Recontextualizing Physicians Associations: Revisiting Context, Scope, Methodology

A Draconian Law: Examining the Navigation of Coalition Politics and Policy Reform by Health Provider Associations in Karnataka, India

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Abstract

A comprehensive picture of provider coalitions in health policymaking remains incomplete due to the lack of empirically driven insights from low- and middle-income countries. We examine the politics of provider coalitions in the health sector in Karnataka, India, by investigating policy processes during 2016–2018 to develop amendments to the Karnataka Private Medical Establishments Act. Through this case, we explore how provider associations function, coalesce, and compete, and the implications of their actions on policy outcomes. We conducted in-depth interviews, document analysis, and non-participant observations of two conferences organized by associations. We find that provider associations played a major role in drafting the amendments and negotiated competing interests within and between doctors' and hospital associations. Despite the fragmentation, the associations came together to reinterpret the intentions of the amendments as being against the interests of the profession, culminating in a statewide protest and strike. Despite this show of strength, provider associations only secured modest modifications. This case demonstrates the complex and unpredictable influence of provider associations in health policy processes in India. Our analysis highlights the importance of further empirical study of the influence of professional and trade associations across a range of health policy cases in low- and middle-income countries.

Keywords Doctors' associations, hospital industry, coalitions, Karnataka, India, health policy, politics, power

Doctors' associations are major political actors in health policy around the world. The literature on the politics of medical associations in low- and middle-income countries (LMICs) is, however, sparse. The politics of doctors' associations in these contexts departs from their high-income country (HIC) counterparts due to specific configurations of policy networks, state involvement in health, and societal and professional hierarchies—many with

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the imprint of colonialism—that strongly shape the organizational character and policy objectives of associations (Johnson 1972; Nigenda and Solórzano 1997). Accelerating marketization of health care in many contexts is also reshaping power dynamics between doctors' associations and other stakeholders with increasing power, such as the hospital industry (Chakravarthi 2013; Lefebvre 2010)

Integral to the politics of doctors' associations is the way in which these groups engage in coalitions to impact policy outcomes. Coalitions have been well-established by scholars as an important factor in advancing or opposing health policy at the global, national and subnational level (Kwon 2007; Payán et al. 2017; Sabatier and Weible 2007; Shiffman 2016; Skocpol 1996). In LMICs, the formation of coalitions involving provider groups—including doctors and hospitals—is impacted by the heterogeneous landscape of associations (Alvarez-Rosete and Hawkins 2018). For example, in South Asia, medical associations exist along sectors (e.g., government doctors) and seniority (e.g., early-career doctors) (M. Gopinathreddy et al. 2006). As a result, provider coalitions in LMICs are more complex than what we might observe in high-income countries but not less important to achieving policy goals (Alvarez-Rosete and Hawkins 2018; Holcombe 2018; Mayka 2019). Organizations in these coalitions may also coordinate strategies, ranging from large-scale strikes (Russo et al. 2019) to direct access to decision makers facilitated by networks, elite status and dominance as biomedical practitioners (Agyepong and Adjei 2008; Holcombe 2018; Sriram et al. 2018). The organization, actions, and politics of these coalitions, however, remain a black box in many LMICs.

India's health policy landscape provides a unique context within which to examine the politics of doctors' associations and their behavior in coalitions. Interest groups in the provider space—including doctors' and hospital associations—are numerous and traverse

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national, state, and local jurisdictions. Coalitions are key to achieving policy gains nationally and within states (Gaitonde et al. 2017), and coalitions with provider groups at the center are increasingly gaining visibility in contemporary health policy debates in the country, such as prevention of violence against doctors and regulating medical education (Dhillon 2019; Sharma 2019). Yet, questions remain regarding how these coalitions involving associations come together, how they strategize and take action, and how these actions shape policy outcomes. These questions are particularly important in the context of states, which in India's federal system are primarily responsible for health policy. Investigating these questions is important to unpacking the influence of these groups on health policy and identifying the barriers and facilitators to equity-oriented policy development.

In this article, we examine the politics of provider-association coalitions in the Southern Indian state of Karnataka by investigating policy processes during 2016–2018 to develop amendments to the Karnataka Private Medical Establishments Act (KPMEA). Initially aimed at strengthening regulation of private health facilities, the amendments became a contested site for regulating the medical profession more broadly, culminating in a statewide strike of 50,000 doctors and other health workers (IANS 2017). Using a qualitative examination of KPMEA policy process, this case provides rich insight into how provider associations, notably the Indian Medical Association (IMA), lobby, function and strategize, and the implications of their actions on policy outcomes in India and potentially other LMICs experiencing similar issues. This case also provides fertile ground for examining the growing influence of the hospital industry in India and the ways in which doctors' associations and the hospital industry coalesce in order to achieve policy gains.

We argue that coalitions of doctors' and hospital associations operate in a landscape where, despite conflicting interests amongst coalition members, overlapping membership

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structures facilitated a coordinated stance by the associations and the strategic use of inside and outside lobbying to convey their policy stance. We show that while these coalitions ultimately only achieved modest gains for the coalition, their ability to temporarily overcome conflicts, build coalitions, and implement strategies such as large-scale strikes highlights a more fluid nature of power and partnership than we have hitherto observed in high-income countries.

Theoretical and Empirical Background

Doctors' associations occupy a unique space in the interest group ecosystem and remain the "paragon of professional power" in many settings (Peterson 2001). For decades, scholars in high-income countries have analyzed and debated the pursuit of professional self-interest by professional groups, including doctors' associations (Freidson 1970; Johnson 1972; Larson 1977; Saks 2016). The pursuit of these policies has been complicated by what scholars have characterized as the declining power of doctors' associations vis-à-vis industry actors (Peterson 2001; Starr 2017) and the growing fragmentation of medical associations along sectoral and ideological dimensions (Goldberg 2020; Peterson 2001). Recent scholarship has challenged this narrative by uncovering how associations buttress their power through the diversification of revenue sources and access to valuable positions in policymaking processes that further the economic interests of their members and affiliates (Laugesen 2016; 2019).

The literature on doctors' associations in LMICs presents a mixed picture of association interests, and their power to influence policy outcomes, unsurprisingly due to the impact of state power, configuration of service delivery and financing, and organization of civil society, among other factors (Duran-Arenas and Kennedy 1991). Doctors' associations are typically described in the literature as pursuing professional self-interest, such as

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opposing (often successfully) scope-of-practice modifications in the context of traditional healers, informal providers, and lower-level health worker cadres (Badejo et al. 2020; Cockcroft et al. 2011; Jeffery 1977). There are two important caveats to this claim. First, securing self-interest takes on different meanings for particular policy goals, such as striking to receive delayed salaries (Irimu et al. 2018). Second, associations have also acted against their presumed self-interest and promoted shifts in scope of practice for health services, such as emergency obstetric care and abortion (Holcombe 2018), for reasons of equity and access expansion.

The ability for associations to achieve their policy goals is shaped by historical trajectories, state power, and countervailing forces. Examples from Latin America illustrate this point. For decades, the medical profession in Mexico experienced pervasive fragmentation, divergent interests, and weak coordination, blunting the profession's pursuit of greater autonomy and power vis-à-vis the state (Nigenda and Solórzano 1997). Brazilian private sector providers found themselves unable to oppose or stall the development of a major health sector reform driven by a diverse reform coalition, but rather acquiesced to a system that allowed for increased societal participation in policymaking but maintained a mixed public-private arrangement (Mayka 2019). Faced with the possibility of health reform that could enhance their autonomy vis-à-vis powerful insurance groups, the medical profession in Colombia formed a coalition (*Gran Junta Medica*) encompassing key organizations representing the medical establishment; despite enjoying access to the highest levels of government, this coalition—and a competing progressive coalition—was unable to overcome the influence of a powerful coalition of government, as well as insurance and provider interest groups (Alvarez-Rosete and Hawkins 2018).

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As evidenced by the examples above, coalitions are an important determinant of success or failure in determining health policy outcomes, enabling interest groups to gain political attention through strategic advantages of coalition members, numerical strength, and projected unity (Heaney 2006). In OECD countries, the nature of health sector coalitions—formal and informal—operates in a neopluralist mode, rather than one dominated by a central actor. Even in these decentralized contexts, coalition leadership is key to ensuring policy success (Heaney 2006; Payán et al. 2017), processes that are undoubtedly aided by the presence of professional advocacy staff. Leadership of coalitions appears to be aided by long-term engagement on policy issues, the availability of organizational resources, and a clear mandate for the policy issue at hand and public perception (Heaney 2006; Mizrahi and Rosenthal 2001; Payán et al. 2017). While coalitions involving doctors' and hospital associations regularly feature in empirics from HICs, theory has not been tested in the context of doctors' associations in LMICs (see Alvarez-Rosete for a broader discussion of coalition politics in the health sector), where personal relationships and individualized leadership have also been found to be important in the context of health policy development (Dalglish et al. 2015).

The specific relationships of coalition partners, and the strategy that the coalitions use in pursuing their goals, is also salient (Hojnacki 1998; Weiler and Reißmann 2019). The mechanisms adopted by provider associations range from the highly visible "outside lobbying" approaches—which apply pressure on policymakers by going public, such as strikes, boycotts and marches (Kollman, Weiler, and Brandli; Russo et al. 2019; Harrison 1994)—to "inside lobbying" that is predicated on gaining access, such as bargaining, brokerage, and negotiation between association leadership, policymakers, and other stakeholders (Heaney 2006; Laugesen 2016). Scholars posit that mature interest groups, such

as organized medicine, rely less on outside lobbying for several reasons—fear of losing their "insider access" given their application of pressure on elected officials and other policymakers, the risk of a failed mobilization campaign, and the likelihood of conflict within the membership regarding a policy (Strate et al. 2005; Beyers 2004). However, outsider strategies such as public-facing media campaigns have been utilized when insider influence fails to yield results (Goldsteen et al. 2001; West et al. 1996). In the context of coalitions, Weiler and Reißmann (2019) find that intense collaboration amongst coalition members results in more use of insider approaches.

In summary, doctors' associations tend to pursue and protect professional self-interest, retaining economic, strategic, or occupational control (although recent evidence complicates this view). Similar to the behavior of other professional and trade associations, doctors' associations regularly form coalitions with other interest groups, such as the hospital industry, when aligned on a particular issue or policy goal. Groups with attributes such as organizational resources, policy niches, and/or longstanding policy experience often serve as coalition leaders. Professional and trade associations, including when in coalition, use insider and/or outsider approaches to pursue their particular policy goals. Using the KPMEA case, we will examine whether the IMA pursued self-interest by opposing policies that threatened their economic and strategic control and whether they formed coalitions with provider groups having shared interests. We will also explore the specific strategies—insider, outsider, or a combination of both—that were utilized during this process.

Methods

This paper discusses emerging findings as part of a broader cross-country comparison of medical associations in the U.S. and India. We conducted a case study of the policy process

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to draft and adopt amendments to the KPMEA in 2017, drawing upon in-depth interviews, document analysis of meetings minutes of the amendment committee and media reports on KPMEA amendments, websites and news bulletins of the IMA and other associations, and non-participant observations of two conferences organized by associations. Between July 2018 and March 2019, we conducted 22 in-depth interviews with office holders and members of the IMA national, state, and district chapters as well as members of other doctors' associations, members of the KPMEA Amendment committee, former government officials, and civil society members (though in many cases the members in each of these categories overlapped significantly). Respondents were asked to describe the policy negotiation processes, the relationship between stakeholders during these processes, their positions and the interests underlying these positions, and their strategies. We prepared detailed notes following each interview and observation, including verbatim quotes from the interviews. We drew upon these data to develop a detailed timeline of the case and then analyzed the interview data with the goal of understanding interests, strategies, and relations within the provider coalition and in the context of other key stakeholders. We presented early findings to stakeholders familiar with the policy process to amend the KPMEA in April 2019.

[Insert Table 1]

Case: The Karnataka Private Medical Establishment Act

The Indian health sector is heterogeneous in both financing and service delivery. Out-of-pocket expenditures account for 58% of health spending, with state-sponsored and private insurance steadily increasing over the last decade, covering approximately 25% of the population (Keshri and Ghosh 2020). The private sector accounts for 80% of outpatient and 60% of inpatient care (Patel et al. 2015). The regulation of the private health sector in India

has been a longstanding challenge (Nandraj 2019; Sheikh et al. 2013). Faced with growing privatization yet weak oversight, central and state governments have sought to institute measures to strengthen the regulation of the private health sector, to ensure affordable and equitable quality health care (Bhat 1996b; Rao 2012). However, the growth of the private sector also led to a mushrooming of associations representing the interests of smaller scale hospitals, corporate hospitals, and others that resist any overt form of regulation of medical practice and institutions (Baru 2013; Bhat 1996a; Premdas Pinto et al. 2018).

Karnataka is a state in southwestern India, with a population of approximately 61,130,704 (the eighth largest state in the country) (Government of India 2011). In recent years, administration of the state has oscillated between the Bharatiya Janata Party and a coalition of the Indian National Congress and a regional party, Janata Dal (Secular). In Karnataka, like other parts of India, the private health care system has grown exponentially in the last two decades, with a large number of private nursing homes, small hospitals, clinics and diagnostic centers offering both curative and preventive services (Baru 2006). Only 10.5% of the population is covered by some form of insurance, and 74.3% of health financing occurred through out-of-pocket payments (Ravi et al. 2016). Seventy-five percent of health facilities in the state are part of the private sector, with the majority of these facilities previously subject to little to no regulation, raising major concerns regarding the quality and affordability of services and care (Huss et al. 2011). Karnataka was also an early adopter of government-funded, privately delivered health care in India for low-income populations, amplifying concerns regarding the lack of regulation and its implication for equity (Kilaru et al. 2016).

In an effort to strengthen health care in the state, a task force was instituted by the Government of Karnataka in 2001 to make critical recommendations on equity, quality, and

integrity in health care (Government of Karnataka 2001). Along with several other recommendations, this task force drafted the bill on Karnataka Private Medical Establishments for ensuring common minimum standards for private health establishments through registration of the facility, accreditation, and transparency on services and fees. Ensuring that health facilities were adequately registered (i.e., formally permitted to exist by the state) and functioning within a system of oversight was an important aspect of ensuring quality. Nearly 7 years later, in 2007, the state legislature passed the KPMEA. Unusually, this Act explicitly mentioned the IMA as a member of the committee responsible for conducting an inspection and registering health facilities (echoing a similar arrangement in the neighbouring state of Maharashtra) (Chakravarthi and Hunter 2019). This act preceded the Clinical Establishment Act (Registration and Regulation) which passed at the national level in 2010 but requires ratification at the state level (although this was not required in Karnataka due to the passage of KPMEA).

KPMEA laid out clear guidelines for registration of all private establishments and mandated specific parameters on physical infrastructure, human resource requirements, operational procedures, and delivery reforms, such as mandating transparency in prices and ensuring private sector involvement in all state public health programs. However, the Act was very poorly implemented, even according to the Government (Government of Karnataka 2017). One report states that only 50% of private medical establishments were registered following the Act (Vasan, Premdas Pinto, et al. 2017). These failures have been attributed to faulty design (overriding focus on registration at the expenses of accountability), limited state oversight, poor coordination between actors responsible for enforcement, and overreliance on the arguably overburdened District Health Officer's team for implementation (Putturaj 2018; Vasan, Pinto, et al. 2017).

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[Insert Box 1]

[Insert Figure 1]

KPMEA had been amended with minor changes twice in 2010 and 2012 (Government of Karnataka 2018) . One primary impetus for a third set of amendments to KPMEA seemingly came from the reporting of gross violations of human rights in the wake of an "unusual large number of hysterectomy procedures without any medical justification" by private hospitals in northern Karnataka in 2015 (Premdas Pinto et al. 2018; Xavier et al. 2017). Civil society representatives had demanded a probe into these alleged violations, which prompted the attention of the National Human Rights Commission and the State Commission for Women; both groups confirmed the unethical procedures. These commissions also called for stricter accountability of the private sector by the state government. A new state health minister assumed office in September 2016 and was eager to strengthen regulation of the private sector through the amendments (Deccan Chronicle 2017).

A committee with the chairmanship of a retired High Court judge was constituted in 2016 with 30 members, including five provider associations (doctors and hospitals), two research institutes, civil society networks, and the Government (Government of Karnataka 2016b). Doctors were represented by the IMA, and hospitals were represented by the Association of Health Care Providers in India (AHPI), Private Hospitals and Nursing Homes Association (PHANA), Karnataka Private Medical Establishment Association (KPMEA), and Hospital Owners Association, South Canara. Table 2 provides further details on these associations.

[Insert Table 2]

The KPMEA amendments focused on two major provisions that included (a) laying out the charter of patients' rights, instituting grievance redressal mechanisms, and monetary

penalty measures; and (b) standardizing the cost of treatment and procedures. The key features of the amendment are provided in Table 3. The amendments were passed in 2017 and formalized in 2018 (Government of Karnataka 2018).

The policy process to finalize the spirit and content of these amendments was mired in controversy and tensions across the three key sets of policy actors including the government, provider associations (doctors' and hospital associations), and civil society representatives. These negotiations also occurred in a complex political context with the ruling and opposition parties taking contrasting positions (Vasan, Pinto, et al. 2017). Here, we focus on the dynamics of doctors' and hospital associations in shaping policy outcome.

[Insert Table 3]

Results

Formation of the Coalition

The core features of the KPMEA amendments—regulation of prices and the grievance process—were of greatest concern to the IMA according to respondents and document analysis. These interests were also shared by the hospital industry. As noted in an early proceeding of the amendment committee meeting, "Charges by the hospital should be self-regulatory, it should be displayed and counseling with patients should be done prior to treatment" (Government of Karnataka 2016a, Proceedings of Amendment Committee Meeting). In a reflection of the diversity of the private health sector in India, the industry was represented by a number of organizations. One of the key players was the Association of Health Care Providers in India (AHPI), an industry group established in 2012 to represent primarily large-scale hospitals but also diagnostic centers, equipment and device companies, and even insurers, with strong roots in Karnataka. Its overall strategies in policymaking were

considered by respondents to be more proactive with multi-sectoral collaborations, including setting up a policy "think tank" in a premier law university. These activities were facilitated by the robust elite networks of its founders and the presence of a permanent staff to run the organization's affairs, a rarity with provider associations in India. AHPI played a key role in drafting the amendments in the initial stages of the policy process. Similarly, the Private Hospitals and Nursing Homes Association (PHANA), an association representing small-scale hospitals primarily in the state capital Bengaluru, played a critical role during the amendment process.

Respondents noted that the boundaries between doctors' and hospital associations was overlapping. The IMA is the oldest and largest doctors' association in the country, with 1,700 local branches in 29 states and union territories with approximately 300,000 doctors as members, wielding power through its historical legacy and numerical strength (Indian Medical Association n.d.). The large scale ownership of private health facilities by doctors therefore created an overlap in membership between doctors' associations and the various manifestations of the hospital industry. This overlapping membership came into play at later points in the policy process.

"IMA is an association for all doctors. However, there is no strict separation. As I mention IMA is the mother body, those who are part of IMA will be part of AHPI, ANBAI like that" (Office holder, AHPI).

Navigating Coalition Politics during Amendment Negotiations

In the KPMEA amendment process, AHPI took on a major role according to respondents involved in the process. While IMA had the advantage of membership, AHPI had more organizational resources, as well as a policy niche (Peterson 2001). As noted by a KPMEA

amendment committee member, “IMA was there but more than IMA, other associations like AHPI seemed more powerful and influential in these deliberations.”

The leadership of AHPI did not mean that the hospital industry spoke in unison. Rather, the deliberations brought to the fore tensions between “corporate hospitals and small hospitals,” due to a sense that the KPMEA standards were too onerous on small hospitals and would result in their closure. Conversely, small hospitals believed that corporate hospitals were largely responsible for excessive pricing, noting, “KPMEA is not needed for small hospitals and clinics, it is needed where hospitals are largely for profit like the corporate hospitals” (Former office bearer, a senior member IMA). This conflict drew in the IMA, which had been playing a relatively passive role, given overlap in the interests with the associations representing small hospitals and clinics. The boundaries between the IMA and associations representing small hospitals such as PHANA were therefore often blurred during these deliberations, although individuals with dual membership would strategically and selectively pivot between IMA and other associations representing interests of small hospitals membership depending on the issue at hand while articulating against the interests of associations representing bigger hospitals (seen as the purview of AHPI).

At another level, the resentment of the associations representing small hospitals against the Act was directed toward the government, suspecting their intentions for the amendments to be more “populist” and lacking serious concern about patients’ interests.

> It looks like the Government wants to close down all small hospitals by putting down so many conditions. Ultimately the patients will only suffer as they will have to depend on big corporate hospitals where costs are very high (KPMEA member amendment committee/IMA office holder)

Yet all associations concurred that the amendments should apply to both government and private facilities, despite the original intention of the Act to regulate the private sector. The reasons for this were based in the perception that government hospitals were held to a "lower" standard when compared to private hospitals, compromising the stated policy goal of quality health care. Associations were also unified in their opposition to proposed price regulation, which would in their collective view drastically reduce their revenue sources. Finally, the associations believe that the district-level patient grievance redressal mechanism for violations was a sign of over-regulation and that measures were already in place to protect patients. As noted by an IMA member, "There are about seven different forums where my professional work can be challenged. This is not about professional work. This is about medical establishments, whether the establishment is providing the basic facilities, is it maintaining the standards that are required, that's it, it's not about regulating my work."

Their pressure appeared to achieve initial gains. The committee noted in their report that the Act should be applicable to government facilities, despite fierce opposition from the civil society representatives, who believed that the private sector had been permitted to function with negligible oversight while government institutions were subject to considerable scrutiny through public accountability mechanisms.

Balancing Insider and Outsider Lobbying Strategies

While the associations successfully wielded power in drafting the amendments during the committee stage, the government pushed back on some of their recommendations. The government decided to limit the Act to the private sector alone, strengthening the charter of patients' rights with adequate grievance redressal mechanisms at the district level and introducing price regulation of treatments and procedures (Vijay 2017). The government also

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made their intentions public by announcing the report through a press conference, drawing sharp reactions from the associations (The Hindu 2017). At this stage, respondents noted that the associations closed ranks, facilitated by overlapping interests and overlapping membership structures. As noted by an AHPI office holder, "This was something no doctor or association would be comfortable with…. So we discussed it among ourselves and decided to fight." The opposition to these amendments witnessed several lobbying strategies, some of which are discussed below. In addition to these strategies, the associations employed other approaches such as engaging with opposition political parties, as well as informal communications between associations and lawmakers (Putturaj 2018).

Building support by reshaping the narrative. Associations began to define their opposition and, in the process, reshaped the spirit, intentions, and content of the KPMEA. Earlier discussions and debates about quality of care and the tension between profit and service orientation of hospitals were replaced by the projection of a highly vulnerable profession that was overregulated by the government. The arguments against regulation were expressed in terms of: (a) misplaced intent of the government to gain sympathy; (b) lack of proper infrastructure within government hospitals themselves; and (c) biased treatment of medicine compared to other professions, particularly the legal profession. The projected vulnerability and unfairness to the doctors featured across different forums including issuing media statements and articles in the newsletter of the IMA Karnataka chapter (IMA Bulletin, Bangalore Branch, February 2018) that was circulated to all the members in the state/district chapters, and reiterated in meetings and conferences to ensure a united voice. Projecting unity was important in bringing together associations and members of the profession who were not actively involved in the amendment discussions, such as government doctors' associations, which offered "moral support being part of the medical fraternity" (Member, Government

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Medical Doctors Association). The narrative of the associations successfully shifted from a focus on the private sector to the medical profession *as a whole.*

The projected vulnerability of the medical profession also weaved narratives of the overall lack of trust in private sector doctors from the viewpoint of the government and civil society.

"The politicians are against us, the Judiciary is against us, nobody is with us so we have to get back the credibility and all of us have to strive for it" (Member, PHANA).

> The private healthcare sector caters to 80% of the population and it is unfair to bring in such unrealistic amendments (to the Karnataka Private Medical Establishments Act) without taking us into confidence. We are not against regulations but the proposed amendments are draconian and will only result in more inconvenience to patients (IMA Karnataka State President quoted in The Hindu, November 2017)

Expanding support through the WhatsApp group "Oppose KPMEA." One of the forums for building support for opposition to the Amendments was the use of the messaging technology, WhatsApp, a commonly used mobile application across India. According to respondents, a WhatsApp group "Oppose KPMEA" was created for sharing information about why the amendments imperiled medical practice and why it was important to oppose. Respondents reported that the information shared on the forum heavily focused on: (1) the unfair targeting of the private sector; (2) the negative of impact of price regulation on health facilities; (3) the establishment of additional grievance redressal mechanisms; and (4) the increase in punitive measures, such as potential jail time for individuals in violation of the amendments.

According to respondents, the WhatsApp group facilitated a united stance among the medical profession in Karnataka, and the versions promoted by the associations began to gain

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traction publicly. Civil society groups also created online forums to share "correct" information about the amendments (*KPME-Yake* n.d.). Government representatives too issued clarificatory statements in the media countering the narrative propagated by the associations.

> Terming the doctors' agitation against the amendments as one driven by misunderstanding, Mr. Kumar [the health minister] said that the amendments were driven by State government's commitment to realise the goal of universal healthcare and not by any ill-intention against private practitioners (The Hindu November 19, 2017)

Formalizing the coalition. Beyond these existing forums, the associations sought more formal mechanisms to project collective strength and more effective strategizing. Associations were cognizant of the fact that the provider groups, such as the IMA and the hospital associations, had their own priorities and interests as well as varying levels of organizational capacity and strategic ability. For an effective policy stance against the KPMEA amendments, associations realized the need to come together through a formal network. As one of the members of the private hospitals and nursing homes said,

> The government does not take individual associations seriously. So it was important for all of us to come together under one umbrella to strengthen our advocacy. We know that engaging with Government requires strategies which need to be consistent, continuous, more organized with inputs from legal and management streams (Office holder, PHANA)

This realization led to the formation of a formal coalition, the Federation of Hospital Association of Karnataka (Putturaj 2018). The role of the coalition was to ensure the

common policy stance against the amendments, decide on the key strategies (including collating evidence), and present it to the government.

"Belagavi Chalo": Strikes against the Amendments

The associations launched plans for a strike against the proposed amendments in early November 2017, and the IMA began to reach out across its membership, other associations, the medical profession, and para-medical associations to join the strike.

"Doctors from across the State representing various associations, including the KPME association, would participate" (State Branch, President IMA, quoted in The Hindu November 2017).

Notably, other associations looked to the IMA to lead the strike because of the numerical strength and its reputation as historically representing the profession. One IMA member said, "They [hospital-based associations] wanted IMA lead the strike as IMA has the numbers."

Media reports indicate that up to 50,000 doctors in Karnataka went on strike, and 25,000 doctors staged a protest at Belagavi, the site of winter session of the Karnataka state legislature (IANS 2017). Such a strike, although not unprecedented in the state and nationally, received extensive attention in the media due to the shutdown of a vast majority of health care in the state. The projected collective strength of the profession was reiterated through images of banners of different associations and giving statements on the united opposition by doctors, nurses, paramedics, and other cadres. Notably, several members interviewed joined the strike out of a moral pressure to support the IMA but acknowledged that they lacked clarity on the specific content of the KPMEA. A senior member of Federation of Obstetric and Gynaecological Societies of India stated,

> For KPMEA we went to Belgaum and shouted slogans. No one knew what is KPMEA and what it is about, but we said anyway we will go, some of us who tried to understand it got confused. Each one said one thing and finally a third thing came out of it. So, regarding the KPMEA, it was all confusion.

The national IMA supported the mode of opposition echoing the predominant narrative of favoring patients' right over doctors. While the strike intensified the opposition, civil society groups rallied behind several other networks of laborers and farmers to show their collective strength of being pro-patient and appealed to the political parties not to succumb to the pressure of the private sector (*KPME-Yake* n.d.).

"We urge all the MLAs to respond to the pain and suffering of patients who bear the brunt of exploitation by private hospitals. We urge MLAs to unanimously approve the amendments to the Act (Vasan, quoted in The Hindu November 2017).

Amendments: A "Compromised Success"

The massive demonstration by the medical profession was heralded as a success story of collective action by the associations themselves. However, a planned extension to the strike was called off due to an intervention by the High Court of Karnataka, directing facilities to resume services (Scroll.in 2017). Provider associations were also given a four-hour closed door meeting with the Chief Minister immediately following the strike (DH News Service 2017). Despite the jolt to the process, the demonstration only manifested in modest gains (Deccan Herald 2017; Mint 2017).

Much against the medical community's wishes, the government included private facilities alone under the purview of the act, strengthening the charter of patients' rights and the grievance-redressal process. These were in broad concurrence of the civil society efforts

(Karnataka Janaarogya Chaluvali 2017). Another contentious clause was the capping of prices of services by the government which was vigorously opposed by the associations. This clause, though included, was deferred by the establishment of an "expert" committee which would recommend uniform package rates for private health facilities participating in government-funded insurance plans.

However, members of civil society, on the other hand, were supportive of certain "citizen-centric" aspects of the amendments but criticized what they considered a "watered down" set of policies that appeared to have been drafted in "collaboration with the private medical establishments" (Karpagam 2018). For example, in their view, the proposed composition of the price setting committee did not have sufficient representation from public and civil society stakeholders. This concern appears to have been well founded, as the committee that was finally named in 2019 includes representation from the KPME Association (whose President noted that they are working with the IMA on analyses for recommending prices) (The Hindu 2019). Provider associations were able to retain the representation of IMA as well as a representative of the largest hospital association of the district in the Registration and Grievance Redressal Authority. The committee thus includes a member of the IMA, a representative of another registered association that represents private medical establishments and has the largest membership in the district. Discussing the issues of representation on the district level authority, "We said it can't be handled by activists. These are medical matters." Finally, associations were able to drop the imprisonment clause for doctors except in the case of failing to register the establishment (Mint 2017). Activists were also skeptical about its viability given leadership changes in the Health Ministry, reflecting an overall uncertainty about the implementation of the KPMEA amendments.

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Discussion

This article provides some of the first evidence and analysis regarding the politics of provider associations and their behavior in coalitions in the Indian health sector. Supporting existing theory, doctors' and hospital associations did pursue their interests in opposing private sector reform (Freidson 1970; Saks 2016; Starr 2017) and joined in coalition to do so (Heaney 2006). Our analysis extends this theory by highlighting the heterogeneous nature of interests within the coalition, yet the ability of coalition partners to overcome these conflicts and coalesce under the stated umbrella of threats to the medical community. Our analysis also shows that coalition leadership was not the purview of the IMA; rather, the IMA as an organization played a more passive role until it was needed for mobilizing its membership and the medical community at large for a statewide strike. The overlapping membership between small-scale hospital associations and the IMA also resulted in fluidity in terms of coalition leadership. These aspects of coalition politics depart from what is typically observed in high-income countries. Despite a seemingly well-organized coalition, associations were only modestly successful in modifying the amendments in their interest, indicating that their influence is modulated by the government, political parties, and civil society, as observed in other LMICs (Alvarez-Rosete and Hawkins 2018; Mayka 2019).

In this policy case, associations used both inside and outside lobbying, similar to what is observed in wealthy countries. However, these strategies did not yield similar results in terms of policy. The insider and outsider approaches mutually facilitated gains at various points in the process, the clearest example being the closed door session held by the provider associations and the Chief Minister following the strike. Yet these approaches were only partly successful. This study is also among the first to comment on the use of messaging technologies such as WhatsApp as an advocacy tool and its role in facilitating common

stances, a strategy that must be considered in the context of the growing use of social media for organizing within doctors' associations (Tully and Ekdale 2014). Further research is needed to understand how national, state, and local associations balance insider and outsider approaches in the context of national and state health issues, an issue that gained particular traction in India in 2019 with widespread strikes across the country against the National Medical Commission Bill and opposing violence against doctors.

The findings of this study should be considered in the context of certain limitations. We were unable to explore the underlying connections between associations and political parties, which might have played a role in shaping the outcomes of the policy (Mint 2017). We were also unable to secure interviews with certain individuals within the government due to their level of seniority in the administration.

Conclusion

In this article, we have shown that in India, the politics of health provider associations, and their behavior in coalitions, is complex and fluid. Our analysis highlights the importance of further empirical study of the role of health-worker associations across a range of health policy cases in LMICs in order to expand our understanding of these important, yet underexamined stakeholders.

■■■

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Table 1 Summary of Tools Used

Methods	N=	Category/description
In-depth interviews	22	IMA – 7 (3 office holders, 4 members) Researcher/civil society representatives – 5 PHANA office holders [2] AHPI office holders [2] Former government officials – 2 Other associations (Federation of Obstetric and Gynecological Societies of India, Association for Medical Consultants, Alliance of Doctors for Ethical Medical Care, Karnataka Government Medical Officers' Association) – 4 [5 respondents were members of the amendment committee]
Media analysis	55	National English-language daily newspapers – The Hindu, Deccan Herald, Times of India, English-language and Kannada-language TV panel discussions
Document review	24	News bulletins of IMA, Minutes of meetings of the amendment committee, Government circulars relating to KPMEA, websites of professional medical associations
Non-participant observation	2	Conferences organized by the Indian Medical Association

Table 2 Medical Associations Involved in Committee to Draft Amendments[1]

Association	Stakeholders	Composition
Indian Medical Association [established in 1928]	Doctors of 'modern scientific system of medicine '(membership is largely in the private sector although open to doctors practicing in all sectors)	Number of chapters nationwide etc. 1700 local ranches in 29 state and union territory branches [305, 458 members]
Association of Health Care Providers in India [AHPI] 2012	Private health providers, including hospitals, nursing homes and clinics, diagnostic centers, medical equipment companies and insurance providers	National headquarter in the capital city, 29 state chapters 6 partner associations including IMA, NAThealth, CAHO, ANBI, AMED, ANEI, [www.ahpi.in]
Private Hospitals and Nursing Homes Association [PHANA], 2000	Private hospitals and nursing homes in Bangalore	Bangalore city, Karnataka state only [approx. 290-300 hospitals/nursing homes in the city as members]
Karnataka Private Medical Establishment Association [KPME Association] 2000	Private hospitals/nursing homes in Hubli/Dharwad, Shimoga, Hassan	Private hospitals and nursing homes around the specific region in north Karnataka [approx.. 200 members, website not available information obtained in interview]
Hospital Owners Association, South Canara	No information available	No information available

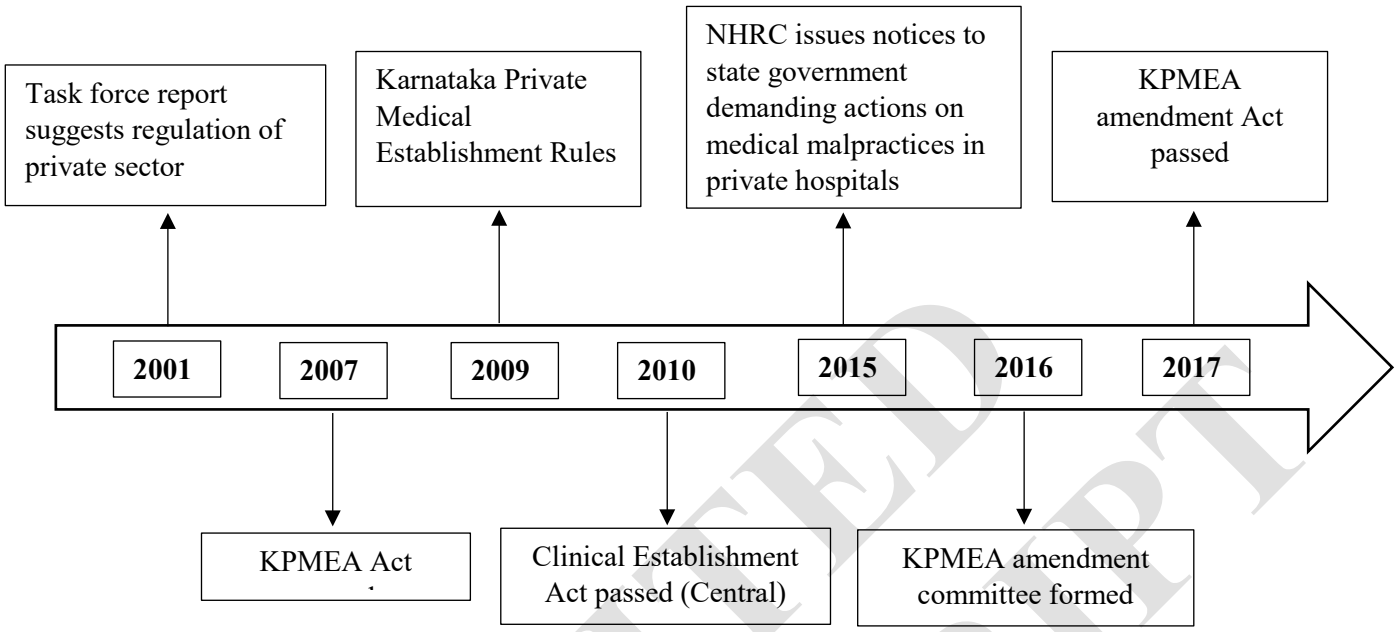
[1] Websites of IMA, AHPI, PHANA, interview data

Table 3 Key Provisions of KPMEA 2007 and the KPMEA Amendments 2017

Key Provisions	KPMEA – 2007	KPMEA Amendment – 2017
Registration of medical establishments following specific guidelines on physical infrastructure, equipment, and human resources	Registration authority that would conduct inspection included representatives of the IMA and the state government.	• Registration authority replaced with Registration and Grievance Redressal Authority: • Representation expanded to include representatives of IMA, another professional medical association, and a woman member (social worker, academic or a medical professional)
Transparency through display of charges for services offered by the establishment	The schedule of charges for various treatments to be displayed on the establishment in the form of brochures or booklets.	• The establishment has to prominently display the system of medicine authorized to practice, along with contact details of the establishment, and the charges of procedures • Information was also to be made available on the government portal and website, along with brochures and booklets
Punitive actions failing to conform to the guidelines of registration and other requirements prescribed by the Act	• Running a medical establishment without registration can be punished with imprisonment for up to three years and with a fine up to INR 10,000 • Failure to maintain clinical records and refusal to provide a copy of clinical records to patients can be punished with imprisonment up to six months and with a fine up to INR 2000; in case of a subsequent offence,	• The fine amount for running a medical Establishment without registration increased up to INR 100,000 • Imprisonment clause retained same as in 2007 (imprisonment for doctors only in the case of failure to register the establishment) • In case of a complaint from a patient regarding over charging, a penalty equivalent to one and half times of the overcharged amount can be levied from the establishment.

	imprisonment may extend to one year and fine may extend to INR 5000	
Standardisation of infrastructure, staffing pattern and staff qualification Standardisation of protocols for treatments and procedures Standardization of price through uniform package rates under the health care assurance schemes	None	An expert committee would be appointed to execute the following tasks: • Develop classifications, standards of infrastructure, staffing pattern and staff qualification of the establishments • Recommend standard protocols for treatments, procedures and prescription • Recommend uniform package rates for healthcare assurance schemes of the State Government for participating private medical establishments
Patients' charter	None	• Introduction of patient and establishment charter which spells out patient's rights, patient's responsibilities and private establishment responsibilities. • Every patient or authorized family member and Private Medical Establishment have right to make complaint to the Registration and Grievance Redressal Authority.

Figure 1 Key milestones in the KPMEA amendment policy process.



Box 1 Definition of Private Medical Establishments

"Private medical establishment" defined as a hospital or dispensary with beds or without beds, a Nursing Home, Clinical Laboratory, Diagnostic Centre, Maternity Home, Blood Bank, Radiological Centre, Scanning Centre, Physiotherapy Centre, Clinic, Polyclinic, Consultation Centre and such other establishments by whatever name called where investigation, diagnosis and preventive or curative or rehabilitative medical treatment facilities are provided to the public and includes Voluntary or Private Establishments (KPMEA 2001).