Social determinants of health and institutional complementarities in Africa: a challenge for health policies

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Déterminants sociaux de la santé et complémentarités institutionnelles en Afrique : un défi pour les politiques de santé

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Résumé *: Cet article examine les défaillances dans la mise en œuvre d'une approche fondée sur les déterminants sociaux de la santé en Afrique. Nous prolongeons cette approche en adoptant une perspective d'économie politique qui considère le processus de décision politique comme étant non linéaire et l'absence d'idéal-type institutionnel. La notion de complémentarité institutionnelle est mobilisée pour analyser les lacunes des politiques de santé en Afrique à partir d'une perspective systémique. Nous voulons montrer que les programmes de santé sont fondés sur une vision rationaliste et verticale des problèmes et caractérisés par de faibles complémentarités institutionnelles. La contribution de cet article à la littérature réside dans la mobilisation d'une perspective d'économie politique qui cherche à rapprocher la santé publique des analyses en termes de politique publique.*

Mots-clés : déterminants sociaux de la santé, Afrique sub-saharienne, économie politique, complémentarités institutionnelles.
Codes de classification JEL : I10, I18, O55

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 and are characterised by 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
JEL classification codes: I10, I18, O55

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Introduction

Besides the growing number of empirical articles and political discourses about the role of social determinants of health (SDH) in sub-Saharan Africa, the SDH-based framework has been very poorly implemented (CSDH, 2008, Houéto and Valentini, 2014). This article aims to analyse the causes of this situation and contribute to the conceptualization of the weaknesses from a political economy perspective. 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. We would like to show that the health programmes are reflected in low levels of institutional complementarity. A systemic approach (Cambien, 2007) to the functioning of health systems is therefore required in order to understand the interactions, both positive and negative, between the various elements that constitute a more closely integrated health policy (Boidin, 2018).

The present article is based on a literature review. Significant studies of the benefits of a political economy perspective applied to SDH (O'Laughlin, 2016, Review of African Political Economy, 2015) highlight the need for a break with the conventional models for taking account of SDH. 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. Firstly, we are seeking to enrich the political economy approach sketched out by these authors by introducing studies that focus on institutional complementarities. 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 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.

We begin by highlighting the poor implementation of the SDH-based approach in sub-Saharan Africa (section 1). 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 2. Section 3 examines the contribution of political economy, based in particular on institutional complementarities. 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 SDH (sections 4 and 5). This enables us to highlight the need for better institutional complementarities in public health actions in sub-Saharan Africa (section 6).

1 The weak implementation of the SDH-based approach in sub-Saharan Africa

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). 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 Harriss-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. The Covid-19 pandemic raises the same risks.

Some significant advances have, however, been made on the institutional level, with efforts being made to take SDH 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). 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 SDH 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.

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).

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 policymaking. 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. 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.

2 The contribution of studies of SDH to the analysis of the health situation in sub-Saharan Africa

Studies of SDH 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 two that 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.

The first of these advances 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 analyses 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).

The second 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 SDH imply that the rationalist view of the policymaking process should be abandoned. Russell et al. (2008) refers to a 'naive rationalist' vision of policymaking, 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 policymaking 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 SDH 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 policymaking processes.

3 The contribution of political economy

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 regulation, 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, Boyer, 2007) 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.

The first characteristic of political economy 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.

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.

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, Boyer, 2007), 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 policymakers 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.

4 Analysis of institutional complementarities applied to health

Bambra et al. (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 policymaking process and its context. Furthermore, these

studies are 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 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. 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. Such a model cannot be reduced to a number of superimposed elements that constitute the health policy. On the contrary, it is a system of actors who may prove to be more or less complementary. 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.

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 policymaking (Carey, Crammond, 2015, 139).

5 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 enable us to link our analytical framework based on institutional complementarities to the literature on SDH. 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 Dahglren 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 policymaking, 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 SDH 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.

6 Application of institutional complementarities to health programmes in sub-Saharan Africa

Several policies and mechanisms have 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. From a systemic point of view, the result is that the multiple interactions between the actors and elements of the health policy are ignored. We consider two main components of the health policies implemented since the 1990s under the influence of the international partners, namely: universal health coverage and pay for performance.

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.

6.1 Universal health coverage: the case of Senegal

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; Ridde et al., 2018). 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. There are several aspects of such initiatives that make them innovative. Firstly, in order to make payment easier, contributions are set at different levels depending on family size and the subscription period. Secondly, in order to avoid providing insurance for poor-quality care, the UDAMs offer a quality control procedure for the care provided. Finally, in order to facilitate membership and community participation, the populations with their origins in community organisations are guaranteed local representation through outposts set up by the regional authorities. These organisational and financial

innovations have given the UDAMs a certain degree of resilience during the pandemic (Ridde, Mbow, Senghor, 2020).

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. They also represent a departure from the "user driven innovation" approach (Lundvall, 1985) that emphasises not only responsiveness to users' needs but also the involvement of those users in the processes. If such involvement is to be ensured, power relations within the health system will have to undergo change.

6.2 Pay for performance (P4P): the case of Burkina Faso

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 the systemic dimension is not taken into account in the P4P approach, which focuses on the performance of the health services to the detriment of the interactions between those services and the other determining factors. 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. This points once again to the value of adopting a "user driven innovation" approach (Lundvall, 1985). However, approaches of this kind are more or less ignored in the way the health systems currently operate, with the exception of a few all too rare experiments (cf. 6.1 above for the case of the UDAMs in Senegal). 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.

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. In the healthcare sector that has been more particularly investigated here, power relations are forged between users and health services as well as within health service providers. 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 SDH, 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.

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