did not contain sufficient analysis for extraction. Seven studies were excluded as they were not accessible (reports not retrieved). Thirty seven studies were identified for data extraction, which was conducted by one author (A.M.). During extraction, three further studies were excluded because they were perceived by the analysts to be of limited analytic value.

Data extraction was conducted based on the following analytic categories: (1) policy domain; (2) the IMA's position on the issue; (3) impact of IMA activities on policy outcomes. This was refined through consultation with coauthors. Through this process, we inductively identified seven overarching healthcare delivery and health workforce policy domains around which papers were clustered. Narrative reviews were developed and synthesized for each policy domain. We conducted a literature review to provide a brief background of the history of the IMA and its role in policy to provide context for the results. To contextualize these findings, we consulted the official IMA website to gather context for the organization's priorities and activities conducted a literature review to provide a background of the history of the IMA and its role in policy to provide context for the results.

Results

History of Indian Medical Association and its role in policy processes

During the colonial period, doctors' associations in India were dominated by European membership, often affiliated with the British Medical Association (BMA), though attempts to create official branches of the BMA in India stagnated and failed (Jeffrey 1985). As the medical workforce became increasingly fractious, reflecting political differences and social hierarchies, alternative medical associations cropped up in the late nineteenth century. A stable, nationwide organization of doctors did not materialize until the mid-1920s, when regular All-India Medical Conferences began to take place (Jeffrey 1985). The Indian Medical Association was established in 1928 (then the All-India Medical Association) at the 5th All India Medical Conference, as a coalition of local medical associations with a starting membership

Table 1 IMA organizational information (as of 2022).

Objectives	<p>'The objects of the association are:</p> <ol style="list-style-type: none"> 1. Promote and advance medical and allied sciences in all their different branches and to promote the improvement of public health and medical education; 2. Maintain the honour and dignity and to uphold the interest of the medical profession and to promote co-operation amongst the members thereof; and 3. Work for the abolition of compartmentalism in medical education, medical services and registration in the country and thus to achieve equality among all members of the profession.'
Activities	<ul style="list-style-type: none"> • Academic outputs (Journal of the Indian Medical Association publications, lectures, conferences) • Educational public health campaigns • Organizing the medical corps in emergencies • Creating and assisting branches • Cooperating with public bodies with shared interests • Consider and express its views on all questions and the laws of India or proposed legislation affecting public health, the medical profession and medical education • Initiate or watch over or take such steps and adopt such measures from time to time
Leadership and Governance	<ul style="list-style-type: none"> • Central Council (general management and direction of policy) <ul style="list-style-type: none"> ◦ National President-Elect ◦ 4 national vice-presidents ◦ 2 honorary joint secretaries ◦ Branch representatives ◦ IMA committee members • Working Committee (executive authority of IMA policy and programme) • More than 350 000 members
Geographical distribution	<ul style="list-style-type: none"> • National IMA headquartered in New Delhi • 34 State and Territory branches • 1274 local branches

Table outlining The Indian Medical Association's (IMA's) objectives, activities, leadership and governance, and geographical distribution of IMA offices. Information is drawn from the organization's official website.

of 200 doctors ([Indian Medical Association 2020](#)). By 1947, the year of India's independence, it had reached 10 000 members. One of the drivers of its formation was opposition to specific provisions of proposed all-India legislation on the regulation of medical education proposed in the 1920s ([Jeffery 1979](#)). From its origin, the IMA was vested in India's nationalist movement, with Indian leaders faulting subservience to Britain for the country's slow medical progress ([Jeffery 1985](#)). On select issues, IMA leaders sought to align objectives with the Independence movement, such as the abolition of the Indian Medical Service ([Jeffery 1979](#)). The IMA has since taken positions on major national and state-level health policy processes that impact the interests of the medical profession. During this time, these positions were frequently in contention with those of emerging civil society groups advocating for patient-centred policies.

Table 1 describes key organizational features of the IMA. The national office is headquartered in New Delhi. States and Union Territories have branches, which are autonomous but under the ambit of the IMA headquarters. In turn, these branches maintain jurisdiction over all local branches within their state or territory. Any medical practitioners registered with the Medical Council of India or any State Medical Council in India based on their medical qualification are eligible for paid membership in a local chapter. Privileges of membership include IMA journal subscriptions, participation at meetings, lectures and demonstrations, attendance at medical conferences, and other local membership benefits

([Indian Medical Association 2022](#)). Though in the initial years during the colonial period, the IMA mulled the idea of including traditional practitioners or Indian systems of medicine practitioners, this idea was soon abandoned when it became clear that the inclusion of those practitioners in the national register would mean summary derecognition by 'international' medical councils like the General Medical Council of the UK ([Jeffery 1979](#)).

Key policy domains

Twenty four studies discussed national-level policy issues, while 10 discussed state-level (or city-level) issues. As demonstrated in **Table 2**, seven policy domains emerged in the literature, including: (1) violence against doctors; (2) regulation of the private healthcare sector; (3) delivery and regulation of services by traditional medical and non-physician providers; (4) professional authority or autonomy for physicians; (5) public health reforms; (6) medical ethics; (7) and partnership in public health programmes (**Table 2**).

Violence against doctors

Three studies discussed the role of the Indian Medical Association in regards to its advocacy for legislation restricting and redressing cases of violence committed by patients against doctors ([Wood 2013](#), [Mishra et al. 2021a](#), [Samant et al.](#)

Table 2 Studies categorized by policy domain.

Policy domain	Relevant bills, acts, schemes or programmes	Number of studies	Studies
Violence against doctors	Epidemic Diseases (Amendment) Act (2020)	3	Samant et al. (2024) Wood (2013) Mishra et al. (2021a)
Private healthcare sector regulation	Consumer Protection Act (1986) (IMA vs VP Shantha and others, 1995) Clinical Establishments Act (2010) Karnataka Private Medical Establishments Act (2007), Amendment (2017) Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act (1994)	13	Bhat (1996) Peters and Muraleedharan (2008) Phadke (2010) Nagral (2012) Srinivasan (2013) Phadke (2016) Vasan et al. (2017) Shukla et al. (2018) Mishra et al. (2021b) Kelkar (2021a) Kelkar (2021b) Putturaj et al. (2021) Hunter et al. (2022)
Delivery and regulation of services by traditional medical and non-physician providers	Chhattisgarh Chikitsa Mandal Act (2001) National Health Scheme for Rural Areas (1973) Community Health Volunteer Scheme (1977)	4	Jobert (1985) Yadav et al. (2009) Raha et al. (2010) Sujatha (2021)
Public health reforms	Pradhan Mantri Jan Arogya (PM-JAY) (2018) Other Publicly Funded Health Schemes Insurance (PFHI) Schemes	2	Chikermene and Kurian (2018) Nandi and Schneider (2020)
Medical ethics	Drugs and Cosmetics Act (1940) Indian Medical Council (Professional Conduct, Etiquette and Ethics), Regulations (2002) Clinical Establishments Act (2010)	3	Chatterjee and Srinivasan (2013) Priya and Ghodajkar (2018) Ahuja et al. (2021)
Partnership in public health programmes	Public–Private Mix for Tuberculosis control Global Polio Eradication Programme	3	Engel and van Lente (2014) Salve et al. (2018) Majumdar et al. (2022)
Professional authority and autonomy	Indian Medical Council Act (1956) Drugs Act (1940) National Medical Commission Act (2019)	10	Jeffery (1977) Jeffery (1979) Jeffrey (1985) Frankenberg (1981) Peters and Muraleedharan (2008) Nagral (2012) Engel and van Lente (2014) Kelkar (2021a) Jeffery (2024) Kumbhar (2024)
Cross-cutting		8	Jeffery (1979) Jeffrey (1985) Nagral 2012 Kelkar (2021a) Kumbhar (2024) Samant et al. (2024)

Table indicating the seven identified policy domains in which IMA is active according to the literature, with the relevant bills, acts, schemes or programmes, and the number and titles of reviewed papers found in each policy domain.

2024) (Violence is here referred to as incidents when health workers/medical professionals are abused, threatened, or assaulted in the circumstances related to their work, encompassing both physical and psychological forms of violence. Cases in the Indian context include physical attacks, sexual assault, murder, kidnapping, and extortion.). This issue has received increasing media and academic attention in recent decades, with cases on the rise (Samant et al. 2024). The IMA recently conducted a study reporting that 75% of doctors experience some form of violence at work (Samant et al. 2024). In a narrative review of national trends in violence against healthcare workers, Mishra et al. (2021a) note that the IMA has demanded the federal government enact a central law specific to violence against medical professionals with nonbailable Indian Penal Code and Code of Criminal Procedure sections, with procedures to investigate cases and issue punishments. The IMA has called for hospitals to be declared a protected zone with mandatory security.

Wood's (2013) analysis of middle class protest from 1998 to 2008 in Varanasi, Uttar Pradesh highlights the contentious nature of IMA advocacy. The IMA is described to possess unparalleled political capital through its formal and informal access to bureaucrats and politicians when compared with three other 'upper middle class occupational groups' (traders, lawyers and teachers). Wood also emphasizes IMA's effective use of protest as a mobilizing tactic, detailing strike actions from 2005 to the time of study organized by the IMA voicing dissatisfaction with legal responses to crimes against doctors. This mode of advocacy is highly effective as the IMA is 'able to organise public actions quickly, garner wide media attention, and receive a relatively quick and favourable response' (Wood 2013, 84). Demands are framed by statistics on rates of violence produced by IMA studies, the stress of the pandemic crisis, and the tendency for doctors not to pursue legal action due to sympathy with patients (Mishra et al. 2021a). In a content analysis of newspaper accounts of violence against doctors in Maharashtra and Goa between 2012 and 2022, Samant et al. find that a narrative of victimization is deployed by the IMA to garner support for policies against doctor violence. News articles documenting IMA-led demonstrations circulate IMA demands and slogans, indulge a pro-doctor narrative by situating events in the context of doctors' deaths during the pandemic and appealing to the image of doctors as selfless martyrs, and even provide a direct platform for IMA representatives to pen their own articles. Samant et al. interpret the press' emphasis on doctor victimization as the medical profession's enduring social status and exemption from scrutiny, and further, as an expression of the consolidated power of the profession and its elite representatives to shape the media agenda. According to Jeffrey's study of the changing medical profession in India, attention on violence against doctors has resulted in the passage of Acts in 23 Indian states since 2009 to protect medical personnel and facilities against violence, as well as a temporary amendment to the Epidemic Diseases Act (1897) during the Covid-19 pandemic that enabled sanctions against medical personnel (2024).

Private healthcare sector regulation

Thirteen papers concentrated on private healthcare sector regulation (Bhat 1996, Peters and Muraleedharan 2008, Phadke 2010, Nagral 2012, Srinivasan 2013, Phadke 2016, Shukla et al. 2018,

Kelkar 2021a; Kelkar (2021b); Mishra et al. 2021b, Putturaj et al. 2021, Hunter et al. 2022). The Indian government has attempted to develop policies to regulate standards and costs of care in the expanding private sector (Peters and Muraleedharan 2008). Largely representing private physicians, the IMA has obstructed these reforms (Nagral 2012). Demands include objecting to reform bills or provisions and calling for self-regulation in place of state regulation through professional councils, voluntary accreditation, and specific legislation targeting aspects of healthcare (Putturaj et al. 2021).

This became a prevalent issue for the IMA in 1995 with a Supreme Court ruling, 'Indian Medical Association vs. V.P Shantha', which brought private medical practice under the 1986 Consumer Protection Act (CPA), a law ensuring redressal for aggrieved consumers (Bhat 1996). In a qualitative study detailing the CPA ruling and views of private providers in Ahmedabad, Bhat (1996) explains that the IMA opposed the judgement, insisting that medical services constitute personal contracts, not akin to a seller-buyer relationship. IMA appeals to have cases tried under the Indian Medical Council Act (1956) instead of CPA were rejected (Bhat 1996). In a review of bureaucratic approaches to the regulation of health services in India, Peters and Muraleedharan (2008) identify trends in defensive medicine and increases in diagnostics and other practices that drive up costs of care as a consequence of the 1995 judgement, with the IMA creating an insurance scheme for doctors' financial and legal assistance in 2001.

In 2010, the IMA pushed back against the Clinical Establishments (Registration and Regulation) Act introducing registration, regulation and minimum standards for clinical establishments—private establishments are often owned by private practitioners (Phadke 2010, Nagral 2012, Srinivasan 2013, Phadke 2016, Kelkar 2021b, Putturaj et al 2021, Mishra et al. 2021b). Many studies regarding the IMA's role in private sector regulation discuss its dissension with the CEA. Anant Phadke's (2010) commentary on the medical profession's opposition to the CEA frames the association's responses as irrational and lacking cohesion. The IMA has demanded specific amendments, especially around hospital rate stabilization, though in a 2016 essay on the regulation of doctors and private hospitals in India, Phadke interprets this as a divisive effort to upend the Act altogether. In a commentary on the medical profession's opposition to the Act, Srinivasan (2013) categorize IMA claims under three logics: the CEA will add to existing laws resulting in over-regulation and harassment of doctors by an 'inspector raj'; the law will force small establishments to shut down, making healthcare unaffordable; and inspections will cause patients to doubt the competence of their physicians, weakening trust in the healthcare system. The IMA discredited health reform in the private sector, pointing to non-biomedical practice as pervasive 'quackery' in the health system, which Act would only further encourage (Phadke 2010, 229). In its campaigns, the IMA pushed for the government to make accreditation voluntary, a financial incentive to improve standards and raise competition, or to exempt doctor-run establishments from the Act (Srinivasan 2013). In the 2021 book 'India's Private Healthcare Delivery: Critiques and Remedies', Sanjeev Kelkar examines the significance of the CEA to private sector regulation, citing financial fallout as the fundamental motivation for the IMA's objections. This concentration on market interests is echoed in a commentary by Nagral

(2012) evaluating the overwhelming turn to industry across the Indian medical profession and the reflection of this in the IMA's politics, depicting the IMA as 'doctors in entrepreneurial gowns'. Kelkar labels the IMA's reaction to the CEA as 'voluble and often vitriolic' in its arrogance, driven by the sense that its power is being undermined (Kelkar 2021a, 192). While Nagral (2012) describes the IMA's nationwide strike in 2012 to be 'hardly effective' in deterring the legislation, the author acknowledges the general success of the organization's dramatic action to please its constituency and attract new members (10). IMA was also able to impact its development on pressing provisions such as hospital rate regulation, as a participant in the drafting process (Phadke 2016). In its efforts to undermine state regulation over private hospitals such as the CEA, the IMA has pointed to accreditation mechanisms and existing laws as sufficient existing systems for regulation. The IMA's Hospital Board of India, launched in 2011 to protect the interests of smaller clinical establishments, signed an agreement with the National Accreditation Board of Hospitals and Healthcare Providers (NABH) in 2015 to promote NABH accreditation to its members. It has pushed back against federal policies regulating medical prescriptions and criticized advertisement of services by larger hospitals but not individual practitioners (Hunter et al. 2022).

State CEA bills have been stalled by state-level IMA branches. The private sector was assertive in lobbying to weaken grievance redressal, as observed in Maharashtra and Karnataka (Mishra et al. 2021b, Hunter et al. 2022). In attempts to disrupt progress, the IMA has called large-scale strikes backed by public misinformation campaigns, achieving modest gains towards its demands (Phadke 2016, Vasani et al. 2017, Kelkar 2021b, Mishra et al. 2021b, Hunter et al. 2022). Participating in drafting committees, IMA representatives would variously refuse to offer inputs on provisions they categorically opposed or use the dominance of IMA stakeholders in committees to reject provisions proposed by patients' rights groups (Phadke 2016, Shukla et al. 2018). A 'mother body' in the medical community, the IMA has mobilized coalitions with aligned associations to amass collective bargaining power and used its relationships with health ministry officials to access both formal and informal venues to lobby (Puttaraj et al. 2021, Mishra et al. 2021b, 717).

Delivery and regulation of services by traditional medical and non-physician providers

Six studies address the IMA's stance on traditional ('AYUSH') medical practice (Jeffery 1979, Frankenberg 1981, Jobert 1985, Yadav et al. 2009, Raha et al. 2010, Jeffery 2024). The IMA has sought to preserve biomedical standards, opposing initiatives to qualify traditional practitioners through specialized training programmes or empower them to diagnose, prescribe and treat patients through conventionally biomedical means (Jeffery 1979, Sujatha 2021, Kumbhar 2024). IMA complaints warn of 'mixo-path', as a dilution of biomedical standards and threat to the purity of traditional practice (Raha et al. 2010, Sujatha 2021, Kumbhar 2024).

The IMA was not categorical in its opposition to traditional medicine in its early days. In a 1977 study of the evolution of healthcare and health politics in India, Roger Jeffrey highlights that the IMA did not exclude traditional practitioners from membership until debates in the 1930s came to focus on achieving

international standards of medical education, for which traditional practice did not qualify (Jeffery 1977). Jeffrey cites two schemes to mainstream traditional medicine in the 1970s opposed by the IMA that were defeated—though not solely due to IMA advocacy—amidst many other failed campaigns (1977). In the early 1970s, the medical profession reacted aggressively, launching petitions, protests, strikes, and proposals to nationalize medical practice, to a National Health Scheme for Rural Areas, which would certify traditional healers to practice biomedicine (Jobert 1985). In a 1985 study, Bruno Jobert analyses the populist Indian Community Health Volunteer (CHV) Scheme introduced in 1977, appointing volunteers trained in basic primary healthcare to underserved villages. With health policy debates bringing confidence in the biomedical system down in 1977, the IMA tempered its response to the CHV scheme, recommending stricter conditions, including a higher minimum education level, longer training period, and prohibition of curative action for CHVs. These demands were included in the draft policy document. A similar policy in 2001, the Chhattisgarh Chikitsa Mandal (CCM) Act certifying Rural Medical Assistants through a 3-year course, is discussed by Raha et al. (2010). The IMA filed a case questioning the legality of the programme, slowing but not preventing implementation of the course and forcing the licence to be renamed (Raha et al. 2010). Yadav et al. (2009) identify the IMA as a hurdle in implementing policies in favour of AYUSH systems.

The IMA has advocated against decisions authorizing prescriptions by nonbiomedical practitioners (Kumbhar 2024) and licensing postgraduate Ayurveda practitioners to conduct surgical procedures (Jeffery 2024). Sujatha's (2021) commentary on the politics of medicine during the Covid-19 pandemic in 2020 documents how the IMA publicly discredited the Ministry of AYUSH's public Covid-19 management protocol, dubbing AYUSH drugs placebos and rebuking the government for promoting them.

Public health reforms

Two studies cover health insurance policies in India (Chikermane and Kurian 2018, Nandi and Schneider 2020). Postindependence, the government released plans focused on developing nationwide public health infrastructure and strengthening primary care. However, after the 2000s, a health financing scheme, Rashtriya Swasthya Bima Yojana (RSBY), sought to address health financing for citizens below the poverty line. The government sought to accelerate health insurance efforts under the 2017 National Health Policy (NHP), proposing strategic purchasing of healthcare services from public and private sectors. This led to the launch of the Pradhan Mantri Jan Arogya Yojana (PM-JAY) programme to ensure health coverage for low-income citizens in 2018 (Chikermane and Kurian 2018). Chikermane and Kurian (2018) assess features of the Pradhan Mantri Jan Arogya (PM-JAY) programme launched by the federal government in 2018. The IMA resisted lowered treatment package rates and called for an exclusive trust model for insurance, eliminating insurance companies as intermediaries and enabling claims to be reimbursed directly (Chikermane and Kurian 2018, Nandi and Schneider 2020). Although the IMA has claimed this model would better protect the interests of patients and reduce financial losses to third parties, the authors speculate that given the limited capacity of the state to monitor hospitals, as compared

with that of the insurance industry, this model would provide for more opportunities for transgressions by hospitals and private providers (Chikermane and Kurian 2018).

Nandi and Schneider (2020) assess the efficacy of publicly funded health insurance (PFHI) PFHI schemes in the state of Chhattisgarh under PM-JAY. The private healthcare industry notably advocated for higher package rates and reduced regulation in the development of PFHI schemes. This culminated in a 3-month strike across the state in 2013 led by the IMA to pressure the government to raise package rates. The state decided to re-view the schemes (Nandi and Schneider 2020).

There is limited scholarship indicating direct participation of the IMA in the formulation of India's National Health Policies, launched in 1983, 2002, and 2017, respectively. While the IMA was not engaged in National Health Committees (Agrawal et al. 2024), it may have exerted influence on committees during or after the formulation of the NHPs. Two *Journal of the Indian Medical Association* papers highlighting IMA perspectives on the NHP under development in 1979 were identified (Chaudhuri and Roy 1979, Dutta 1979) though only abstracts, not full texts could not be retrieved for analysis.

Medical ethics

Three studies fell in the domain of medical ethics (Chatterjee and Srinivasan 2013, Priya and Ghodajkar 2018, Ahuja et al. 2021). Given the dynamics of poorly governed and funded public healthcare infrastructure and a prolific profit-driven private medical industrial complex in India, regard for medical ethics has eroded over time. The former Medical Council of India (MCI), mandated with the regulation of medical education and medical standards, has seen its credibility wane amid corruption scandals and strategic alignments with the private medical profession. Priya and Ghodajkar (2018) discuss corruption in the Indian healthcare industry, from its inception under colonial structures to its expansion under the present biomedical industrial complex. In particular, the IMA's influence over the MCI and prevention of state regulation has enabled private practitioners to curtail professional codes of conduct and evade accountability (Priya and Ghodajkar 2018). According to Jeffrey, the IMA historically did little to raise ethical standards in medicine, with the organization engaging only where IMA members flout IMA decisions or in response to complaints, for instance in the case of practitioners dispensing medications for profit in 1973 (1977). The IMA has however advocated against practice of biomedicine by practitioners unqualified in biomedicine by calling on standards in the Code of Medical Ethics and Regulations (2002). Chatterjee and Srinivasan (2013) provide an overview of ethical issues facing the medical field in India and discuss the role of IMA in the policy responses to these issues. The IMA has taken marketing and promotion of pharmaceuticals under more careful consideration (Chatterjee and Srinivasan 2013). In a review of ethical issues relating to endorsements and advertisements in healthcare, Ahuja et al. (2021) highlight that while the erstwhile Medical Council of India Code of Ethics prohibits advertisement of services or commercial products by medical professionals, the IMA has approved and endorsed several commercial products (Ahuja et al. 2021). The association has defended this as endorsement of 'nutritional programmes' rather than retail products (Ahuja et al. 2021).

Partnership in public health programmes

Recognizing the dominance of the private sector over healthcare delivery, the central government has launched several public-private partnership programmes to tackle public health issues in India, including disease control. As the Indian Medical Association maintains strong networks with private providers across the country, it is seen as a strategic partner to ensure widespread penetration of these programmes. Three studies discussed in detail IMA interactions with government-led public health initiatives (Engel and van Lente 2014, Salve et al. 2018, Majumdar et al. 2022). The IMA has been an active and engaged partner in planning and implementation of public health initiatives, influencing their efficacy and shaping the involvement of traditional practitioners in government programmes. In a study of the role and mobilization of power amongst different actors involved in implementing India's Global Polio Eradication Initiative (GPEI), Majumdar et al. (2022) consider the status of the IMA. Given the IMA's large presence in the health space, it was enlisted to participate in the GPEI. The authors classify IMA representatives as technical experts with academic credentials, asked to hold talks, conduct research, and publish articles to encourage vaccine uptake and spread information. Influence from the IMA was a factor in the success of the GPEI in India (Majumdar et al. 2022).

Two studies analysed the IMA's role in the national public-private partnership for tuberculosis programme, a partnership between public and private providers to control TB spread. In a study of the relationships between actors involved in implementation of Public-Private Mix (PPM)-TB policy in India, Salve et al. (2018) deduce that the IMA had influenced policy development according to its interests in promoting biomedicine. Policymakers deliberately excluded non-biomedical providers from legal documents fearing an unfavourable IMA response, despite traditional practice accounting for significant TB referrals. IMA resistance to non-Western trained practitioners proved to be an obstacle to the full-scale implementation of the programme (Salve et al. 2018). Weighing implementation strategies of PPM-TB in a study of organizational innovation and control practices under the policy, Engel and van Lente (2014) discuss the outcomes of an IMA-led model in Kerala. The IMA focused programme engagement with practitioners of biomedicine, registered with the association, and left out nonbiomedical providers and 'unqualified slum doctors' in communities where TB might be prevalent. IMA informants leveraged the association's greater access to patients as compared to government officials to direct the programme in favour of its interests. While the IMA model would be easily replicable in different states, it did not foster trust between providers and hindered collaboration (Engel and van Lente 2014).

Professional authority and autonomy

Ten papers review the status of the medical profession in India as it has transformed over time, including public image, scope-of-practice, and self-regulation (Jeffery 1977, Jeffery 1979, Frankenberg 1981, Jeffrey 1985, Nagral 2012, Engel and van Lente 2014, Kelkar 2021a, Jeffery 2024, Kumbhar 2024, Samant et al. 2024). The IMA has sought to protect the professional autonomy of private, biomedical practitioners, calling for the distinction of biomedical doctors through registration

and licensing, advocating for self-regulation, and undermining centralized regulation. In the years after its inception, the association had difficulties recruiting from the public sector once government doctors were permitted to join and distinguished its interests from those of traditional practice to maintain Western standards (Jeffery 1977). In this way, the IMA developed a corps of biomedically trained, private practitioners and eventually structured its advocacy accordingly. However, the organization's policies have lacked consistency with this positioning, with calls to nationalize medical services in the 1970s (Jeffery 1985) and revive the Indian Medical Service in the 2010s. The IMA has otherwise pushed back on reforms to centralized regulation. It opposed the 2010 National Commission for Human Resources in Health (NCHRH) and 2017 National Medical Commission (NMC) bills, which sought to install new federal regulatory bodies to oversee medical practice in place of the Medical Council of India, with which the IMA was closely aligned (Nagral 2012, Kelkar 2021a).

The IMA relies on its status for legitimacy in calls for professional autonomy. Describing the dimensions of status and class in the Western medical community in India, Frankenberg (1981) highlights how the profession is defined by its concept of status, its class base as the emerging 'petty bourgeoisie' of that time period, and its position in the structure of the international medical economy. This manifests in its attitude towards traditional medicine, with the IMA's public statements coloured by dramatic claims against non-Western practice (Frankenberg 1981). With a focus on the portrayal of doctors in cinema peddled by the Indian urban elite, Kumbhar (2024) narrates a 'golden era' of the biomedical doctor in the decades following Independence. Popular culture diffused an image in which 'doctors were largely hard-working, compassionate and skilled, and biomedicine was shown to be impeccable, even miraculous, in its therapeutic potential', with underprivileged patients depicted as 'perennially grateful beneficiaries' (2024, 825). It is through this rhetoric that the IMA maintains its high esteem, often citing nobility, merit and community-orientation in calls for greater, institutionalized respect (Jeffery 1977, Jeffery 2024, Samant et al. 2024). This depiction has garnered some success in achieving sympathy in the press (Samant et al. 2024). This image is invoked less, or even refuted, by the IMA in calls for improved working conditions (Jeffery 1977).

More recent studies herald transformations to the medical profession by a changing medical industrial landscape, namely prolific corporatization and decentralized regulation in the healthcare sector. As healthcare becomes increasingly market-driven in India, the self-interested, profit-driven strategies of the IMA expose its lack of credibility to be a self-regulating profession with much concern for social welfare (Peters and Muraleedharan 2008). As state regulation and patient protections are weakening, regulatory functions are instead diffused across various industries and sects of the health network, including accreditation companies, insurers, platform operators, and consumer courts, which the IMA is variously positioned to align itself with (Hunter et al. 2022). Alongside globalization of the labour market and failure of occupational closure, the IMA and the body it represents are involved in what Jeffrey terms a 'reprofessionalization' of India's doctors, whereby professional power is being reinvested in specialist elites of the corporate hospital sector, fragmenting the medical professional community (Jeffery 2024).

Discussion

This scoping review aimed to identify the policy stances, policy engagement strategies and degree of influence of the IMA on health policy issues in India, based on available, published literature. IMA policy stances are narrowly based in conserving the dominance and ideology of biomedicine and in protecting the interests of private practice. As such, policy stances are resistant to state reforms, seeking to weaken regulatory legislation, expansion of traditional medicine, and affordable health insurance rates. The only case of calls for new legislation is for protections against violence against doctors. These ends are achieved through a combination of interior and exterior strategies, exhibiting a high level of organization and execution capacity but inconsistent logics underpinning their public stances. While the IMA has not always succeeded in achieving its stated demands towards policy issues, it has consistently been successful in influencing, stalling, or limiting legislation during development and/or implementation, particularly through its strong access to government administration and its campaigns to control public opinion. This success has been partial with big-ticket reforms, such as the CEA and NMC Acts, which were passed in spite of the IMA's resistance. Civil society groups presented opposition to IMA advocacy. The IMA was still able to impact the implementation of these reforms, such as capturing, stalling, or slowing the development of rules for implementation of these Acts, in favour of its professional interests through its access to government.

In this review, we highlight how the literature on the Indian Medical Association's policy stances shows a consistent focus within the organization around the preservation of biomedicine as the dominant system of medicine in Indian healthcare delivery, advocating for the interests of the private healthcare sector, and the protection of physician autonomy. Though these have evolved with the healthcare landscape in India, there is a through line to the origins of the Association. Early on, membership was oriented towards private practice, with this group retaining greater interest and capacity for advocacy than that of public practitioners (Jeffery 1977, Jeffrey 1985). As doctors in India continue to work in an under-regulated private practice, they have in turn looked to the IMA to protect related interests. This pattern has been observed in the literature on professional medical associations in many contexts, particularly in numerous examples of organized medicine opposing distributive health reform (Denis et al. 2023, Marchildon and Schrijvers 2011, Quadagno 2004). However, it should also be noted that the role of organized medicine in health reform debates is not uniform. Movements within organized medicine have advocated directly for policy supporting health justice or universal health coverage, such as in the case of Brazil and Thailand (Harris and Libardi Maia 2022, Ianni Segatto et al. 2020).

In the papers included in this review, authors frequently identified IMA stances seeking to defend or preserve the policy environment's status quo that has secured the organization's dominance in the health sector. Across the domains of traditional practice, private sector regulation, health insurance programmes, public health programmes and professional autonomy, the IMA has opposed new legislation wholesale, rejected or eroded provisions affecting the status of biomedical or private practice, or sought stricter enforcement of existing policy to enshrine the dominance of biomedical and/or private practice.

In this review, the IMA has been relatively inactive on issues of medical ethics but has defended itself against accusations of misconduct. Only in the domain of violence against doctors has the IMA advocated for the creation of new policy. While the IMA has not seen significant policy-level advancements in calling for new legislation for doctors' workplace protection, the association would appear to enjoy a defensive advantage in other policy domains, calling on existing relationships in the policy space, delaying or obstructing legislative processes and harnessing control over representations of public interest (Truman 1971). This is consistent with Mancur Olson's 'collective action dilemma', in which groups, such as organized professional associations, in a position to suffer the costs of policy reforms tend to be better organized and more powerful than groups of potential beneficiaries, such as general consumers, of those reforms (Campos and Reich 2019). This approach has been observed among peak or umbrella medical associations opposing or stalling health reforms that would diminish their advantage in financing and regulation, as we have seen in this study.

The IMA's focus on policies that affect the autonomy of the private medical profession, and the selective silence on issues such as ethics, pharmaceuticals, professional conduct, malpractice, and universal healthcare is revealing. The Association's choice to exert influence largely to protect the interests of private practitioners indicates that the IMA is currently more concerned with and proactive in ensuring it continues to be a beneficiary of the health system rather than a participant in achieving a robust and accessible public health system in India. In this way, with its outsized influence, the IMA functions, as noted by Nagral, to function more like a self-interested guild than a professional association, undermining professionalism (Nagral 2015, 2021). By Nagral's account, this narrowing and solidification of market interests has been increasingly characteristic of the IMA's activities since the 2010s (Nagral 2015, 2017, 2021). The nature of federalism in the Indian context also provides some important insights on the actions taken by the IMA. According to Immergut, the power of organized medicine depends on political and institutional context (1992). Applying this idea to the relationship between institutional context and the organization and function of national and provincial/state medical associations yields important insights. Based on our review, policy stances appear to be well-aligned across national and state branches of the IMA, with state legislation responses mirroring the stances of federal legislation responses in the same domains, especially in the case of private sector regulation. Advocacy at the national level is often characterized by its scale and aggression, with numerous nationwide protests and strikes carried out against policy reforms, effectively overwhelming public and administrative channels to stall legislation. Meanwhile, analyses of state- or city-specific policy issues indicate more calculated and concerted approaches by IMA branches. Studies of the Karnataka Private Medical Establishments Act document a more coordinated use of administrative access and social capital to influence the policy-making system. In this way, the national and state chapters of the IMA appear to be held together by a more cohesive ideological and organizational framework when compared to contexts such as the United States (Brophy and Sriram 2021a, 2021b) and also Canada (Marchildon 2016).

Drawing on interest group theory, IMA lobbying activities can be classified according to use of inside tactics or resources (i.e.

inclusion in decision-making) and outside tactics or resources (i.e. public arenas) (Kollman 1998, Binderkrantz 2005, Binderkrantz et al. 2015, Weiler and Brändli 2015, Hanegraaff et al. 2016). Taken alongside interior and exterior strategies, Wood's (2013) classification, in the context of middle class protest, of 'politicization', defined as a measure of engagement of politicians and government officials on issues through interior channels, and 'contentiousness', defined as a measure of generating public attention and friction around issues through exterior campaigning, proves a useful frame through which to understand the IMA's advocacy. While interest groups experience varying degrees of access to inside and outside resources mediated by their proximity to government, the IMA holds access to both arenas. This sets their actions apart from behaviours of many medical associations described in the literature till date.

Our analysis indicates that the IMA adopted two broad-based strategies for influencing health policy: interior strategies by engaging with processes across the policy cycle, and exterior strategies which include public advocacy, pressure building, protest, judicial intervention and even public misinformation campaigns (Table 3). Inside resources are secured through the IMA's intertwinement with health administration, with the organization channelling demands through existing working relationships to officials and holding a well-established role in policy consultation, development, and implementation processes. Moreover, the scale of the IMA's membership of private practitioners, strengthened when members overlap or interests align smaller adjacent groups such as specialized PMAs and hospital associations, earns it undeniable authority and sway to the government. IMA's external advocacy consists of public statements and announcements, press releases, public letters, petitions, nationwide and local protests or strike days, sit-ins and demonstrations, and case submissions against legislation. The discursive and material resources of the association, not distinct from those favoured for internal advocacy, enable high levels of coordination for concerted public action and for accessing media narratives that direct public opinion. Given that the IMA sits in an optimal location between inside and outside arenas, a theory of cumulative arena access may be applied, where for major policy players access in different arenas is cumulative and mutually reinforcing such that they dominate across all arenas (Binderkrantz et al. 2015). Interest groups act depending on policy context, i.e. relying on inside lobbying to increase success where media debates lack broad public approval (De Bruycker and Beyers 2019). Understanding the conditions under which different lobbying strategies are successful is more pertinent than focusing on whether inside or outside lobbying is inherently more successful (Lowery 2007, De Bruycker and Beyers 2019).

Interior strategies have amounted to varying degrees of success for the IMA. Participating in policy drafting processes, the IMA has produced significant pressure to weaken regulatory provisions over the medical profession and clinical establishments. Building formal and informal coalitions or alliances with similar organizations representing overlapping or aligned private interests within these closed policymaking environments has provided for more successful obstruction of policy development. Perhaps more telling, several studies find that the government anticipates IMA responses to policy processes and takes proactive measures to account for them, either by adjusting policy to the will of the IMA despite a detraction from equitable health outcomes, or by

Table 3 IMA interior and exterior engagement strategies.

Lobby	Strategy	References in review papers
Interior ('politicization')	'Operating' with administrative officials and committees	Jeffrey (1985) Wood (2013) Salve et al. (2018)
	'Operating' or conducting exchanges with politicians	Wood (2013) Vasan et al. (2017)
	Participation in policy drafting committees	Phadke (2016) Mishra et al. (2021a, 2021b) Putturaj et al. (2021) Hunter et al. (2022) Shukla et al. (2018) Salve et al. (2018)
	Coalition building or dominance over policy actors	Mishra et al. (2021b) Putturaj et al. (2021)
	Participation in implementation of policies or programmes	Engel and van Lente (2014) Salve et al. (2018) Majumdar et al. (2022)
	Exterior ('contentiousness')	Agitation/protest/demonstration/march/sit-in/strike
Petition		Jobert (1985)
Public statements (press announcements and releases, letters)		Frankenberg (1981) Jeffrey (1985) Ahuja et al. (2021) Phadke (2010) Raha et al. (2010) Srinivasan (2013) Chikermane and Kurian (2018) Nandi and Schneider (2020) Kelkar (2021b) Sujatha (2021)
Media invocation (newspaper op-eds, articles)		Samant et al. (2024)
Misinformation campaigns		Vasan et al. (2017)
Court Case		Bhat (1996) Raha et al. (2010) Hunter et al. (2022)

Table distinguishing between interior lobbying and exterior lobbying, the strategies included in each lobby type, and the titles of reviewed papers referencing each strategy are given.

moving legislation that the IMA is expected to disapprove of along in a swift and insular manner to limit interventions.

Exterior strategies are, by nature, more difficult to assess in terms of efficacy. Advocacy in public arenas such as the media is considered to contribute to broader agenda setting (Binderkrantz et al. 2015, De Bruycker and Beyers 2019) which, when diffused in an organized manner, can inform policy decisions through long-term, implicit processes of percolation (Contandriopoulos 2011). Authors in the review reference the IMA's campaigns against failed policies, but do not credit these failures exclusively to the association. The size, resources and networked authority of the association ensure swift and

widespread public action that garners substantial media attention; however, the reviewed works suggest that the logics and argumentation the IMA carries forward is less convincing. Various studies and commentaries dissect public campaigns and statements by the IMA, finding them to be misinformed, inconsistent, exaggerated, or excessively emotive. While the effect of this is difficult to tease out in the current review, it would appear that Indian policymakers are wary of where the IMA is adamant in its disapproval. In this vein, the aggression and grievance heavily associated with IMA public campaigning may be a tactic through which the association succeeds in provoking policy development spaces.

Ultimately, the IMA can produce a pronounced effect on policy when both inside and outside avenues are accessed, understood as interdependent through the theory of cumulative arenas. Outside lobbying serves to consolidate and reinforce stances and demands made through inside lobbying. Across different domains, particularly those of most contention for the association, such as private sector regulation and violence against doctors, the IMA alternated between informal interior channels or formal committees and large-scale protests or publicity campaigns to inundate policy discourses at the political and public levels alike. This functions to develop an unyielding, if inconsistent or exaggerated, stance and set of demands; while the full extent of such demands is rarely met, this aggressive approach can result in modest gains.

This review has several limitations. Themes identified are specific to the papers in this review; this omits other important policy issues in the health policy landscape where the IMA may be active, such as National Health Policy and family planning. Though IMA activities may be publicized or documented in commentaries and news media, they are not all studied empirically. Moreover, the papers under review are subject to varying degrees of bias, with some commentaries proposing more opinionated perspectives, as well as varying degrees of rigour in their analyses. Finally, certain papers speak to the Indian medical profession at large with some reference to the IMA, while others are specific to the IMA.

Conclusion

This scoping review sought to identify the policy stances, strategies, and influence of the Indian Medical Association over India's health policy. Uniquely, our review covered policy domains outside of health sector reform, presenting a more comprehensive understanding of the organization's actions in health policy. Reviewing 37 papers, it finds that the IMA has been active in seven main policy domains: violence against doctors; regulation of the private healthcare sector; restriction of traditional medicine; professional authority or autonomy for physicians; publicly funded health insurance; medical ethics; and partnership in public health programmes. It has been reactive against new legislation, reform, or regulation in all domains except for violence against doctors. Through interrelated interior and exterior strategies, the organization has been successful in influencing, stalling, or limiting legislation. While the IMA holds influence through the size of its membership and its embeddedness in health administration and corporate interests, the tactics of the organization often lack coherence and consistency. Situating these findings in the broader landscape of health governance, our review contributes further evidence for the need to develop more inclusive and transparent pathways for participation in decision-making.

Author contributions

Conception or design of the work—A.M., V.S. Data collection—A.M., V.S. Data analysis and interpretation—A.M., V.S., K.K., V.K. Drafting the article—A.M., V.S. Critical revision of the article—A.M., V.S., K.K., V.K. Final approval of the version to be submitted—A.M., V.S., K.K., V.K.

Supplementary material

Supplementary material is available at [Health Policy and Planning](#) online.

Conflicts of interest

The authors have no perceived or real conflicts of interest.

Funding

This study was funded by the Canada Research Chair Program (Veena Sriram).

Data availability

The data underlying this article are available in the article and in its online [supplementary material](#).

Ethical approval

Ethical approval for this type of study is not required by our institute.

Reflexivity statement

This research is focused on India, though it was conducted mainly at the University of British Columbia in Vancouver, Canada. The team also includes authors based at the O.P. Jindal Global University (Haryana, India) and the University of Pennsylvania (United States). All authors are of Indian origin or have mixed Indian origin. A.M. is an undergraduate research assistant at the University of British Columbia and was closely supervised by V.S. K.K., and V.K. provided comments and feedback throughout the writing process. V.S., K.K., and V.K. are mid-career and established researchers, having conducted and published research in public health systems and health policy in India.

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