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**The social determinants of health in Africa from a political economy perspective:  
an exploratory contribution**

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**Abstract**

This article investigates the shortcomings in the implementation of an approach based on the social determinants of health in sub-Saharan Africa. This approach is extended by looking at health and development from a political economy perspective. This perspective acknowledges the non-linear nature of the political decision-making process and the absence of any institutional ideal type. The notion of institutional complementarities is used to investigate the deficiencies in this area in sub-Saharan Africa. It will be shown that the health programmes are based on a rationalist postulate and vertical concept of the problems. They are reflected in low levels of institutional complementarity. The article's contribution to the literature rests on its use of an expanded political economy perspective to help bridge the gap between public health and analyses of public policy.

**Keywords:** social determinants of health, sub-Saharan Africa, political economy, institutional complementarities

## **1. Introduction**

### *Context and objectives*

A large number of books and articles have already demonstrated the importance of social determinants of health (SDHs) in high income countries (Ahnquist et al. 2012; Mahamoud et al. 2013; Markwick et al. 2015). The WHO's Commission on Social Determinants of Health (CSDH) has played an important role in promoting SDHs (CSDH, 2008). It defines SDHs as the social, political and economic conditions in which people are born, live, work, play and socialize (CSDH 2008, 3).

In low income countries, SDHs are also crucial even if specificities have to be taken into account. Sub-Saharan Africa did not achieve the Millennium Development Goals (MDGs), with health giving rise to particular concern (United Nations 2015a). The literature has shown that an SDH-based approach is very relevant to any analyses of healthcare deficiencies in these countries. Among the key social determinants are maternal education and the status of women. For instance, empirical and methodological studies (Richards et al. 2013; Saith and Harriss-White 1999; McKinnon et al, 2015; Yamin et al. 2015) have revealed the significance of intra-household bargaining power and processes as gendered dimensions of child health and nutrition. It confirms Caldwell's earlier findings (Caldwell 1993), which also emphasise the place of political will, community involvement and education.

Besides the growing number of empirical articles and political discourses about the role of SDHs in sub-Saharan Africa, the SDH-based framework has been very poorly implemented (CSDH 2008, Houéto and Valentini 2014).<sup>1</sup> This article aims to substantiate this statement, analyse the causes of this situation and contribute to the conceptualization of the weaknesses from a political economy perspective offered as an alternative to mainstream economic analysis. This perspective draws on the notion of institutional complementarities in which institutions are regarded as effective not simply by their nature but when they are

appropriately linked to each other and to their social environment. It will be shown that the health programmes are based on a rationalist postulate and vertical concept of the problems. They are reflected in low levels of institutional complementarity.

After all, our initial observation is that the literature on SDHs has not yet borne fruit on the ground, despite the contribution of studies of the conditions under which SDH-based approaches have been implemented. A political economy perspective is precisely what has been lacking from analyses of SDHs. Such a perspective would analyze the obstacles to the implementation of an SDH-based approach. The difference between a political economy perspective and mainstream economics is that, in the former, the health system is regarded as embedded in local social conventions even before serving as a framework for technical proposals. However, the dominance of technical and rationalist approaches prejudices any attempt to take that reality into account.

### ***Analytical background and methods***

The present article is based on a literature review. It is positioned in the literature on SDHs as follows. Significant studies of the benefits of a political economy perspective applied to SDHs already exist (O’Laughlin, 2016, Review of African Political Economy, 2015). They highlight the need for a break with the conventional models for taking account of SDHs. Thus concerning to the battle against HIV, O’Laughlin (2015) argues that the fight against HIV in South Africa should go beyond the traditional distinction between distal and proximate determinants in favour of a holistic approach centred on the structural factors that lead certain categories of populations to be exposed to this disease. Our positioning complements these studies, for many reasons. Firstly, we are seeking to enrich the political economy approach sketched out by these authors by introducing studies that focus on institutional complementarities (this notion is explained in section 4). Secondly, while subscribing to the idea that the health system is just one of the social determinants, we have chosen in the

present article to focus on illustrations (section 5) of the internal determinants within the health sector. After all, as O’Laughlin (2015) rightly pointed out, a truly alternative approach to the conventional approach should consider the structure to be holistic and relational and “efface the distinction between proximate and distal determinants”. We absolutely position ourselves within this line of thinking but adopt a different practical angle, namely that of institutional complementarities, whether they be inside or outside the health system. The illustrative section of our article (section 5) examines some of the problems with institutional complementarities that are visible within the health service (i.e. social determinants located within that system). The aim of this section is to substantiate the notion that health policies remain compartmentalized within the sphere of public health and that actions on healthcare are still mainly technical in nature, whereas they should not only be connected with each other but also linked to factors external to the health system (i.e. social determinants that do not come solely within the province of the healthcare system itself). More specifically, this article links two analytical frameworks that seem to us convergent, namely one based on a vision that is holistic and relational rather than on the sum of individual situations (an holistic approach well represented by issue 146 of the Review of African Political Economy published in 2015) and another based on institutional complementarities. Even though for didactic and illustrative purposes, they are presented here within the health system, institutional complementarities are, after all, not limited in reality to the relations between the various actors in the health service but are most decidedly inter-sectoral and multi-actor. Thus this approach based on institutional complementarities is consistent with a concern to examine the structural relations that might impede access to healthcare services for certain groups of populations rather than certain individuals.

### ***Outline of the article***

We begin by highlighting the poor implementation of the SDH-based approach in sub-Saharan Africa (section 2). However, the benefits there would be to use the SDH framework to gain a better understanding of the issues at stake in a holistic approach to health actions in sub-Saharan Africa are significant. These benefits are outlined in section 3. Section 4 examines the contribution of political economy, based in particular on institutional complementarities. It explores the conditions required for better implementation of the SDH-based framework within the policy-making process and among the numerous actors playing a role in health policies and programmes. It is assumed that an interdisciplinary approach based on social science and public health studies can be supplemented by a political economy perspective applied to health and development issues. This framework is developed by presenting the political economy approach and demonstrating its links with social science applied to SDHs. This enables us to highlight the need for better institutional complementarities in public health actions in sub-Saharan Africa (section 5).

## **2. The weak implementation of the SDH-based approach in sub-Saharan Africa**

Twenty years ago, Link and Phelan (1995, 81) noted that studies of SDHs were still focusing largely on the social determinants of individual illnesses over precisely defined periods. Consequently, the dynamic, multidimensional processes that determine health were going unrecognised and the social determinants of health were being underestimated. While the literature has improved considerably in this respect in wealthy countries, this deficiency remains a significant problem in low income countries (Richards et al. 2013, Yamin et al. 2015).

## ***2.1. The dominance of sectoral approaches to health***

A major issue in low income countries is that the boundaries between health disciplines need to be broken down if the problems of the various populations are to be fully understood (Sen 1993). It might be concluded, therefore, that health programmes have suffered from an insufficiently cross-cutting approach and have tended rather to espouse a vertical, disease-by-disease approach. In the field of gender sensitivity of well-being indicators, Saith and Harris-White (1999, 492) pointed to the neglect of underlying determinants in policies devoted to gender equality. A study in the developing and transition countries, Stillwaggon (2006) found that HIV infection is influenced by poor living conditions, the quality of the environment and access to adequate health services and not solely by sexual behaviour. However, international aid for the fight against HIV has depended largely on vertical risk management (England 2007; Mackellar 2005), which leads to neglect of the economic, social and environmental causes.

Some significant advances have, however, been made on the institutional level, with efforts being made to take SDHs into account through a series of resolutions and conferences: the 'health for all by the year 2000' programme (1978), the Ottawa Charter (1986), the Bangkok Charter (2005), the CSDH Report (CSDH 2008), the Sustainable Development Goals in the field of health (United Nations 2015b, 2015c) and the Shanghai Conference (2016).

Despite these institutional advances, the gap between discourses and actions is still significant in low income countries. The situation in sub-Saharan Africa is hardly satisfactory (Houéto and Valentini 2014). The history of health initiatives in Africa explains this lack of progress. When the primary health care programme was launched in 1978, it was received with

considerable enthusiasm. Governments expressed a desire to make it one of their top priorities. However, the funding difficulties caused by the economic crisis and its effects on aid programmes led to considerable disenchantment. The Bamako Initiative (BI) launched in 1987 as a follow-up to the Ottawa Charter launched the previous year was an attempt to breathe new life into health promotion by taking account of the financial difficulties and giving communities a key role. The division of responsibilities between populations and health professionals was one of the BI's strengths that was not to be called into question by subsequent policies and declarations. Ultimately, however, the BI was reduced to little more than its goal of improving efficiency, to the detriment of achieving equity (Ridde 2008). Community participation was limited to management committees, which were concerned primarily with financial matters. The participatory spirit dwindled. The first lesson drawn by experts (WHO 2008) was that the failure of the BI and primary care was due to the weakness of national healthcare systems, a conclusion that reflected the background of structural adjustment and the decreasing power and influence of the public authorities following the rise of neoliberalism. Thus the BI and primary health care were implemented in a piecemeal fashion, whereas they were based initially on a cross-cutting, intersectoral approach. The current re-emergence of nation-states as actors in development has not exactly led to a revival of this approach. Despite the gradual involvement of African states from 1997 onwards (first attendance at the WHO's world congress on health promotion in Jakarta) and their subsequent commitments as expressed in joint declarations (adoption of the first African regional strategy on health promotion in 2001, organisation for the first time of the seventh world conference on health promotion in Nairobi in 2009), little progress has been made. In 2010, the African states in the WHO's Africa regional bureau adopted the African regional action strategy on SDHs, which was revised in 2012 (WHO 2010a, 2012) following an evaluation that showed that very little progress had been made.



Therefore, we are a long way from a comprehensive health policy such as that recommended by the Ottawa Charter in 1986. The Charter, after all, recommends that action should be taken on SDHs by giving individuals and communities greater autonomy in order to improve their health; however, such programmes require the involvement of non-health sectors in health promotion campaigns. This issue is also emphasised by the health capability paradigm (HCP) (Chakraborty and Chakraborti 2015, Ruger 2015, Kinghorn 2015) which argues that individuals and the public health system have a shared obligation to contribute to health agency and capabilities.

## ***2.2. Some explanatory factors***

The lack of progress in implementing the SDH-based approach in sub-Saharan Africa is due to various contextual factors. Firstly, the decreasing power of the public authorities in the wake of the structural adjustment programmes undermined the capacity of nation-states to implement comprehensive health policies. From this point of view, the ‘health in all policies’ paradigm (HiAP) has scarcely been applied at all in Africa. This paradigm is defined as ‘an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies and avoids harmful health impacts to improve population health and health equity’ (WHO 2013). As Carrera (2014) notes, implementing HiAP is difficult enough in high income countries. One can, therefore, only imagine how difficult it is to implement in low income countries where governments do not ensure fundamental services. By way of example, the structural weaknesses of public social services in Africa include the shortage of human resources in the health sector and the considerable inequalities in pay and careers among healthcare professionals, depending on whether they

hold reasonably privileged positions, particularly in urban areas and large organisations, or low-status jobs, such as those in small healthcare centres and primary care services. It was partly for this reason that the United Nations Secretary General established the High-Level Commission on Health Employment and Economic Growth (2016). Based on this Commission's recommendations, the Five-Year Action Plan for Health Employment and Inclusive Growth (launched by the World Health Assembly in May 2017) aims to promote employment in the health care sector to fulfil the sustainable development goals related to health. This plan focuses on two points in particular. The first is the potential shortfall of 18 million jobs in the healthcare sector, particularly in low and lower intermediate income countries. The second is the need for an intersectoral approach involving the governmental health, education, labour, finance and foreign affairs sectors (p. 4). However, such an intersectoral approach requires strong leadership from the state (regulatory capacity), which is often lacking in Africa (Boidin 2017).

A second contextual element is the unequal relationship between donors and development partners, on the one hand, and countries in receipt of aid, on the other. As noted in several analyses (Laverack 2007; United Nations Platform on Social Determinants of Health 2012), African countries are subject to considerable pressure from donors and technical partners that amounts to a donor-driven approach to policy-making. The resultant policies are, for the most part, based on a top-down philosophy from which attempts to improve the capacities of the groups concerned to act autonomously are largely absent. G. Laverack explains (2007) that programmes that have not really involved communities have little chance of improving empowerment as recommended in the Ottawa Charter. The compartmentalisation of health care systems reinforces these weaknesses since it emphasizes a vertical concept of disease rather than on health seen as the result of collective action.

### **3. The contribution of studies of SDHs to the analysis of the health situation in sub-Saharan Africa**

Studies of SDHs as applied to low income countries remain limited in number but they do include some significant contributions (Caldwell 1993; CSDH 2008; McKinnon et al. 2015; Richard et al. 2013; Yamin et al. 2015). Among the many advances in analysis, there are three that, in our view, are particularly useful in helping to explain the challenges and problems encountered in sub-Saharan Africa. Unfortunately, these advances are barely implemented in public policies.

#### ***3.1. The role of upstream determinants***

The first of these advances is the distinction that can usefully be made between proximal and distal health factors, to use the terminology adopted by Link and Phelan (1995). Distal factors are the fundamental causes of disease because ‘the health effects of causes of this sort cannot be eliminated by addressing the mechanisms that appear to link them to disease’ (Link and Phelan 1995, 85-86). This distinction is applied, using similar terminology, by Lönnroth et al. (2009) to an analysis of the factors influencing the incidence of tuberculosis across the world. The authors identify two categories of determinants. Firstly, there are the upstream determinants (weak and inequitable economic, social and environmental policy, globalisation, etc.), which themselves affect the intermediate upstream determinants (deficiencies in health care systems and access problems, inappropriate search for treatment, poverty etc.). Secondly, there are the proximate risk factors (number of cases in the community, poor ventilation, tobacco smoke, air pollution, HIV, malnutrition etc.), which are the vectors of transmission

between the upstream determinants and the disease itself. It is not sufficient to take action against the proximate factors only since the upstream determinants remain unaffected.

One important lesson is that the HiAP approach represents an attempt to go beyond excessively compartmentalised approaches to health policy, but to date it has not been widely adopted in Africa. However, as will be seen in section 4, we have to go beyond the conventional distinction between distal and proximate factors if the structural causes of the incidence of health problems in a population are to be taken properly into account.

### ***3.2. Analysis of inequalities and power relations essential***

The second contribution of studies of SDHs is to show that, even though socio-economic and power inequalities are regarded today as a fundamental cause of health inequalities, the international and national institutions responsible for dealing with these issues have left their analyses of these inequalities on the ground relatively underdeveloped. This is a shortcoming that prevents the real policy levers for change and improvements in health from being revealed. Thus the role of inequalities is certainly made explicit in two very significant documents that analyse and promote SDH-based approaches, namely the CSDH report (2008) and the Marmot Review (2010), which examines the situation in England.

However, as Whitehead and Popey (2010, 1235) note, while the central role of inequalities is certainly highlighted in these two reports, the reality of these power relations and the actual form they take are not explored in greater depth. Over and above these observations, the power relations between the WHO and the other global actors in health may also help to explain that organisation's timidity in moving from observation to action. The fragility of the

WHO's situation is, after all, revealing of the difficulties inherent in any attempt to develop common health goals on a global scale. Unlike in the 1970s, the greater share of the WHO's resources is now provided by voluntary contributions, 91 per cent of which are allocated to specific projects and programmes (Legge 2012). Thus it is the donors rather than the assembly of member states that control the WHO'S actions (Boidin 2015). Consequently, the voice of the actors who might demand greater equality in terms of the upstream determinants of health (the African States as well as actors in civil society and local communities) remains of little account, which is at odds with the Ottawa Charter (Laverack 2007). Thus these local actors' lack of power is the corollary of this weakening of the WHO. The pressure exerted by pharmaceutical companies in defence of their drug patents and by other producer lobbies (agro-food, tobacco etc.) is, after all, a major obstacle to the WHO's capacity to regulate. Philanthropic foundations also play their part in depriving African states of their policy-making prerogatives by narrowing the range of choices available to governments depending on the funding they grant (Kerouedan 2013).<sup>2</sup>

### ***3.3. The policy-making process is not linear***

The third useful contribution made by the SDH-based approach arises out of the analysis of local socio-political processes, which can be obstacles to the implementation of a cross-cutting notion of health. In general terms, studies of SDHs imply that the rationalist view of the policy-making process should be abandoned. Russell et al. (2008) refer to a 'naive rationalist' vision of policy-making, in which the implementation of scientific advances is viewed as a linear process. On the contrary, Carey and Crammond (2015, 135) take the view that, as was demonstrated by Kingdon (1984) in more general terms, this process is a 'complex, iterative and contextually embedded process – not a linear one'. This

conceptualisation of the policy-making process helps to explain why major scientific discoveries, such as identification of the social determinants of health, are not reflected in significant changes in the way in which policy-makers tackle health issues. Embrett and Randall (2014, 147) show that the literature on policies intended to influence SDHs focuses on advocacy rather than on analysis and that very little use is made of political analysis. Thus these studies agree that the failure to implement an SDH-based approach is linked to a failure properly to understand policy-making processes. At the same time, the view expressed in the present article is that studies of SDHs have made insufficient use of the political economy of development and health, which provides some analytical frameworks that can be applied to great advantage in this area.

#### **4. The contribution of political economy**

In our view, efforts have been made to link the contributions of the SDH literature to studies in political economy (O’Laughlin 2016, Review of African Political Economy 2015). After all, there is considerable overlap between the three results outlined above (the role of upstream determinants, inequalities in power and the non-linear public decision-making process) and political economy. In political economy, after all, economic actions and relations are seen as embedded in environmental and social frameworks and that, consequently, it has to be assumed (which mainstream economics does not) that they are influenced by the socio-political context and power relations. More particularly, we would like to supplement the already existing studies (O’Laughlin 2015, 2016, Review of African Political Economy 2015) with some additional contributions whose roots also lie in an approach that takes account of the socio-political context. These additional contributions are, firstly, French-language studies in political economy applied to development (Revue de la régulation 2009) and health

(Batifoulier, Domin 2015, Mc Master, Batifoulier et al. 2015, Batifoulier, Da Silva 2014).

Secondly, we draw on an approach based on institutional complementarities (Aoki 2001) from which the French *régulation* school has also derived a framework for the analysis of institutions that has not yet, to the best of our knowledge, been applied to healthcare.<sup>2</sup>

#### ***4.1. The principles of political economy applied to development and health***

The first characteristic is the concern to deconstruct the rationalist approach, with economic forces being regarded as primarily the result of a socio-political process. Political economy is concerned with how the social relations of production underpin the economic process by which goods and services are produced (see for example the analytical framework developed by Karl Polanyi, 1957). In health care, these social relations can be explored by examining the act of delivering healthcare as an interaction between service provider and user (rather than considering supply and demand separately). This interaction makes it generally impossible to identify each person's contribution to the patient's state of health and makes the relationship part of a process of co-construction. The effectiveness of this co-construction in improving health depends on the role played by health institutions and collective rules. Health needs are not, after all, simply natural facts but are dependent also on the historical context, political framework, level of welfare state, etc. Health cannot be naturalised; it is a social construct and as such individuals perceive it differently depending on the sociopolitical context and their place in society.

Thus if it is accepted that healthcare needs are not fixed but, on the contrary, depend on the context in which they are expressed, then what has to be investigated is not just a purely technical relationship between healthcare professionals and patients but also a political

economy of health defined as the totality of the power relations and negotiations between the actors in health.

These power inequalities can be observed at several levels. In the healthcare system, firstly, users suffer from inadequate capacity and the poor management of healthcare organisations. They also suffer from the inequalities of status among healthcare workers, who do not all enjoy the same working conditions, the same pay or the same degree of influence on their regulating body (Ministry of Health, regional authority, etc.) depending on whether they are employed in urban or rural public hospitals, private clinics, health centres run by religious bodies or NGOs, etc. (in the case of community centres in Mali, cf. Boidin, Laidet, Manier 2012). Secondly, users' ability to influence public decisions on the workings of health services and strategic choices in public health varies very considerably. Policies succeed one another ('healthcare for all', payment for treatment, targeted exemptions from payments, universal health cover, etc.) without populations really being involved in the decision-making process. Finally, the relations between African states and the international actors are themselves asymmetrical, particularly with the growing activism of large companies in multiparty partnerships (e.g. the Drugs of Neglected Disease Initiative) and the emergence of philanthropic capitalism (the Gates Foundation, for example). This activism is in part motivated by companies' desire to improve their brand image but it scarcely helps to strengthen African states' ability to influence strategies.<sup>3</sup>

The second major characteristic of political economy applied to development and health is the use of the institutional complementarities criterion as a means of examining institutional effectiveness, in contrast to mainstream economics and the 'new institutional economics' (Williamson, 2000), in which this question is approached from the perspective of 'good institutions'. The new institutional economics tends to give primacy to a certain institutional



framework that is regarded as superior (incentives, ‘good governance’, market-oriented reforms – see Wu and Ramesh 2009) as advocated by the Bretton Woods institutions (Kaufmann et al. 2004, 2008). In political economy, on the other hand, a distinction is made between institutional functions (e.g. contributing to health improvement or human development) and institutional forms (common law or civil law, taxation or direct payment, competition or constraint, etc.). Political economy seeks to understand how very different institutional frameworks can produce favourable results. To that end, we can draw on the notion of institutional complementarity (Aoki, 2001), in which institutions are regarded as effective not simply by their nature but when they are appropriately linked to each other and their social environment. From this point of view, the notion of institutional complementarities constitutes a fault line between mainstream economics and the contribution of political economy to health policy. It introduces into the analysis inequalities of power (first characteristic above) and the lack of attention policy-makers pay to the dominated actors (e.g. users of primary healthcare centres or rural populations). These relations of domination are factors contributing to the weakness of institutional complementarities. However, this notion of institutional complementarity has never, to the best of our knowledge, been applied to economic studies of healthcare. This is what we are proposing to do in the rest of this article.

The two principles outlined above (non-linear policy-making process and institutional complementarities) constitute the two foundation stones of political economy. In the following two sections, we investigate in greater detail these two aspects of healthcare in Africa.

#### ***4.2. Challenging the linear, rationalist nature of the policy-making process***

For several decades, logical framework analysis has been the tool most widely used by the technical partners in development aid policies (World Bank 2000). The so-called log frame has become a universal tool used across all sectors, including health. It reflects a depoliticised vision of development (Giovalucchi and Olivier de Sardan 2009). Even though the objectives may be ethical and political (“health for all”, universal health coverage etc.), the ways of achieving them are presented by the international development partners as purely technical and rationalist. Local value systems (for example, whether individuals or the community take priority), conflicts between factions, ethnic groups or social categories are not taken into account in the log frame. However, the radical nature of certain political propositions intended to promote good health, such as egalitarianism, undoubtedly constitutes a challenge to the existing social power relations. Consequently, some groups (political, social and economic elites) may well oppose them.

Consequently, logical framework analysis has the same deficiencies as those identified by Easterly (2006) in respect of development planners. According to Easterly, a distinction should be made in development aid between experimenters and planners. While the former have the asset of capacity for feedback and accountability, the latter take no account of these two decisive factors. Thus genuinely political choices are neglected in favour of decisions made on the basis of management criteria alone. This leads to a loss of accountability on the part of decision-makers, who are no longer regarded as able to guarantee that a programme will be consistent with other actions. In Africa, for example, many health programmes are managed by several different bodies (USAID, cooperation agencies, the WHO, ministries of health, NGOs etc.) operating relatively autonomously. Thus free care for certain procedures or

conditions (caesarean sections, HIV, TB) or certain categories of patients (the elderly or the destitute) are not sufficiently well linked to other areas of health policy, such as the quality and accessibility of healthcare systems (Meessen, Gilson et al. 2011). This question of overall coherence and complementarity links up with the institutional complementarities framework discussed below.

Because numerous studies since the 1970s have highlighted the inadequacies of linear analytical frameworks, it is surprising that the log frame has become the reference model. Empirical studies in Africa have shown that health policies tend to proceed very much by trial and error (Meessen, Hercot et al. 2011). This is consistent with the findings of numerous studies in the socio-anthropology of development (Mosse 2005; Olivier de Sardan 1995), which emphasise the unpredictability of development programmes, buffeted as they are by the interventions and actions of many different actors.

In sum, if the light is to be shone on the interactions between the actors in the field of health in Africa, then the linear concept needs to be abandoned. To understand how this idea reveals the deficiencies in health policies and programmes in sub-Saharan Africa, we need next to embark on an analysis of institutional complementarities.

#### ***4.3. Analysis of institutional complementarities applied to health***

Bambra, Gibson, Sowden, Wright, Whitehead, and Petticrew (2010), Coburn et al. (2003) and WHO (2017) emphasise the importance of a ‘whole of government’ approach to health and the extreme timidity of African governments in this regard. However, as Carey and Crammond (2015) note, the two major approaches recommended for implementation of a

‘whole of government’ approach (i.e. the HiAP statement and Marmot’s fairness agenda) have weaknesses that are due principally to an inadequate conceptualisation of the policy-making process and its context. Even though their analysis is centred on Australia, which obviously differs in numerous respects from Africa, their conclusions are particularly consonant with the situation in that continent. Furthermore, these studies are absolutely congruent with the concerns of African researchers about the implementation of health policies (Houéto and Valentini 2014). After all, the gap between research evidence and practice makes it necessary to investigate on the ground the factors causing it, using an approach based on implementation science (see for example Ridde et al. 2013). In our view, such studies could, to their great advantage, be extended to incorporate the political economy of development and health, in particular by highlighting the low level of institutional complementarities.

An approach of this kind departs from mainstream economics in two ways. Firstly, the role and effectiveness of healthcare institutions and collective rules depend on institutional complementarities. If it is accepted that different institutional frameworks can produce favourable results, then it is not the ‘good institutions’ that should be characterised but rather the institutional complementarities that have produced this effect (for example, free care for the destitute combined with geographically accessible health service and an increase in educational levels). Secondly, health needs are not simply natural data. They are shaped by the historical context, the policy framework, the level of welfare state provision and so on. In this sense, people perceive health differently depending on their position in society. In low income countries, the social definition of health needs is seldom the result of the expressed views of the poor, sick or vulnerable populations but rather, in many cases, it is the expression

of a desire on the part of influential international and national actors to achieve goals that they have defined (Laverack 2007, Kerouedan 2013, Boidin 2015).

On the theoretical level, institutional complementarities question the view that policy decisions and development programmes are solely rationalist and managerial in nature. This rationalism was promoted in the aid policies of the 1990s and 2000s, under the influence of the World Bank and the International Monetary Fund (Kaufmann et al. 2004, 2008), through the mechanism of benchmarking, which enabled every country to copy best public policy practices, which were thereby reduced to optimal management. Taking a stance against this approach, Kahn (2004) has shown that the state cannot be a neutral actor but is rather an institution putting forward a model for social change. However, Kahn also takes the view that this model is designed and implemented by a process of trial and error and not in a linear fashion. This approach is extended by Aoki's analysis (Aoki 2001) of institutional complementarities. Aoki takes the view that institutions are interlinked. Consequently, it is impossible to calculate each institution's marginal contribution to the overall performance of policies and programmes. The complementarity arises out of the fact that an increase in the quantity or quality of service provided by one department (for example, a policy on women's education) increases the contributions made by other departments (for example, the primary health care policy). This interdependence raises the question of inter-institutional coherence. In the field of health, in which the notion of institutional complementarity has not been explored by economists, this notion is reflected in the fact that there is no institutional ideal type (the best institution or best programme). Rather, there are just comprehensive, coherent policies that link the various actors together or, conversely, incoherent policies that simply stack programmes one on top of the other. The reality of health policies in Africa shows that much remains to be done to ensure coherence (cf. section 5).

By analysing institutional complementarities, we can better characterize, firstly, the institutional silos in the field of health (or, within that field, the government silos, Marmot, 2010) and, secondly, the messy nature of public policy-making (Carey, Crammond 2015, 139). In our view, the first characteristic, namely the existence of institutional silos, constitutes a case of weak institutional complementarity, while the second characteristic is produced by the non-linear nature of health policy.

#### ***4.4. The link between institutional complementarities and the social determinants of health: the two levels of analysis***

However, the degree of institutional complementarity in the field of healthcare can be examined on two levels. These two levels will enable us to link our analytical framework based on institutional complementarities (i.e. our political economy framework) to the literature on SDHs. The first level is internal to the actors in health policy: the actors at national (ministries of health, hospitals, etc.), international (WHO, international NGOs etc.) and local (local NGOs, patients' rights defence networks, etc.) level constitute a group of actors within the field of health. In the SDH literature, this is what Dahlgren and Whitehead (1991) called health care services (these being only one SDH among others). At this local level, it seems to us relevant to examine not just the relations between the institutional actors themselves (healthcare providers, governments, development partners) but also between these institutional actors and health service users. After all, the degree of institutional complementarities can be seen as closely linked to how populations and communities are involved in or, conversely, excluded from political decision-making processes. In this regard, we establish a link between analyses of public health that emphasise the need for communities

to be actively involved in policy-making (cf. Laverak, 2007, section 2 above), and the inclusion of populations in the search for institutional complementarities.

A second level of analysis encompasses, in addition to the actors just mentioned, all those not actually located within the health field but able to exert influence over it: ministries of education, of rural development and infrastructure, NGOs fighting hunger, etc.. In the typology developed by Dahlgren and Whitehead (1991), these other SDHs are located in various sectors of activity and levers: agriculture and food production, education, work environment, unemployment, water and sanitation, housing, as well as social and community networks (see the adaptation of Dahlgren and Whitehead' typology for the healthcare sector by Bambra et al. 2010).

In the following analysis, the focus of our investigation will be the first level (the internal level of the healthcare system and its actors), we aim to identify concrete examples of healthcare programmes that take little account of the social determinants. Extending O'Laughlin's analysis (O'Laughlin 2015), we will not be considering mechanical relationships between distal and proximate factors but rather a holistic and relational structure between all the determinants, whether direct or indirect. After all, these various factors constitute a continuum and can, in reality, be located in different social determinants. In our study, therefore, we take the view that policies within the healthcare system cannot be separated from the structural factors causing health inequalities that are located in other spheres (education, employment, inter- and intra-community relations etc.). It is for this reason that, in the following section, we examine the problems within the healthcare system as arising out of a lack of synergy between policies and actors within the system and a focus on micro-level interventions that ignore the structural determinants of health located in other spheres.

## **5. Application of institutional complementarities to health programmes in sub-Saharan Africa**

Our aim is to substantiate the notion that there is a lack of institutional complementarities in health policies and programmes. By initiating an analysis in terms of institutional complementarities, we are hoping to enhance the studies that seek to forge the missing link between work on public health that adopts an SDH-based approach and public policy analyses that highlight the complexity of the political process (O’Laughlin 2015, 2016, ROAPE 2015, Olivier de Sardan, Ridde 2015, Ollila 2011). We hypothesize that the inadequate results of actions on health are due to a discrepancy between the need to promote a multidimensional and multisectoral approach to health and a tendency to distribute the resources made available between different levers and measures. Even though, taken in isolation, these various levers and mechanisms have a certain degree of relevance, they do not constitute a genuinely comprehensive health policy. In order to contribute to analysis of this phenomenon, we will attempt to establish a link between, on the one hand, those studies that offer an alternative approach to the social determinants (which amounts to examining the truly structural causes that affect the incidence of health problems) and, on the other, the analytical framework based on institutional complementarities.

Table 1 below provides a general overview of the main aspects of the health policies implemented since the 1990s under the influence of the international partners.



Table 1. The main aspects of health policies and programmes in Africa since the 1990s

<b>Aspect</b>	<b>Key concepts</b>	<b>Main lever activated</b>
Organisation of healthcare systems	Cooperation	Multipartite partnerships
Health coverage	Fairness	Universal health coverage
Financing of services	Performance	Pay for performance
Pricing of services	Fairness/justice	(Reversion to) Free healthcare

Source: author

Each of these mechanisms has been promoted by many actors in the field of health, at both national and international level. However, they have all encountered difficulties with implementation, which raises questions about the lack of horizontal links between the various mechanisms and about the patchwork of ‘turnkey’ systems put in place. For each of these aspects, we show that irrespective of the relevance of these various measures in themselves, the outcome of their implementation depends on the overall coherence both within health policies themselves and between those policies and actions in the other sectors, a coherence that is not currently evident.<sup>5</sup>

### ***5.1. Multipartite partnerships (MPPs)***

Multipartite partnerships (MPPs) for health bring together actors of different kinds (public, private, market, non-market) wishing to collaborate to attaining a common public health goal (Buse and Waxmann 2001). They include classic public-private partnerships (PPPs) involving one company and one public actor as well as much more complex forms (NGOs, regional authorities, central government, international organisations, etc.).

MPPs are usually invested with numerous virtues (Shifmann, Beer et al. 2002; Utting 2002). They are said to combine the advantages of the public and private sectors (public interest objectives and institutional durability, on the one hand, and innovation and spirit of enterprise, on the other). Nevertheless, the academic literature shows that this model does not offer all the necessary guarantees in terms of a comprehensive, integrated approach to health. In the literature review by Roehrich, Lewis and George (2014), several difficulties are identified that have a direct bearing on this issue. Firstly, MPPs are said to suffer from power asymmetries that disadvantage public organisations. Secondly, private partners are allegedly motivated principally by the financial opportunities offered by MPPs. Finally, MPPs are said not to be collaborative in nature, even though the initial argument in their favour was their ability to help a diverse range of actors collaborate with each other. For their part, Ramiah and Reich (2006) focus more specifically on MPPs set up to combat HIV/AIDS in Africa. In their view, collaborative partnerships are difficult to set up because of the inequalities of power, values and objectives. In sum, the studies reveal the asymmetries of power and objectives that lie behind the apparent convergence of objectives. This being so, the search for institutional complementarities is not one of MPPs' strong points.

The ASAQ partnership (Artesunate-amodiaquine combination) launched in 2007 to promote effective treatment of malaria is a fairly exceptional example of a balanced partnership between public and private actors. Nevertheless, even this partnership still struggles to address the other inequalities in the context in which partners work.

One important lesson to be drawn about MPPs is that the essential issue at stake is the norms of justice that predominate in them. In the case of the ASAQ mentioned above, leadership is in the hands of actors who provide a certain guarantee that market justice will not prevail. In many MPPs, however, whether or not they come under the authority of healthcare actors,

there is no such guarantee since the local public authorities are reduced to the role of facilitators rather than regulators (O’Laughlin 2016 p. 698). Thus in reality the MPPs in healthcare reflect a structural tendency to neglect the guarantee of social justice in all segments of society: after all, this tendency is also present in other social determinants of health (the external level of the SDHs), such as the partnerships in the agricultural sector with the influence of the agro-food multinationals or the question of access to energy resources, with private companies being called on to supply electricity or water.

### ***5.2. Universal health coverage***

Universal health coverage has become an important element of the measures recommended by international actors in the field of health, particularly the WHO (WHO 2010b). In contrast to many wealthy countries, where tax revenue and social security contributions have been used to establish universal healthcare systems, in low-income countries bottom-up initiatives, particularly community-based health insurance schemes, have been regarded at one time as viable ways of extending health coverage (Ridde et al. 2018).

However, the literature shows that attempts to do so have generally come up against the limits of voluntary mutual benefit insurance schemes. As the WHO notes (2010b), establishing universal coverage without compulsory insurance contributions poses serious problems about funding in the long term. Funding health cover solely through community-based mutual benefit insurance schemes also comes up against the fragmentation of the funding system (Bennett 2004; Carrin, James and Evans 2005) and the loss of power for communities that is said to be a consequence of compulsory membership.

Moreover, one of the essential conditions for the success of attempts to extend health coverage is an improvement in the deficiencies of health care provision and, more generally, in all essential services and needs (education, employment, energy etc.). As far as healthcare services are concerned, the WHO (2010b) states that improving access to health care is an essential condition for achieving the goals with regard to health coverage. The lack of coordination and linkage between the measures put in place in Africa has been highlighted in various reports (Waelkens and Criel 2004, Ouattara and Soors 2007). Thus one significant issue concerns the linkage between the top-down and bottom-up approaches to extending health coverage. These two levels of action have to be regarded as complementary in the process of extending coverage, which itself must be linked to a more “whole of government” policy. In the wider sphere of the other determinants of health (the external level), the extension of health coverage seems to be closely linked to general living conditions: gender inequalities and inequalities in access to food and jobs in which earnings are guaranteed by social regulations are major causes of the failure to engage with the health mutual, despite the fact that they were established to meet the needs of the least well-off populations.

Senegal’s experience clearly illustrates the weakness of the links between the various health promotion initiatives (Alenda, Boidin, 2019; Boidin, 2012). Since the beginning of the present decade, Senegal has been trying to develop statutory health insurance for employees in the formal economy (supplemented in part by mutual health organisations) as well as cover for the informal sector that relies on occupational or community-based mutual health organisations. To support the mutual movement, priority is being given to the decentralisation of healthcare provision, particularly in rural areas, to ensure that local needs are being met appropriately. The promotion of mutuals has led to an increase in the number of such organisations across the country (from 19 functional units in 1997 to more than 200 by 2010). However, this trend may,

in reality, reflect an increase in the number of small mutuals, which are financially extremely weak and do not provide access to high-quality medical care.

The shortcomings of the strategy of promoting mutuals as a means of providing universal health coverage are due in part to a failure to coordinate and connect the multiplicity of schemes of variable scope. The country has seen a cluster of more or less unconnected initiatives, ranging from mutuals based on the private insurance model (e.g. Transvie, the truck drivers' mutual) to those targeted at micro-companies (Pamecas) via purely community-based initiatives or specifically public programmes such as the *Sésame* schemes for the elderly (cf. below). This fragmentation poses problems when it comes to scaling up the various schemes to provide universal coverage. Furthermore, the efforts to extend coverage have also suffered from problems of coordination between the development partners. By way of example, USAID and the Belgian cooperation partner have developed two different programmes relatively independently of each other. One is a very ambitious attempt to link mutual health organisations financially at the department (sub-regional) level (development of health cover in the context of decentralisation – DECAM), while the other has adopted a more localised, district-based approach (Unité départementale d'assurance maladie/Departmental health insurance unit - UDAM) that uses a mixture of more or less innovative protection tools and aims to professionalise the mutuals.

Finally, the Senegalese experience also highlights how the representations and practices of users of the healthcare system may differ from those of practitioners, managers and decision-makers. A qualitative survey of four community-based mutuals by Alenda and Boidin (2019) highlights several trends. Firstly, the mutuals established without taking into account social, cultural, ethnic and religious diversity do not operate satisfactorily or sustainably. Thus the establishment of

numerous mutuals is not an effective strategy if they do not take into account another social determinant of health, namely inequalities between communities (depending on their religion, culture or ethnicity) in access to those mutuals. The effects of social domination come into play to restrict access for certain strata of the population to the detriment of other groups. Secondly, members' motivations are frequently complex and varied, reflecting a range of different concerns: to protect the immediate family, to pay contributions out of solidarity with the less fortunate, to maintain social status or to support the local community. Finally, the principles of democratic governance are clearly laid out in the statutes but not much in evidence in practice, with members sometimes voluntarily leaving the delegation of power up to the managers of the mutuals. Thus fragmentation and heterogeneity are the rule rather than the exception among the mutuals. There is no guarantee that these organisations will converge towards the unified system promised by the aid organisations and the public authorities. All things considered, the fragmentation of the mutualist universe is a reflection of social fragmentations that go far beyond the healthcare sector and open up the analysis to other determinants of health (the external level).

Overall, the case of Senegal illustrates the low level of institutional complementarities, both between the institutional actors (at national and international level, inside and outside the healthcare system) and between them and the users of healthcare systems. In this respect, the community of users is the missing link in the institutional complementarities, despite the aid organisations' pronouncements on community empowerment. Nevertheless, the most fervent promoters of community empowerment see it not simply as mere community participation but also as a renegotiation of power to exercise greater control over decision-making (cf. Girard, Sozanski, 2016, p. 12). The situations presented in the examples above seem to depart from this principle.

### ***5.3. Pay for performance (P4P)***

Pay for performance (P4P) is emblematic of an approach that may result in problems being addressed discretely unless it forms part of a broader, more comprehensive policy. P4P links the funding of health services to the achievement of predefined targets. Its defenders (Soeters, Habineza, Peerenboom 2006) regard it as an appropriate way of improving the utilisation and quality of health services. Other authors have their reservations and point to the lack of any real evidence of its efficacy (Fretheim, Witter et al. 2012) or its negative effects in terms of equity and comprehensive coverage of health needs (Ireland, Paul et al. 2011).

It is interesting to note that one of the most significant critiques of P4P (Meessen, Soucat et al. 2011) concerns the fact that it is limited to a sectoral approach to health, based as it is on the performance of health services alone (i.e. solely at the internal level of the social determinants). This critique reflects the fact that health programmes and health experts tend to operate discretely, in isolation from other areas of public policy (and hence without any link to the external level of the social determinants of health). Consequently, P4P clearly illustrates Aoki's argument (Aoki 2011) as applied to healthcare, since it turns out to be very difficult to measure one establishment's marginal contribution to overall system performance. Thus P4P cannot be regarded as an adequate solution without a shift within the healthcare system towards a HiAP-based approach.

Returning to the internal level of the social determinants of health (the healthcare system), can the actual impact of P4P be verified in practical terms from the point of view of its linkage – whether good or bad – with other health initiatives and the healthcare system itself? Very few empirical studies of this question have been conducted. The case of Burkina Faso seems to us

illuminating since it illustrates the potential disconnect between P4P techniques and realities on the ground. In a qualitative study of the implementation of the P4P approach in Burkina Faso, Ridde et al. (2017) reveal that a considerable gap can be observed between the theoretical principles of pay for performance and how it is adapted by the actors on the ground. Public actors and aid donors are unable to monitor actual implementation. The people and community chiefs are not always told by practitioners about the existence of performance bonuses. The payment of individual bonuses to healthcare providers raises questions of justice and equity. The payment of bonuses can be subject to considerable delays and their effectiveness in improving health outcomes cannot be demonstrated. These factors seem to us to illustrate the need to incorporate pay for performance into a broader analysis of the asymmetrical and complex relations between the actors in healthcare, users and political decision-makers. Ultimately, this reflects the necessary link between the internal functioning of the healthcare system and the other social determinants: after all, the power asymmetries between patients and healthcare workers as well as among healthcare workers themselves are not specific to the healthcare system since they are the product of the social organisation of the work environment and of inequalities in the management of access to employment.

In another survey carried out in Burkina Faso by Turcotte-Tremblay et al. (2017) in 7 healthcare facilities in rural areas, the unintended consequences of involving communities in P4P programmes are highlighted. Checks carried out by community representatives are, after all, intended to monitor service providers' actual activities to prevent them from declaring services not actually provided to increase the size of their bonuses. Even though these checks enable some patients to express their perceptions of the health services, they can still be skewed by various factors. They include: excessive workloads for the community verifiers, which can adversely affect the gathering of patients' statements; fear and apprehension on respondents' part in view of the social control that is still prevalent within communities;



mistrust of service providers' reactions to bad evaluations, etc. Overall, these various limitations arise out of the failure to take proper account of users' and local communities' perceptions of health programmes. After all, community monitoring of P4P is regarded by the programme promoters as community participation in the programmes. In reality, however, it is reduced to ex-post monitoring under the aegis of the promoters, which cannot be regarded as community empowerment. Users are still the absent actors in institutional complementarities.

#### ***5.4. Free health services***

Exempting certain treatments or health services from payment for targeted categories of patients (the destitute, pregnant women, children, the elderly) was reaffirmed at the end of the 2000s, particularly by the WHO, as an important way of making healthcare systems more equitable (2008). However, any attempt to put in place free health services comes up against difficulties caused by deficiencies in the institutional framework and overall strategies for health services. Recent studies have shown that free services introduced in isolation do not lead to any structural changes in access to better health, even though they help the populations concerned. Without any change in the overall goals and institutional frameworks (Ridde, Meessen et al. 2011), general reforms to make health service funding more sustainable and improvements in their quality and ability to meet rising demand (Meessen, Gilson et al. 2011), the effects of free health services remain limited.

An emblematic example of the failure of targeted free healthcare that does not take account of the structural weaknesses of the healthcare system is provided by the *Plan Sésame* in Senegal (Boidin 2012). This was an initiative launched by the President of the Republic, Abdoulaye

Wade, in 2006. Under the terms of the plan, healthcare was to be provided free of charge to citizens aged 60 and over. In particular, it targeted 70% of the population that did not have a pension. Its cost to the nation posed considerable problems, since it was extremely successful for beneficiaries but had not been sufficiently well planned by the central government, the main source of funding. The additional cost borne by the hospitals (massive influx of patients, absence of upstream funding) destabilised a healthcare system that lacked the necessary human and technical resources.

## **Conclusion**

Contrary to the standard vision of health policies based on transfers of good practices and technologies concentrated in hospitals, we have sought in this article to develop an approach that incorporates the political economy of health. The particular characteristic of this approach is that it takes account of the often implicit power relations in healthcare. In the healthcare sector that has been more particularly investigated here, these power relations are forged between users and health services as well as within health service providers, whose power is very unevenly distributed. However, these power relations are also the product of forces external to the healthcare system and it is in this direction that our approach, which uses a different analytical framework, seeks to extend the studies cited here as important milestones in a political economy of the social determinants of health (O’Laughlin 2015, 2016, Review of African Political Economy 2015). We have investigated this question by incorporating into political economy studies in public health and public policy. This, in turn, led to an analysis of institutional complementarities, whose inadequacies arise out of precisely those power relations and the fragmentation of health policies. After all, the weakness of the institutional complementarities in the examples cited in the present article may be closely linked to the limited power of the local public actors to formulate health policies or to the fact that the

public authorities have not reappropriated the social, education and employment policies that exert considerable influence over the health of their populations. The limited leadership displayed by the public authorities is reflected in low levels of institutional complementarities (which are further reduced by the fragmentation of development aid and the influence of neoliberalism over that aid, as noted by Navarro 2009), which in turn causes approaches based on the social determinants of health to be applied in an overly conventional manner, with an emphasis on the micro-level rather than on the structural causes.

This article is not the first to be written on the social determinants of health but it has sought to show how political economy might make it possible to uncover the structural obstacles to health promotion in Africa. In this respect, it seems necessary to continue to forge closer links between political economy, public health and political science. This work should be extended since the most recent major initiatives on international health promotion (in particular, the sustainable development goals) have emphasised the need for intersectoral approaches but have not directly confronted the question of inequalities of power. It might be noted, however, that the WHO, which has been very active on the question of SDHs, has now acknowledged the fact that ‘lack of control and powerlessness are the real causes of the health inequities’ (WHO, 2017, p. 15). However, concrete initiatives intended to deal with these causes are more or less completely absent in Africa, although they seem to be developing on other continents (for example in Europe with the *WHO Small Countries Initiatives*, which are targeted at European countries with fewer than one million inhabitants).

The interpretative framework developed here could be deployed in studies that draw on implementation science applied to health policies (Madon et al. 2007) which, as Ridde notes, has been insufficiently used in Africa, particularly in the French-speaking countries (Ridde, Morestin 2011). Country studies could then use this notion of institutional complementarities

in order to gain a better understanding of the critical points that must be addressed in designing effective health actions and effective policies for health in all sectors.

In more concrete terms, there are various avenues through which researchers can act to bring the contribution of political economy, with its analysis of institutional complementarities, to bear on health policy. Firstly, alongside the technical assessments made by health economists in the Global South (which are largely dominated by neoclassical analyses), alternative interpretative frameworks, such as that based on institutional complementarities, could be promoted, which would help to put into perspective the hegemony of technical tools such as marginal analysis applied to healthcare (cost-effectiveness analysis). After all, insofar as the existence of institutional complementarities makes it impossible to calculate the marginal contribution of one particular actor rather than that of another and tends instead to highlight the effects of systemic coherence or incoherence, non-mainstream analyses should be accorded a more important place in training programmes. Secondly and relatedly, reasserting the value of empirical studies conducted in the field with the use of qualitative techniques (which are often regarded in neoclassical economics as outside the scope of economics) would help to shift the balance of the research methods used in the field towards those that take greater account of local specificities, recognise specific trajectories and even hold out the hope of re-politicising healthcare.

## **Endnotes**

1. A distinction is made in this article between two notions: on the one hand, the social determinants (SDHs) as an academic notion and, on the other, the principle of health in all policies (HIAP) as an organisational framework arising out of studies on SDHs.
2. The studies cited here fall within the scope of a particular field of economic research in France that led to the founding in 2009 of the French Association for Political Economy (*Association française d'économie politique/AFEP*) whose members seek to promote a different approach to that adopted in neoclassical economics. They include adherents of

the Marxist-inspired *régulation* school, some of whom have adopted the institutional complementarities approach in order to point up the diversity of modes of regulation.

3. Thus the WHO's global prevention policies against risky behaviours (smoking, unbalanced diets, unprotected sex etc.) run counter to the economic interests of the pharmaceutical companies (which sell withdrawal aids or drugs) and those of the healthcare professionals who treat obesity. By way of example, when the UN and the WHO attempted in 2011 to launch a coordinated international policy on the prevention of non-transmissible diseases, which accounts for only 3 % of global aid in the health sector, the producer lobbies, supported in many cases by the wealthy countries' governments, put a damper on this initiative by pointing to the potential job losses in industries selling products that are harmful to health (alcohol, tobacco, foods with a high sugar, fat or preservative content, etc.).
4. The health problems that beset populations in low income countries require multidimensional, cross-cutting approaches, which cannot be implemented without being orchestrated by a state capable of asserting its national priorities. However, the arrival of private donors and vertical aid funds that focus on certain specific diseases has actually contributed to the compartmentalisation of aid and the proliferation of health programmes, to the detriment of cross-cutting approaches. Furthermore, this turns the principle underlying health aid on its head: governments tend to accept any aid project to which funding is attached rather than first setting out their priorities and drawing up programmes that address them in order then to make a request for the appropriate aid.
5. This section presents a panoramic, classified overview of the various strands of health policy. It aims to illustrate the possible linkage between the analytical framework based on institutional complementarities and critical studies of the conventional model of the social determinants of health. We acknowledge its programmatic nature and the need to analyse in greater detail each of these strands in further studies.

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