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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

22 **Introduction**

23 Advocacy for development assistance for health often assumes beneficence; an assumption that is
24 implicit in calls for governments and other actors to increase pledges to development aid. However,
25 the potentially adverse effects of 'aid' projects had been highlighted in a significant body of work
26 that critiqued the ways in which ideologically driven multilateral and bilateral development aid
27 programmes undermined public health during structural adjustment reforms during and following
28 the 1980s and 1990s (Keshavjee, 2014; Lister and Labonté, 2009; Rao, 1999; Turshen, 1999), and in
29 particular the inequities associated with user fees introduced in that period (McIntyre et al., 2006;
30 Ridde and Morestin, 2011; Russell and Gilson, 1997). Such critique has often been side-lined in
31 analyses of development assistance for health in the period since 2000 – a period described by one
32 influential US-based institution as a 'golden age' for global health financing (Institute for Health
33 Metrics and Evaluation, 2012) during which substantial increases in development assistance for
34 health commitments have been given (Dieleman et al., 2016) and which led to sympathetic calls
35 from leading commentators to maintain and increase such funds (Jamison et al., 2013; Sachs, 2010).
36 Critical attention has tended to focus on the influence of new commercial actors such as
37 philanthrocapitalists in global health governance (Birn, 2018; McCoy et al., 2009; McGoey, 2012), a
38 public health agenda reliant on private for-profit actors (Birn et al., 2016; Qadeer and Baru, 2016),
39 and the implications of new global health initiatives such as the Global Fund to Fight AIDS,
40 Tuberculosis and Malaria, Gavi and the US President's Emergency Plan for AIDS Relief (PEPFAR)
41 (Buse and Walt, 2000; Ruckert and Labonté, 2014; Storeng, 2014) and their relative (mis)alignment
42 with health priorities and needs for recipient countries (Hawkes et al., 2017; Mwisongo and
43 Nabyonga-Orem, 2016; Oliveira Cruz and McPake, 2011). Far less critical attention has been devoted
44 to the bilateral programmes that took place during this period (see Tejerina et al., 2014 for one
45 exception).
46
47 We address this issue with a case analysis of a development assistance for health initiative in India
48 focused on improving reproductive and maternal health for the poorest. Our aim is to highlight how
49 international aid which seems to embrace important public health and access to care concerns can
50 be part of a larger – and damaging – project of neoliberalisation, and we use a detailed case to
51 explore the complex processes of negotiation between different interest groups as attempts are
52 made to roll this out. The subject of our attention is an initiative driven by the US Agency for
53 International Development (USAID) together with the Indian federal government to promote private
54 sector engagement in Uttar Pradesh's health sector during 1992-2013. This was a context
55 characterised by a neglected government healthcare system skewed towards overburdened urban

56 hospitals, and an extensive system of private healthcare provision (Baru, 1998; Chakravarthi, 2013),
57 that included charitable hospitals but which was primarily characterised by informal and formal for-
58 profit private provision (Gautham et al., 2019). 'Dual practice' by physicians in the public and private
59 sectors, although officially prohibited, persists and blurs the boundaries between these systems
60 (ibid.). Launched in Uttar Pradesh during the structural adjustment period of the 1990s, the
61 Innovations in Family Planning Services initiative was later expanded to include neighbouring
62 Uttarakhand (and to a lesser extent Jharkhand) after its creation in 2000, and was then awarded new
63 funds and extended during the 2000s with a revised goal to develop 'public-private partnerships'
64 (understood in project documents and in this article in terms of service delivery models
65 incorporating private actors - see Languille, 2017 for a fuller conceptual examination) for future
66 scale-up. In this article we analyse the detail of one of its projects – the Sambhav health voucher and
67 contracting scheme – and demonstrate the importance of paying attention to context and
68 processes, to subjecting the motives and ideological underpinnings of such initiatives to scrutiny, to
69 considerations of the state not as monolith but as institutional actors at different levels with
70 differing interests, and to highlighting responses in target local communities in urban slums. We
71 conclude by arguing for greater scrutiny of implicit market-oriented aims underpinning development
72 assistance for health.
73
74 ***From neoliberalism the monolith, to neoliberalisation processes***
75 The theory of neoliberalism has offered a compelling narrative for the politics, policies, state-forms
76 and social relations which characterise contemporary capitalism (England and Ward, 2007). It is
77 often understood using Harvey's (2005, p. 2) definition as 'a theory of political economic practices
78 that proposes that human well-being can best be advanced by liberating individual entrepreneurial
79 freedoms and skills within an institutional framework characterized by strong private property
80 rights, free markets, and free trade.' From a public policy perspective, the advancement of
81 neoliberal theory has been associated with a 'new public management' paradigm that redefined
82 public service provision through transparent accounting processes, contractual agreements,
83 purchaser-provider distinctions, and competition between governmental and non-government
84 bodies (Denhardt and Denhardt, 2000; Dunleavy and Hood, 1994).
85
86 Scholars such as Barnett (2005), Larner (2000), Peck and Tickell (2002), Ward and England (2007) and
87 Bell and Green (2016) in this journal have observed that this meta-level narrative tends to obscure
88 the processes, complexities and contradictions that have emerged: as Larner (2003) puts it, the
89 *variegated forms* that neoliberalism takes in different settings. Ward and England's (2007) edited

90 volume *Neoliberalization: states, networks, peoples* remains perhaps the strongest contribution to
91 understanding neoliberalisation processes, by using detailed case studies ranging from the
92 negotiated enactment of microfinance in Nepal to the frontline of time-pressured home care
93 services in Canada. Their volume highlights the importance of knowing how people experience and
94 enact neoliberalisation in ways which 'bring the political project to life, to make it real' (p. 20). Here
95 we too wish to pay particular attention to the roles of *states* and *people* within a contextualised
96 neoliberalisation process: to the varied resistance, collusion and expediency amongst sub-national
97 politicians and technocrats, and to the ways in which such aid programmes are understood and
98 implemented by actors in local communities.
99
100 **Choice of case and methods**
101 By taking a multi-level approach that looks at the funder's accounts of their initiative over time, the
102 responses of domestic political institutions, and the conduct of the project on the ground, we aim to
103 make a contribution to the understanding of how healthcare provisioning can become a field in
104 which the processes of neoliberalisation play out. The findings reported here are drawn from
105 doctoral research conducted by the first author with supervision from the co-authors, that explored
106 how aspects of healthcare commercialisation were driven by development aid in India. Its focus was
107 the widespread promotion by the World Bank and USAID during the Millennium Development Goal
108 era of voucher and contracting schemes (USAID, 2006; World Bank, 2003, 2005), which promote
109 markets in healthcare through contracting arrangements that offer opportunities to develop
110 competitive processes for provision, management, community work and evaluation services. One
111 such vehicle which we study in some detail is the Sambhav voucher and contracting scheme.
112
113 Sambhav is a Hindi word meaning 'possible', implying that private healthcare services would become
114 possible for eligible low-income families, and 'user choice' was central to the ideological
115 underpinnings of the market for healthcare consumption planned for the Sambhav voucher and
116 contracting scheme. In the five Uttar Pradesh cities that participated in the scheme, lay community
117 health workers were allocated vouchers to distribute in slum communities. Women and their
118 families could exchange those vouchers for free maternal and reproductive healthcare services at
119 any one of the accredited private hospitals in the city – up to 20 depending on the city. The Sambhav
120 scheme included no formal role for the government facilities providing such services, rather its
121 designers expected the government's National Rural Health Mission to regulate (and eventually
122 fund) a market of accredited private hospitals. Many aspects of the project were outsourced. A non-
123 governmental organisation, the State Innovations in Family Planning Services Agency (SIFPSA)

124 managed the programme; development consultancies designed and produced programme
125 materials; and non-governmental organisations and governmental agencies were contracted to
126 organise voucher distribution.
127
128 The analysis in the first and second sections of this article's findings draws on texts produced by and
129 for Innovations in Family Planning Services project funder, USAID. These published and unpublished
130 programme and strategy documents related to the Innovations in Family Planning Services Project or
131 its sub-projects, and included project proposals, evaluation reports and an audit report. The third
132 section of the findings brings in fieldwork focused on one of the public-private partnerships pursued
133 by the Innovations in Family Planning Services Project - the Sambhav scheme. That fieldwork was
134 conducted during the final year of programme implementation in the city of Lucknow, Uttar
135 Pradesh, and in the year following the programme's termination. The first author visited Lucknow
136 three times during 2013 and 2014 to observe the day-to-day enactment of the programme and hold
137 conversations and conduct interviews with relevant actors. Each visit lasted around 6 weeks, during
138 which observations and conversations were recorded in field-notes, and semi-structured interviews
139 were conducted with 41 people. They were selected purposively based on the interviewee's
140 involvement with the Sambhav scheme, contacted by phone and invited to participate in the
141 research. Interviewees included: programme managers, hospital owners and clinicians, community
142 health workers and supervisors, and women and families who were voucher users. Ethics approval
143 for the research was obtained from King's College London and Jawaharlal Nehru University Centre
144 for Social Medicine and Community Health. The aims of the research were explained to respondents
145 and they were invited to participate in the research and to complete an English- or Hindi-language
146 consent form. Interview questions examined the Sambhav scheme's aims, and how design features
147 were expected to contribute towards meeting those aims. A research assistant who was fluent in
148 English and Hindi provided interpretation and translation services.
149
150 Thematic analysis was performed on this combined dataset, informed by critical theoretical
151 perspectives on neoliberalisation. An initial set of structural codes were generated during and
152 following the data familiarisation process after the first visit to Lucknow, and the codes were then
153 developed into themes and sub-themes that grouped codes and represented a more implicit,
154 theoretical process. The codes and themes were revised during and following subsequent visits.
155 Here findings are presented in three sections: programmatic design promoting neoliberalisation; the
156 context and 'messiness' of local politics through which programme adoption was resisted, supported

157 and subverted; and the unexpected interpretations by programme workers and users during the
158 policy implementation process.
159
160 **Findings**
161 ***Aid to meet reproductive health needs, or pursuit of neoliberalisation by design?***
162 The belated inclusion of a target for universal access to reproductive health within Millennium
163 Development Goal 5 marked a culmination of decades of concern with population growth in some
164 quarters. India has long been seen as a problematic case for population growth, with such concerns
165 manifested aggressively in the coercive sterilisation practices perpetrated during the 1970s (Rao,
166 2004). In the aftermath of India's national debt crisis in 1990/1991, and the launch of a structural
167 adjustment programme, USAID published a new strategic framework for its activities in India.
168 Population growth was picked out as an important constraint on progress towards sustainable
169 development and the Innovations in Family Planning Services Project was USAID's answer to the
170 neo-Malthusian 'population explosion' (USAID, 1993, p. 1) in northern India. Uttar Pradesh was
171 chosen as the focus because of its large (and growing) population and because it could 'serve as a
172 demonstration [of the Innovations in Family Planning Services Project's approach] for all of northern
173 India' (ibid., p. 2).
174
175 The origins of the Innovations in Family Planning Services Project can also be understood as part of
176 the launch by the US government of a new package of programmes to promote free market
177 capitalism in India by privatising infrastructure, promoting international trade, expanding financial
178 markets and removing business regulations. It followed on from the dissolution of India's close ally
179 the USSR, and USAID's 1993 strategic framework for India pointed to what it referred to as a 'long
180 era of failed Indian socialism' and emphasised the opportunities offered by economic reforms to
181 expand markets and reduce direct roles for Indian national and sub-national governments in the
182 economy (USAID, 1993 pp. 7-8).
183
184 SIFPSA was launched in 1993 to manage and implement Innovations in Family Planning Services
185 project activities rather than using the existing bureaucracies of the Uttar Pradesh government.
186 SIFPSA was a joint venture of Government of India, USAID and Government of Uttar Pradesh under
187 an Indo-US bilateral agreement and described as an 'independent society' (USAID, 1993, p. 51), a
188 term used in India to denote a non-governmental organisation, and was financed by Innovations in
189 Family Planning Services Project funds from USAID and the Indian federal government. It was
190 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 sector services delivery’ (Population Technical Assistance Project, 2003 p. 32).

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

225 Assistance Project, 2012a), and left little room for doubt or question. This third phase specifically
226 aimed to expand at least three of the programmes by seeking subsidy from Indian public funds –
227 government resources from the National Rural Health Mission (Andina et al., 2013).
228
229 This analysis of programme documents points to the importance of underlying motivations in the
230 design of development assistance for health. The Innovations in Family Planning Services Project had
231 as its stated aim the improvement of access to reproductive and maternal care in the slums, but was
232 part of an ideological drive to encourage markets in Uttar Pradesh's healthcare system, and in India
233 more generally, driven by USAID and the Indian federal government (see next section). It was part of
234 a constellation of USAID-supported projects around the world, including Private Sector Partnerships
235 – One (2005-2008), Market-Based Partnerships in Health (2008-2012) and Strengthening Health
236 Outcomes through the Private Sector (2012-2015), and USAID, SIFPSA and US-based development
237 consultancies claimed that programmes in the Innovations in Family Planning Services Project were
238 'successful' based on evaluation reports that they produced and commissioned, for example on the
239 voucher scheme (Innovations in Family Planning Services Technical Assistance Project, 2012b).
240 Claims of success were based on flawed analyses of changes in service usage in which authors
241 compared data to a baseline survey without disaggregating the effects of similar programmes such
242 as the government's cash transfer programme, Janani Suraksha Yojana; there was no assessment of
243 the voucher programme's impact on health or fertility, despite stated aims of the programme to
244 improve those indicators, and no attempt was made to compare the programme's effects with
245 similar investment in expanding public healthcare facilities.
246
247 ***The politics of implementation***
248 Marketised provisioning now occupies a Gramscian 'common-sense' position in many healthcare
249 systems (Mackintosh and Koivusalo, 2005), often clouded under the language of 'partnership'
250 (Hunter, 2018a). Political economy studies on neoliberalism have highlighted the importance of
251 globally driven market-based reforms in the production of new 'neoliberal' state-forms (Harvey,
252 2005; Saad-Filho and Johnston, 2004). However, a contextualised approach to the study of
253 neoliberalisation reveals a more complex picture of piecemeal adoption, in this case periods of
254 institutional resistance, cooperation, and expediency in local politics.
255
256 *Resistance*
257 The implementation of voucher and contracting schemes entails re-casting state bureaucracies as
258 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).

293 *Political cooperation*
294 However, after significant changes in the national and Uttar Pradesh government during 1997 and
295 1998, the domestic ideological context changed. A right-wing Bharatiya Janata Party (BJP)-led
296 government took control in the Uttar Pradesh assembly (1997-2002), and at the national level (1998-
297 2004). The World Bank was exerting pressure on Uttar Pradesh to facilitate greater private sector
298 engagement in the health sector as part of a Health Systems Development Project (2001-2008)
299 provided to the state alongside a structural adjustment loan (World Bank, 2000). The revolving door
300 between government institutions and SIFPSA ended and a new, Harvard-educated civil servant was
301 installed as Executive Director of SIFPSA and remained in place until the 2002 regional government
302 elections. They took 'immediate steps to assure that USAID views and concerns are meaningfully
303 addressed at all levels of decision making' (USAID, 1997, p. 86).
304
305 *Resistance revived*
306 That period, described in one evaluation as a 'golden era' for SIFPSA (Andina et al., 2013, p. 17),
307 ended amidst further political change. The BJP had lost control of both the federal and the Uttar
308 Pradesh governments, replaced at the national level by the Indian National Congress (INC), a centrist
309 party which combined market-oriented reforms with populist social policies, and in the Uttar
310 Pradesh government by populist caste-based parties: Bahujan Samaj Party (BSP) and Samajwadi
311 Party. USAID India was keen to emphasise the continued synergy of their position with the federal
312 government, for example the latter's 2002 National Health Policy which was broadly supportive of
313 expanded private healthcare provision, and claimed that they were responding 'to keen Government
314 of India (GoI) interest in introducing and going to scale with public-private partnerships' (Population
315 Technical Assistance Project, 2004, Appendix A), but there were signs of renewed resistance at the
316 sub-national level after 2004. For example, the government in Uttarakhand (a new state which had
317 been created out of northern Uttar Pradesh in 2000) reneged on plans to contract private
318 organisations to manage government health facilities, encouraged by the local Member of
319 Parliament, and cancelled a new voucher and contracting programme because 'they prefer to utilize
320 their resources to support government institutions, rather than private facilities' (Andina et al., 2013,
321 p. 67).
322
323 *Local expediency and clientelism*
324 SIFPSA was somewhat more successful in creating and implementing public-private partnerships in
325 Uttar Pradesh than in Uttarakhand. Within a year of the BSP gaining a majority in the Uttar Pradesh
326 assembly in 2007, four public-private partnership models were either close to launch or recently

327 launched. Here clientelist, caste-based politics played an important role. Effectively cost-free for the
328 local government because they were funded by the federal government and USAID, each public-
329 private partnership programme offered targeted services to the low-income families who form the
330 core of the BSP's lower caste support, a particularly attractive opportunity for the party to reward its
331 constituency. Indeed the local government was so enthusiastic that it attempted to expand pilot
332 implementation further to include more healthcare services in one of those public-private
333 partnerships – the Sambhav voucher and contracting scheme – a plan eventually thwarted by USAID
334 India on the grounds that it went beyond the family planning and reproductive health remit of
335 SIFPSA (Donaldson et al., 2008). The voucher programme offered additional potential for the reward
336 of some loyal party members - in Lucknow the private hospital which received the most voucher
337 users was owned by the family of a leading member of the BSP (Times of India, 2009).
338
339 ***People-ing neoliberalisation at the local level***
340 Ward and England (2007) emphasised the importance of researching how people experience and
341 enact neoliberalisation. The meaning and application of 'user choice' helps us to understand this.
342 This concept is often a central ideological underpinning of such processes and it featured strongly in
343 the justification and plans for the Sambhav voucher and contracting scheme. Programme documents
344 criticised a current lack of user choice in India's public healthcare system (SIFPSA, 2010), and
345 suggested that the introduction of the Sambhav voucher scheme, operating in parallel to
346 government healthcare provision, would empower users by offering them a choice of providers of
347 maternity care (Innovations in Family Planning Services Technical Assistance Project, 2012b). When
348 interviewed, the programme managers in SIFPSA were keen to celebrate the "expansion of choices"
349 for healthcare among families in slum communities, citing a beguiling selection of maternity care in
350 one of Lucknow's 21 government healthcare facilities or via the voucher in 17 private hospitals
351 accredited in the Sambhav scheme, as well as the option to pay for care in a non-participating
352 private hospital or at home.
353
354 Families 'in the know' did indeed exercise some choice, typically this involved moving across the
355 private and public sector trying to make the most of what they were being offered at any particular
356 moment: many of them opting to use the free antenatal and postnatal care available through the
357 Sambhav voucher scheme (up to three antenatal visits and two postnatal visits) but opting to give
358 birth in government hospitals because there they could receive a payment of 1,000 rupees
359 (approximately £10) via a different scheme - the National Rural Health Mission's Janani Suraksha
360 Yojana. As a result, and to the dismay of project managers and designers, more than 14,100

361 Sambhav vouchers were used for an antenatal check-up in the private sector in Lucknow, but just
362 2,200 vouchers were used for care during labour and birth in the programme's participating private
363 hospitals.
364
365 Such strategic exercise of choice by users caused upset in the Sambhav scheme because project
366 workers' performance – and pay – was predicated on voucher utilisation. The programme's
367 community workers, who distributed the vouchers and accompanied women to hospital, received
368 small monthly stipends that were topped up by payments based on the number and type of
369 vouchers submitted with their name (ranging from 5 rupees for an antenatal care visit, to 50 rupees
370 for childbirth), and managers' and supervisors' performance was also judged by voucher usage.
371
372 Faced with families' subversive behaviour the project community workers began to move to protect
373 their interests. As one-third of men and up to half of women living in Uttar Pradesh's urban slums
374 had no education (Speizer et al., 2012), many families were dependent on the community workers
375 for much of their information. These workers began to assert their control over inconvenient choices
376 by criticising government hospitals and making claims of better quality of care in private hospitals.
377 They withheld details about the programme and held onto the vouchers, accompanying women in
378 labour to the hospital themselves. In some cases women we interviewed who had accessed private
379 maternity care via the vouchers seemed completely unaware of this and thought the community
380 worker had assisted them in getting treatment using personal influence. So, as we have described in
381 more detail elsewhere (Hunter, 2018b), while the project discourse described the community
382 workers in the slums as 'facilitators', in practice the reward structure encouraged them to become
383 self-interested intermediaries – brokers who quickly learnt how to commodify their privileged
384 knowledge and relationships with hospitals and to view friends and neighbours as clients with cash
385 value.
386
387 Aid projects are rarely sustainable beyond the period where international funds are available. The
388 Sambhav voucher scheme had a two-year lifespan in Lucknow but its importance lies in an ongoing
389 influence on behaviours - as the community workers had acquired vested interests in promoting
390 private healthcare consumption in the urban slums. They sought to maintain and expand brokerage
391 relationships that they had developed during the scheme. The commercial benefits to private
392 hospitals of this new client base meant that they paid commissions to the former community
393 workers in return for bringing in paying patients. A former Sambhav scheme supervisor was even
394 employed by one private hospital as a 'public relations officer' in order to maintain access to their

395 network of former community workers from the scheme. Twelve months after programme-end,
396 private hospital managers were paying up to 500 rupees (approximately £5) to former community
397 workers for accompanying a woman to give birth for a fee in the hospital.
398

399 **Discussion and conclusions**

400 Our case study details how international aid which seems to concern important public health issues
401 and access to care can serve as part of a larger project of neoliberalisation that involves privatising
402 infrastructure and promoting market-based exchange. We have noted that this initiative was driven
403 and designed by USAID as part of a global constellation of projects promoting markets in the health
404 sector, in this case with the complicity of the Indian federal government of the period. The longer
405 history of World Bank in activities to promote markets in the health sector is well known, however
406 less attention has been paid to the role of USAID and other bilateral development organisations,
407 whose funding for public health programmes in low- and middle-income countries rose dramatically
408 during the Millennium Development Goal era (Dieleman et al., 2016).
409

410 This scheme in India fed into the propagation of market-based models for healthcare provisioning.
411 Sympathetic findings on the Sambhav scheme were presented by lead Innovations in Family
412 Planning Services consultancy Futures Group at the 2009 International Conference on Family
413 Planning in Uganda. After this, and despite the lack of rigorous evaluation, USAID, the Gates
414 Foundation and the UK Department for International Development funded the implementation and
415 evaluation of two new voucher programmes in Uganda. In an article hailing vouchers as 'a hot ticket
416 for reaching the poor and other special groups', representatives from USAID have cited the Sambhav
417 scheme as a success story (Menotti and Farrell, 2016, p. 390). Similar concerns have been raised
418 regarding the propagation of performance-based financing models more broadly, and in particular
419 their promotion by international agencies and consultancies in spite of their paucity of rigorous
420 supporting evidence (Gautier et al., 2019; Paul et al., 2018). Self-titled 'public-private partnership'
421 models for service delivery too have attracted critique: previous research has highlighted limited
422 supporting evidence for these models in health and education (Languille, 2017) and the use of
423 'partnership' to obfuscate ideologically driven expansion of private activity in social sectors (Hunter,
424 2018a; Standing, 2010; Verger, 2012), and commentators have called for further examination of the
425 effects of these models on equity of health outcomes (Gideon and Unterhalter, 2017). The use of
426 development aid to promote expansion of market-based models in this fashion contravenes basic
427 principles of aid effectiveness and signifies the extent to which neoliberal theory occupies a
428 'common sense' logic in leading international agencies (Mackintosh and Koivusalo, 2005).

429
430 Our analysis highlights the importance of distinguishing the comparative roles of different levels of
431 government within neoliberalisation processes. The Indian federal government actively pursued
432 neoliberalisation through schemes such as this one in much the same way that federal development
433 aid has traditionally been used to influence provisioning in a sector that is constitutionally the remit
434 of sub-national governments. 'Centrally sponsored schemes' have often been powerful tools for
435 imposing policies in the health sector, for example the expansion of the National Rural Health
436 Mission and the national health insurance schemes (Duggal, 2009). What is clear is that such tactics
437 can be used at different points in time to reinforce public sector provisioning or to weaken it.
438 Documents spanning the 20-year lifetime of the Innovations in Family Planning Services Project
439 show how attempts to encourage market-oriented policies encountered resistance at different
440 points from sub-national actors who were more interested in using funds to improve public
441 healthcare provision. Faced with such resistance, USAID and the Indian federal government took
442 steps to assert control over policy design and secured Uttar Pradesh government through political
443 strategies reminiscent of those used for structural adjustment programmes (North, 2007; Veltmeyer
444 and Petras, 2004). SIFPSA facilitated and implemented these policies using project funding that
445 bypassed the Uttar Pradesh government and we saw how local politicians can become willing
446 accomplices, as they served their ranging political constituencies.
447
448 Attempts by Sambhav scheme designers to expand user choice failed to acknowledge that, for many
449 prospective voucher users, understanding and exercising choice was influenced and constrained by a
450 host of other factors. The emphasis on user choice in the Sambhav scheme is common in
451 consumerist subjectivities being documented more widely in healthcare, typically in the Global
452 North (Gabe et al., 2015; Harley et al., 2011). As Willis *et al.* (2016, p. 214) have noted, 'there is now
453 an imperative to research healthcare options and become an expert, active, responsible, fully
454 informed participant in all healthcare encounters.' But individualist claims that greater choice will
455 'empower' users – such as those made in Sambhav scheme reports – do not address the structural
456 factors of financial and social capital that influence decision-making and attainment of healthcare
457 entitlements. Indeed programmes may reproduce inequalities if the burden of choice creates
458 opportunities for the expansion of other subjectivities in which actors position themselves as
459 commercial intermediaries and foster dependence and exploitative practices. By inadvertently
460 encouraging an environment for brokerage relationships, the Sambhav scheme's creators not only
461 undermined public healthcare provisioning, but also helped to embed consumerist behaviours
462 toward healthcare within Lucknow's urban slums.

463

464 The findings point to an important tension between two different public policy manifestations of
465 neoliberal theory included in the Sambhav scheme: the broader market-oriented policy objectives
466 and the individualised performance measures. Managers, supervisors and community workers
467 discouraged particular consumer healthcare 'choices' because they undermined programme
468 performance, reflecting the contradictions between reified notions of user choice driving
469 organisational efficiency and the management practices also meant to enhance organisational
470 efficiency. This reflects pressures working at the 'street-level', where policies and programmes are
471 reinterpreted by the people expected to implement them (Lipsky, 1980), who themselves are
472 subject to social forces stemming from their organisational, social, political and economic context
473 (Allen and Pilnick, 2005). Given the expansion in public health of market-based provisioning
474 (Mackintosh and Koivusalo, 2005) and public-private partnership models (notably health insurance),
475 alongside a deepening of performance management systems (Paul et al., 2018), the tensions that
476 emerge between different logics of neoliberal theory warrant further examination and can help to
477 challenge monolithic interpretations of neoliberalism in public health (Bell and Green, 2016).
478
479 To conclude, the findings point to the value of a detailed understanding of the roles over time of
480 *state institutions*, *local politics* and *people* in the enactment of neoliberalisation. We have shown
481 how policies directed at expanding healthcare markets were varyingly embraced, resisted and
482 distorted by the politicians and civil servants expected to guide them through different levels of
483 government on the way to implementation. Data generated through our detailed study of a voucher
484 and contracting scheme in one city also demonstrate what England *et al.* (2007) call the 'wiggle
485 room' for programme workers and users to interpret programmatic features in unexpected ways.
486 While the more internationally oriented organisations appeared to embrace concepts associated
487 with neoliberal theory, other participants in the scheme worked in the pursuit of their immediate
488 interests. These findings further underline the need for researchers to consider how neoliberal
489 subject-making is pursued by paying particular attention to the state-forms and people involved.
490

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496

497 **Declaration of interest**

498 The authors declare no competing interests.

499

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