Neoliberalisation enacted through development aid: the case of health vouchers in India

Article (Accepted Version)

Hunter, Benjamin M, Bisht, Ramila and Murray, Susan F (2020) Neoliberalisation enacted through development aid: the case of health vouchers in India. Critical Public Health. ISSN 0958-1596

This version is available from Sussex Research Online: http://sro.sussex.ac.uk/id/eprint/91257/

This document is made available in accordance with publisher policies and may differ from the published version or from the version of record. If you wish to cite this item you are advised to consult the publisher’s version. Please see the URL above for details on accessing the published version.

Copyright and reuse:
Sussex Research Online is a digital repository of the research output of the University.

Copyright and all moral rights to the version of the paper presented here belong to the individual author(s) and/or other copyright owners. To the extent reasonable and practicable, the material made available in SRO has been checked for eligibility before being made available.

Copies of full text items generally can be reproduced, displayed or performed and given to third parties in any format or medium for personal research or study, educational, or not-for-profit purposes without prior permission or charge, provided that the authors, title and full bibliographic details are credited, a hyperlink and/or URL is given for the original metadata page and the content is not changed in any way.
Neoliberalisation enacted through development aid: the case of health vouchers in India

Abstract
Despite a history of critical scholarship on development aid and neoliberalism in public health, very little specific attention has been drawn to how a tripling in aid commitments in the health sector after the Millennium Declaration created new opportunities for the advancement of neoliberal ideas and practices. Here we examine an externally funded aid project in Uttar Pradesh, India that seemed to embrace important public health and access to care concerns but that can also be understood as part of a larger – and damaging – ideological project. We adopt a contextualising and process-oriented understanding of ‘neoliberalisation’ to examine its design and enactment. We also show how these policies were unevenly resisted and advanced by the politicians and civil servants who were expected to guide them through different levels of government on the way to implementation. On the frontline, programme workers and users tactically re-interpreted the notion of ‘choice’ to serve their interests in ways that were not anticipated by programme designers. In the case of the programme workers these reflected the individualised performance targets set up by the programme and an existing culture of clientelism. Our analysis challenges uncritical portrayals of development assistance for health as a beneficent reallocation of resources.

Keywords
Neoliberal; development aid; USAID; India; health systems
Introduction

Advocacy for development assistance for health often assumes beneficence; an assumption that is implicit in calls for governments and other actors to increase pledges to development aid. However, the potentially adverse effects of ‘aid’ projects had been highlighted in a significant body of work that critiqued the ways in which ideologically driven multilateral and bilateral development aid programmes undermined public health during structural adjustment reforms during and following the 1980s and 1990s (Keshavjee, 2014; Lister and Labonté, 2009; Rao, 1999; Turshen, 1999), and in particular the inequities associated with user fees introduced in that period (McIntyre et al., 2006; Ridde and Morestin, 2011; Russell and Gilson, 1997). Such critique has often been side-lined in analyses of development assistance for health in the period since 2000 – a period described by one influential US-based institution as a ‘golden age’ for global health financing (Institute for Health Metrics and Evaluation, 2012) during which substantial increases in development assistance for health commitments have been given (Dieleman et al., 2016) and which led to sympathetic calls from leading commentators to maintain and increase such funds (Jamison et al., 2013; Sachs, 2010).

Critical attention has tended to focus on the influence of new commercial actors such as philanthrocapitalists in global health governance (Birn, 2018; McCoy et al., 2009; McGoey, 2012), a public health agenda reliant on private for-profit actors (Birn et al., 2016; Qadeer and Baru, 2016), and the implications of new global health initiatives such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, Gavi and the US President’s Emergency Plan for AIDS Relief (PEPFAR) (Buse and Walt, 2000; Ruckert and Labonté, 2014; Storeng, 2014) and their relative (mis)alignment with health priorities and needs for recipient countries (Hawkes et al., 2017; Mwisongo and Nabyonga-Orem, 2016; Oliveira Cruz and McPake, 2011). Far less critical attention has been devoted to the bilateral programmes that took place during this period (see Tejerina et al., 2014 for one exception).

We address this issue with a case analysis of a development assistance for health initiative in India focused on improving reproductive and maternal health for the poorest. Our aim is to highlight how international aid which seems to embrace important public health and access to care concerns can be part of a larger – and damaging – project of neoliberalisation, and we use a detailed case to explore the complex processes of negotiation between different interest groups as attempts are made to roll this out. The subject of our attention is an initiative driven by the US Agency for International Development (USAID) together with the Indian federal government to promote private sector engagement in Uttar Pradesh’s health sector during 1992-2013. This was a context characterised by a neglected government healthcare system skewed towards overburdened urban
hospitals, and an extensive system of private healthcare provision (Baru, 1998; Chakravarthi, 2013), that included charitable hospitals but which was primarily characterised by informal and formal for-profit private provision (Gautham et al., 2019). ‘Dual practice’ by physicians in the public and private sectors, although officially prohibited, persists and blurs the boundaries between these systems (ibid.). Launched in Uttar Pradesh during the structural adjustment period of the 1990s, the Innovations in Family Planning Services initiative was later expanded to include neighbouring Uttarakhand (and to a lesser extent Jharkhand) after its creation in 2000, and was then awarded new funds and extended during the 2000s with a revised goal to develop ‘public-private partnerships’ (understood in project documents and in this article in terms of service delivery models incorporating private actors - see Languille, 2017 for a fuller conceptual examination) for future scale-up. In this article we analyse the detail of one of its projects – the Sambhav health voucher and contracting scheme – and demonstrate the importance of paying attention to context and processes, to subjecting the motives and ideological underpinnings of such initiatives to scrutiny, to considerations of the state not as monolith but as institutional actors at different levels with differing interests, and to highlighting responses in target local communities in urban slums. We conclude by arguing for greater scrutiny of implicit market-oriented aims underpinning development assistance for health.

From neoliberalism the monolith, to neoliberalisation processes

The theory of neoliberalism has offered a compelling narrative for the politics, policies, state-forms and social relations which characterise contemporary capitalism (England and Ward, 2007). It is often understood using Harvey’s (2005, p. 2) definition as ‘a theory of political economic practices that proposes that human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterized by strong private property rights, free markets, and free trade.’ From a public policy perspective, the advancement of neoliberal theory has been associated with a ‘new public management’ paradigm that redefined public service provision through transparent accounting processes, contractual agreements, purchaser-provider distinctions, and competition between governmental and non-governmental bodies (Denhardt and Denhardt, 2000; Dunleavy and Hood, 1994).

Scholars such as Barnett (2005), Larner (2000), Peck and Tickell (2002), Ward and England (2007) and Bell and Green (2016) in this journal have observed that this meta-level narrative tends to obscure the processes, complexities and contradictions that have emerged: as Larner (2003) puts it, the variegated forms that neoliberalism takes in different settings. Ward and England’s (2007) edited...
Neoliberalization: states, networks, peoples remains perhaps the strongest contribution to understanding neoliberalisation processes, by using detailed case studies ranging from the negotiated enactment of microfinance in Nepal to the frontline of time-pressured home care services in Canada. Their volume highlights the importance of knowing how people experience and enact neoliberalisation in ways which ‘bring the political project to life, to make it real’ (p. 20). Here we too wish to pay particular attention to the roles of states and people within a contextualised neoliberalisation process: to the varied resistance, collusion and expediency amongst sub-national politicians and technocrats, and to the ways in which such aid programmes are understood and implemented by actors in local communities.

Choice of case and methods

By taking a multi-level approach that looks at the funder’s accounts of their initiative over time, the responses of domestic political institutions, and the conduct of the project on the ground, we aim to make a contribution to the understanding of how healthcare provisioning can become a field in which the processes of neoliberalisation play out. The findings reported here are drawn from doctoral research conducted by the first author with supervision from the co-authors, that explored how aspects of healthcare commercialisation were driven by development aid in India. Its focus was the widespread promotion by the World Bank and USAID during the Millennium Development Goal era of voucher and contracting schemes (USAID, 2006; World Bank, 2003, 2005), which promote markets in healthcare through contracting arrangements that offer opportunities to develop competitive processes for provision, management, community work and evaluation services. One such vehicle which we study in some detail is the Sambhav voucher and contracting scheme.

Sambhav is a Hindi word meaning ‘possible’, implying that private healthcare services would become possible for eligible low-income families, and ‘user choice’ was central to the ideological underpinnings of the market for healthcare consumption planned for the Sambhav voucher and contracting scheme. In the five Uttar Pradesh cities that participated in the scheme, lay community health workers were allocated vouchers to distribute in slum communities. Women and their families could exchange those vouchers for free maternal and reproductive healthcare services at any one of the accredited private hospitals in the city – up to 20 depending on the city. The Sambhav scheme included no formal role for the government facilities providing such services, rather its designers expected the government’s National Rural Health Mission to regulate (and eventually fund) a market of accredited private hospitals. Many aspects of the project were outsourced. A non-governmental organisation, the State Innovations in Family Planning Services Agency (SIFPSA)
managed the programme; development consultancies designed and produced programme materials; and non-governmental organisations and governmental agencies were contracted to organise voucher distribution.

The analysis in the first and second sections of this article’s findings draws on texts produced by and for Innovations in Family Planning Services project funder, USAID. These published and unpublished programme and strategy documents related to the Innovations in Family Planning Services Project or its sub-projects, and included project proposals, evaluation reports and an audit report. The third section of the findings brings in fieldwork focused on one of the public-private partnerships pursued by the Innovations in Family Planning Services Project - the Sambhav scheme. That fieldwork was conducted during the final year of programme implementation in the city of Lucknow, Uttar Pradesh, and in the year following the programme’s termination. The first author visited Lucknow three times during 2013 and 2014 to observe the day-to-day enactment of the programme and hold conversations and conduct interviews with relevant actors. Each visit lasted around 6 weeks, during which observations and conversations were recorded in field-notes, and semi-structured interviews were conducted with 41 people. They were selected purposively based on the interviewee’s involvement with the Sambhav scheme, contacted by phone and invited to participate in the research. Interviewees included: programme managers, hospital owners and clinicians, community health workers and supervisors, and women and families who were voucher users. Ethics approval for the research was obtained from King’s College London and Jawaharlal Nehru University Centre for Social Medicine and Community Health. The aims of the research were explained to respondents and they were invited to participate in the research and to complete an English- or Hindi-language consent form. Interview questions examined the Sambhav scheme’s aims, and how design features were expected to contribute towards meeting those aims. A research assistant who was fluent in English and Hindi provided interpretation and translation services.

Thematic analysis was performed on this combined dataset, informed by critical theoretical perspectives on neoliberalisation. An initial set of structural codes were generated during and following the data familiarisation process after the first visit to Lucknow, and the codes were then developed into themes and sub-themes that grouped codes and represented a more implicit, theoretical process. The codes and themes were revised during and following subsequent visits.

Here findings are presented in three sections: programmatic design promoting neoliberalisation; the context and ‘messiness’ of local politics through which programme adoption was resisted, supported...
and subverted; and the unexpected interpretations by programme workers and users during the policy implementation process.

**Findings**

**Aid to meet reproductive health needs, or pursuit of neoliberalisation by design?**

The belated inclusion of a target for universal access to reproductive health within Millennium Development Goal 5 marked a culmination of decades of concern with population growth in some quarters. India has long been seen as a problematic case for population growth, with such concerns manifested aggressively in the coercive sterilisation practices perpetrated during the 1970s (Rao, 2004). In the aftermath of India’s national debt crisis in 1990/1991, and the launch of a structural adjustment programme, USAID published a new strategic framework for its activities in India.

Population growth was picked out as an important constraint on progress towards sustainable development and the Innovations in Family Planning Services Project was USAID’s answer to the neo-Malthusian ‘population explosion’ (USAID, 1993, p. 1) in northern India. Uttar Pradesh was chosen as the focus because of its large (and growing) population and because it could ‘serve as a demonstration [of the Innovations in Family Planning Services Project’s approach] for all of northern India’ (ibid., p. 2).

The origins of the Innovations in Family Planning Services Project can also be understood as part of the launch by the US government of a new package of programmes to promote free market capitalism in India by privatising infrastructure, promoting international trade, expanding financial markets and removing business regulations. It followed on from the dissolution of India’s close ally the USSR, and USAID’s 1993 strategic framework for India pointed to what it referred to as a ‘long era of failed Indian socialism’ and emphasised the opportunities offered by economic reforms to expand markets and reduce direct roles for Indian national and sub-national governments in the economy (USAID, 1993 pp. 7-8).

SIFPSA was launched in 1993 to manage and implement Innovations in Family Planning Services project activities rather than using the existing bureaucracies of the Uttar Pradesh government. SIFPSA was a joint venture of Government of India, USAID and Government of Uttar Pradesh under an Indo-US bilateral agreement and described as an ‘independent society’ (USAID, 1993, p. 51), a term used in India to denote a non-governmental organisation, and was financed by Innovations in Family Planning Services Project funds from USAID and the Indian federal government. It was overseen by a governing body comprising representatives from USAID, the Indian federal
government, Uttar Pradesh government health and finance ministries, and public and private health
and population organisations. The ‘independent’ status of SIFPSA enabled USAID to circumvent

government institutions: USAID’s strategy document for India explained that it would ‘channel’

Innovations in Family Planning Services Project funds outside Uttar Pradesh government institutions
‘to assure program flexibility’ (ibid, p. 13). The anti-government rationale for ‘program flexibility’ was
revealed in a later document which claimed that ‘SIFPSA was created to allow the Innovations in
Family Planning Services project to proceed free of the bureaucratic barriers and burdens inherent in
trying to implement a large family planning project through the government’ (Population Technical
Assistance Project, 2003, p. 13).

Over the course of the Innovations in Family Planning Services Project’s first phase (1992-2004),
USAID Washington’s interest in using the project to promote market logics became increasingly
apparent in programme documents. SIFPSA was to introduce social marketing of contraceptives,
contracting of non-governmental organisations to distribute contraceptives in rural communities,
and family planning training for private practitioners of alternative forms of medicine. On the other
hand, those programmes that encouraged provision of family planning services through public
providers – such as training for government service providers and funding to improve government
facilities – were subjected to criticism in USAID Washington-commissioned reports (USAID, 1997)
that highlighted a ‘culture of government bureaucracy’ in SIFPSA (Population Technical Assistance
Project, 2003, p. 13). A USAID India-commissioned evaluation report claimed one of the project’s key
achievements was greater recognition by the public sector of the private sector’s position as ‘a
legitimate partner’ for service delivery and proposed expansion of private sector involvement in
service provision (Population Technical Assistance Project, 2003). The same report was explicit on
the tactical and temporary nature of activities, recommending that the Innovations in Family
Planning Services Project focus on a small number of districts in order to ‘facilitate creation of the
concentrated number of acceptors necessary to demonstrate the long-term sustainability of private

By the Innovations in Family Planning Services Project’s second and third phases (2004-2013), the
project’s promotion of market logics centred on developing ‘public-private partnerships’ for service
delivery and on expanding healthcare provision models that involved private sector contracting. The
five key steps described for the second and third phases of the Innovations in Family Planning
Services Project were now to ‘develop, design, demonstrate, document and disseminate’
‘innovative’ public-private partnership models (Innovations in Family Planning Services Technical
Assistance Project, 2012a), and left little room for doubt or question. This third phase specifically aimed to expand at least three of the programmes by seeking subsidy from Indian public funds –
government resources from the National Rural Health Mission (Andina et al., 2013).

This analysis of programme documents points to the importance of underlying motivations in the design of development assistance for health. The Innovations in Family Planning Services Project had as its stated aim the improvement of access to reproductive and maternal care in the slums, but was part of an ideological drive to encourage markets in Uttar Pradesh’s healthcare system, and in India more generally, driven by USAID and the Indian federal government (see next section). It was part of a constellation of USAID-supported projects around the world, including Private Sector Partnerships – One (2005-2008), Market-Based Partnerships in Health (2008-2012) and Strengthening Health Outcomes through the Private Sector (2012-2015), and USAID, SIFPSA and US-based development consultancies claimed that programmes in the Innovations in Family Planning Services Project were ‘successful’ based on evaluation reports that they produced and commissioned, for example on the voucher scheme (Innovations in Family Planning Services Technical Assistance Project, 2012b).
Claims of success were based on flawed analyses of changes in service usage in which authors compared data to a baseline survey without disaggregating the effects of similar programmes such as the government’s cash transfer programme, Janani Suraksha Yojana; there was no assessment of the voucher programme’s impact on health or fertility, despite stated aims of the programme to improve those indicators, and no attempt was made to compare the programme’s effects with similar investment in expanding public healthcare facilities.

The politics of implementation
Marketised provisioning now occupies a Gramscian ‘common-sense’ position in many healthcare systems (Mackintosh and Koivusalo, 2005), often clouded under the language of ‘partnership’ (Hunter, 2018a). Political economy studies on neoliberalism have highlighted the importance of globally driven market-based reforms in the production of new ‘neoliberal’ state-forms (Harvey, 2005; Saad-Filho and Johnston, 2004). However, a contextualised approach to the study of neoliberalisation reveals a more complex picture of piecemeal adoption, in this case periods of institutional resistance, cooperation, and expediency in local politics.

Resistance
The implementation of voucher and contracting schemes entails re-casting state bureaucracies as purchasers of healthcare services. In India, the bureaucracies of the state are among the strongest
institutions in the country and they exercise considerable discretion and brokerage in distributing public resources (Corbridge et al., 2005; Gupta, 2012). Policy implementation processes in India typically allow considerable adjustment to occur as part of a polity-wide accommodation and conflict resolution system to maintain cohesion among political communities (Adeney, 2017; Kohli, 1997).

Within this, political interest groups and local workers attempt to influence implementation, often pursuing conflicting interests and competing for access to scarce public resources. Thus, factions, patron-client linkages, ethnic ties, and personal coalitions are often the basis of the implementation process and they also make individualised demands on the bureaucratic apparatus for the allocation of goods and services.

The Innovations in Family Planning Services Project’s first phase was characterised by resistance from the local state. There were tensions between USAID India and the Uttar Pradesh government regarding the spending of Innovations in Family Planning Services Project funds on the public or the private sectors. Although USAID India had representation on all the governing committees for the Innovations in Family Planning Services Project, the Uttar Pradesh government used its larger presence on some committees to resist that influence and to approve investments in public healthcare infrastructure including a USD 2.3 million ‘short-term strengthening of the public sector’ project in 1995 and a USD 1.2 million ‘strengthening the supervisory capacity of government field offices’ project in 1997 (which was subsequently cancelled), these ‘despite USAID reservations’ (USAID, 1997, p. 86). The Uttar Pradesh government also reportedly excluded USAID India representatives from decision-making processes and failed to notify them of plans to introduce or expand projects until just before committee meetings.

The Uttar Pradesh government also acted to consolidate its hold on decision-making power within SIFPSA by merging the role of SIFPSA Executive Director with that of Uttar Pradesh Secretary for Health (a senior civil servant), arguing a ‘need for stronger public sector coordination and oversight in relation to Innovations in Family Planning Services Project activities’ (ibid., p. 89). SIFPSA was also kept close via secondment of senior managers from the Uttar Pradesh Ministry for Health and Family Welfare, and by 1997 one in six of SIFPSA’s staff were from such secondments. All this caused some dismay within USAID Washington, for whom it was considered ‘inconsistent with the project’s design and intent of staffing of SIFPSA primarily from the private sector’ (ibid., p. 90). These close government ties had made SIFPSA ‘slow to invest in the private sector’ (Population Technical Assistance Project, 2003, p. 13).


Political cooperation

However, after significant changes in the national and Uttar Pradesh government during 1997 and 1998, the domestic ideological context changed. A right-wing Bharatiya Janata Party (BJP)-led government took control in the Uttar Pradesh assembly (1997-2002), and at the national level (1998-2004). The World Bank was exerting pressure on Uttar Pradesh to facilitate greater private sector engagement in the health sector as part of a Health Systems Development Project (2001-2008) provided to the state alongside a structural adjustment loan (World Bank, 2000). The revolving door between government institutions and SIFPSA ended and a new, Harvard-educated civil servant was installed as Executive Director of SIFPSA and remained in place until the 2002 regional government elections. They took ‘immediate steps to assure that USAID views and concerns are meaningfully addressed at all levels of decision making’ (USAID, 1997, p. 86).

Resistance revived

That period, described in one evaluation as a ‘golden era’ for SIFPSA (Andina et al., 2013, p. 17), ended amidst further political change. The BJP had lost control of both the federal and the Uttar Pradesh governments, replaced at the national level by the Indian National Congress (INC), a centrist party which combined market-oriented reforms with populist social policies, and in the Uttar Pradesh government by populist caste-based parties: Bahujan Samaj Party (BSP) and Samajwadi Party. USAID India was keen to emphasise the continued synergy of their position with the federal government, for example the latter’s 2002 National Health Policy which was broadly supportive of expanded private healthcare provision, and claimed that they were responding ‘to keen Government of India (GoI) interest in introducing and going to scale with public-private partnerships’ (Population Technical Assistance Project, 2004, Appendix A), but there were signs of renewed resistance at the sub-national level after 2004. For example, the government in Uttarakhand (a new state which had been created out of northern Uttar Pradesh in 2000) reneged on plans to contract private organisations to manage government health facilities, encouraged by the local Member of Parliament, and cancelled a new voucher and contracting programme because ‘they prefer to utilize their resources to support government institutions, rather than private facilities’ (Andina et al., 2013, p. 67).

Local expediency and clientelism

SIFPSA was somewhat more successful in creating and implementing public-private partnerships in Uttar Pradesh than in Uttarakhand. Within a year of the BSP gaining a majority in the Uttar Pradesh assembly in 2007, four public-private partnership models were either close to launch or recently
launched. Here clientelist, caste-based politics played an important role. Effectively cost-free for the local government because they were funded by the federal government and USAID, each public-private partnership programme offered targeted services to the low-income families who form the core of the BSP’s lower caste support, a particularly attractive opportunity for the party to reward its constituency. Indeed the local government was so enthusiastic that it attempted to expand pilot implementation further to include more healthcare services in one of those public-private partnerships – the Sambhav voucher and contracting scheme – a plan eventually thwarted by USAID India on the grounds that it went beyond the family planning and reproductive health remit of SIFPSA (Donaldson et al., 2008). The voucher programme offered additional potential for the reward of some loyal party members - in Lucknow the private hospital which received the most voucher users was owned by the family of a leading member of the BSP (Times of India, 2009).

People-ing neoliberalisation at the local level

Ward and England (2007) emphasised the importance of researching how people experience and enact neoliberalisation. The meaning and application of ‘user choice’ helps us to understand this. This concept is often a central ideological underpinning of such processes and it featured strongly in the justification and plans for the Sambhav voucher and contracting scheme. Programme documents criticised a current lack of user choice in India’s public healthcare system (SIFPSA, 2010), and suggested that the introduction of the Sambhav voucher scheme, operating in parallel to government healthcare provision, would empower users by offering them a choice of providers of maternity care (Innovations in Family Planning Services Technical Assistance Project, 2012b). When interviewed, the programme managers in SIFPSA were keen to celebrate the “expansion of choices” for healthcare among families in slum communities, citing a beguiling selection of maternity care in one of Lucknow’s 21 government healthcare facilities or via the voucher in 17 private hospitals accredited in the Sambhav scheme, as well as the option to pay for care in a non-participating private hospital or at home.

Families ‘in the know’ did indeed exercise some choice, typically this involved moving across the private and public sector trying to make the most of what they were being offered at any particular moment: many of them opting to use the free antenatal and postnatal care available through the Sambhav voucher scheme (up to three antenatal visits and two postnatal visits) but opting to give birth in government hospitals because there they could receive a payment of 1,000 rupees (approximately £10) via a different scheme - the National Rural Health Mission’s Janani Suraksha Yojana. As a result, and to the dismay of project managers and designers, more than 14,100
Sambhav vouchers were used for an antenatal check-up in the private sector in Lucknow, but just 2,200 vouchers were used for care during labour and birth in the programme’s participating private hospitals.

Such strategic exercise of choice by users caused upset in the Sambhav scheme because project workers’ performance – and pay – was predicated on voucher utilisation. The programme’s community workers, who distributed the vouchers and accompanied women to hospital, received small monthly stipends that were topped up by payments based on the number and type of vouchers submitted with their name (ranging from 5 rupees for an antenatal care visit, to 50 rupees for childbirth), and managers’ and supervisors’ performance was also judged by voucher usage.

Faced with families’ subversive behaviour the project community workers began to move to protect their interests. As one-third of men and up to half of women living in Uttar Pradesh’s urban slums had no education (Speizer et al., 2012), many families were dependent on the community workers for much of their information. These workers began to assert their control over inconvenient choices by criticising government hospitals and making claims of better quality of care in private hospitals. They withheld details about the programme and held onto the vouchers, accompanying women in labour to the hospital themselves. In some cases women we interviewed who had accessed private maternity care via the vouchers seemed completely unaware of this and thought the community worker had assisted them in getting treatment using personal influence. So, as we have described in more detail elsewhere (Hunter, 2018b), while the project discourse described the community workers in the slums as ‘facilitators’, in practice the reward structure encouraged them to become self-interested intermediaries – brokers who quickly learnt how to commodify their privileged knowledge and relationships with hospitals and to view friends and neighbours as clients with cash value.

Aid projects are rarely sustainable beyond the period where international funds are available. The Sambhav voucher scheme had a two-year lifespan in Lucknow but its importance lies in an ongoing influence on behaviours - as the community workers had acquired vested interests in promoting private healthcare consumption in the urban slums. They sought to maintain and expand brokerage relationships that they had developed during the scheme. The commercial benefits to private hospitals of this new client base meant that they paid commissions to the former community workers in return for bringing in paying patients. A former Sambhav scheme supervisor was even employed by one private hospital as a ‘public relations officer’ in order to maintain access to their
network of former community workers from the scheme. Twelve months after programme-end, private hospital managers were paying up to 500 rupees (approximately £5) to former community workers for accompanying a woman to give birth for a fee in the hospital.

Discussion and conclusions
Our case study details how international aid which seems to concern important public health issues and access to care can serve as part of a larger project of neoliberalisation that involves privatising infrastructure and promoting market-based exchange. We have noted that this initiative was driven and designed by USAID as part of a global constellation of projects promoting markets in the health sector, in this case with the complicity of the Indian federal government of the period. The longer history of World Bank in activities to promote markets in the health sector is well known, however less attention has been paid to the role of USAID and other bilateral development organisations, whose funding for public health programmes in low- and middle-income countries rose dramatically during the Millennium Development Goal era (Dieleman et al., 2016).

This scheme in India fed into the propagation of market-based models for healthcare provisioning. Sympathetic findings on the Sambhav scheme were presented by lead Innovations in Family Planning Services consultancy Futures Group at the 2009 International Conference on Family Planning in Uganda. After this, and despite the lack of rigorous evaluation, USAID, the Gates Foundation and the UK Department for International Development funded the implementation and evaluation of two new voucher programmes in Uganda. In an article hailing vouchers as ‘a hot ticket for reaching the poor and other special groups’, representatives from USAID have cited the Sambhav scheme as a success story (Menotti and Farrell, 2016, p. 390). Similar concerns have been raised regarding the propagation of performance-based financing models more broadly, and in particular their promotion by international agencies and consultancies in spite of their paucity of rigorous supporting evidence (Gautier et al., 2019; Paul et al., 2018). Self-titled ‘public-private partnership’ models for service delivery too have attracted critique: previous research has highlighted limited supporting evidence for these models in health and education (Languille, 2017) and the use of ‘partnership’ to obfuscate ideologically driven expansion of private activity in social sectors (Hunter, 2018a; Standing, 2010; Verger, 2012), and commentators have called for further examination of the effects of these models on equity of health outcomes (Gideon and Unterhalter, 2017). The use of development aid to promote expansion of market-based models in this fashion contravenes basic principles of aid effectiveness and signifies the extent to which neoliberal theory occupies a ‘common sense’ logic in leading international agencies (Mackintosh and Koivusalo, 2005).
Our analysis highlights the importance of distinguishing the comparative roles of different levels of government within neololiberalisation processes. The Indian federal government actively pursued neoliberalisation through schemes such as this one in much the same way that federal development aid has traditionally been used to influence provisioning in a sector that is constitutionally the remit of sub-national governments. ‘Centrally sponsored schemes’ have often been powerful tools for imposing policies in the health sector, for example the expansion of the National Rural Health Mission and the national health insurance schemes (Duggal, 2009). What is clear is that such tactics can be used at different points in time to reinforce public sector provisioning or to weaken it. Documents spanning the 20-year lifetime of the Innovations in Family Planning Services Project show how attempts to encourage market-oriented policies encountered resistance at different points from sub-national actors who were more interested in using funds to improve public healthcare provision. Faced with such resistance, USAID and the Indian federal government took steps to assert control over policy design and secured Uttar Pradesh government through political strategies reminiscent of those used for structural adjustment programmes (North, 2007; Veltmeyer and Petras, 2004). SIFPSA facilitated and implemented these policies using project funding that bypassed the Uttar Pradesh government and we saw how local politicians can become willing accomplices, as they served their ranging political constituencies.

Attempts by Sambhav scheme designers to expand user choice failed to acknowledge that, for many prospective voucher users, understanding and exercising choice was influenced and constrained by a host of other factors. The emphasis on user choice in the Sambhav scheme is common in consumerist subjectivities being documented more widely in healthcare, typically in the Global North (Gabe et al., 2015; Harley et al., 2011). As Willis et al. (2016, p. 214) have noted, ‘there is now an imperative to research healthcare options and become an expert, active, responsible, fully informed participant in all healthcare encounters.’ But individualist claims that greater choice will ‘empower’ users – such as those made in Sambhav scheme reports – do not address the structural factors of financial and social capital that influence decision-making and attainment of healthcare entitlements. Indeed programmes may reproduce inequalities if the burden of choice creates opportunities for the expansion of other subjectivities in which actors position themselves as commercial intermediaries and foster dependence and exploitative practices. By inadvertently encouraging an environment for brokerage relationships, the Sambhav scheme’s creators not only undermined public healthcare provisioning, but also helped to embed consumerist behaviours toward healthcare within Lucknow’s urban slums.
The findings point to an important tension between two different public policy manifestations of neoliberal theory included in the Sambhav scheme: the broader market-oriented policy objectives and the individualised performance measures. Managers, supervisors and community workers discouraged particular consumer healthcare 'choices' because they undermined programme performance, reflecting the contradictions between reified notions of user choice driving organisational efficiency and the management practices also meant to enhance organisational efficiency. This reflects pressures working at the 'street-level', where policies and programmes are reinterpreted by the people expected to implement them (Lipsky, 1980), who themselves are subject to social forces stemming from their organisational, social, political and economic context (Allen and Pilnick, 2005). Given the expansion in public health of market-based provisioning (Mackintosh and Koivusalo, 2005) and public-private partnership models (notably health insurance), alongside a deepening of performance management systems (Paul et al., 2018), the tensions that emerge between different logics of neoliberal theory warrant further examination and can help to challenge monolithic interpretations of neoliberalism in public health (Bell and Green, 2016).

To conclude, the findings point to the value of a detailed understanding of the roles over time of state institutions, local politics and people in the enactment of neoliberalisation. We have shown how policies directed at expanding healthcare markets were varyingly embraced, resisted and distorted by the politicians and civil servants expected to guide them through different levels of government on the way to implementation. Data generated through our detailed study of a voucher and contracting scheme in one city also demonstrate what England et al. (2007) call the 'wiggle room' for programme workers and users to interpret programmatic features in unexpected ways. While the more internationally oriented organisations appeared to embrace concepts associated with neoliberal theory, other participants in the scheme worked in the pursuit of their immediate interests. These findings further underline the need for researchers to consider how neoliberal subject-making is pursued by paying particular attention to the state-forms and people involved.

Acknowledgements

The authors thank all the respondents who participated in the research and are grateful to Debra Bick for further supervisory support, and to the staff of SAHAYOG, India, for their guidance during data collection. Travel for the research was conducted, in part, with financial assistance from King's College London Department of International Development.
Declaration of interest

The authors declare no competing interests.

List of references


Make High-Quality Reproductive Health Services Possible for Indias Poor. Gurgaon, Haryana: Futures Group, ITAP.


SIFPSA. (2010). *Sambhav voucher project urban slums Lucknow*. Lucknow: SIFPSA.


USAID. (2006). *Vouchers for Health: A focus on reproductive health and family planning services*. Washington D. C.


