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Africanising the social determinants of health: embedded structural inequalities and current health outcomes in sub-Saharan Africa

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Abstract

There is a growing interest in health policy in the social determinants of health. This has increased the demand for a paradigm shift within the discipline of health economics from health care economics to health economics. While the former involves what is essentially a medical model that emphasises the maximization of individual health outcomes and considers the social organization of the health system as merely instrumental, the latter emphasises that health and its distribution result from political, social, economic and cultural structures. The discipline of health economics needs to refocus its energy on the social determinants of health but in doing so must dig deeper into the reasons for structurally embedded inequalities that give rise to inequalities in health outcomes. Especially is this the case in Africa and other low and middle income regions. This paper seeks to provide empirical evidence from sub-Saharan Africa, including Ghana and Nigeria, on why such inequalities exist, arguing that these are in large part a product of hangovers from historically entrenched institutions. It argues that there is a need for research in health economics to embrace the social determinants of health, especially inequality, and to move away from its current mono-cultural focus.

Key words: social determinants of health, inequalities, colonisation, Africa, history
Introduction

Health economics began as an applied sub-discipline of economics dealing with how scarce health care resources might be used to address health needs. Initially it was dominated by economists motivated by the Arrow (1) vision of the economics of medical care. This took into account the intractable uncertainties, information asymmetry, agency problem, and externalities that dominate the health care market. Over time, health economics has gradually come more and more under the influence of the medical profession. This has led health economists to adopt what amounts to primarily a medical model in their analyses. The dominant health production function became tilted toward the maximization of medical outcomes of the individual patient, namely better health. As Mooney (2) notes, under this influence health economists gradually discounted the structural and organization aspects of the commodity as merely instrumental. Health economics turned into health care economics and at the same time became very much based on western values which did little to examine the social, political, cultural and environmental determinants of health.

The voice for a paradigm shift from health care economics which emphasises the individual perspective within health care to health economics which emphasises health as a social good and health care systems as social institutions is growing louder. Edwards (3), Navarro (4) and Mooney (2) among others have argued for a new model more focused on health in a social context. One part of this argument is that there has been a failure in health policy in general to recognise the social nature of prevention and public health (5). That in turn has led to the need for greater acknowledgement that the activities of health prevention and cure should be underpinned by community values.

This quest for a paradigm shift is supported by the increasing recognition by governments of the socioeconomic determinants of health and their avowed commitment to address these underlying causes of ill-health. Such a paradigm shift is also needed to accommodate the fact that health as a concept is multi-cultural rather than universal. A new model of health economics would thus allow consideration of other, for example, non-western cultural values.

There is a demand for a more inclusive view of the social determinants of health (SDH) (6) with greater emphasis on issues around the social power distribution – class as Navarro (7) calls it or social stratification as Wilkinson and Pickett (8) name it. The study of the social determinants of health and particularly inequalities in health has generally been seen from the narrow perspective of proximate social determinants of health and from the prism of western culture. That culture as one of us has argued elsewhere (9) is epistemologically empiricist in outlook. As such it tends to ignore other non-empiricist, more hermeneutical approaches to understanding health and health care. In particular, the literature on the SDH has generally been neglectful of non-western cultures especially African. For example of the 155 papers published in peer reviewed journals reviewed by Wilkinson and Pickett (8) or in an earlier review by Subramanian and Kawachi (10) almost all were focused on Europe, the USA and other OECD countries. Very few were on developing countries, much less on Africa. Recently, within the context of South Africa, one of us has argued for examining historical, social and political contexts and power relations which shape inequalities in health (6). Large amounts of space have also been given in the health economics journals to issues of largely western interest such as obesity. However the issues of poverty, deprivation, inequality, social exclusion and others which are critical to understanding health in Africa and many other regions of the world, and their implications for public health have received relatively
little coverage in these journals. Yet these issues affect the majority of the world’s population.

This paper focuses on one important issue, that of inequality, using that as an example of the sorts of problems that can arise if health economists were genuinely to seek to grapple with the social determinants of health. Most work on inequality and health assumes income inequality or other related measures of socioeconomic status (SES) as the issue, although as mentioned above Wilkinson and Pickett (8) do mention social stratification (of which income inequality is a measure) and Navarro (4) emphasises class and power. Here we look at the question of the distribution of power as the explanation behind the link between inequality and ill-health (6). We argue in turn that SES may not be a particularly useful or appropriate measure of inequality in an African context, thereby drawing attention to the need for research in both health economics and the SDH to adopt a more multi-cultural stance.

The inappropriateness of conventional SES in Africa

Income and other SES measures have been shown to be problematical as a measure of social inequality in the African context (see for example, 11, 12). Basically, the concept of SES derives from the forms of class relationships which characterise industrial Europe and America. In these contexts, SES is a classification scheme arising from either the Weberian or Marxist perspectives of defining social relations. It includes classifications based on occupation (e.g. the British Registrar General’s Occupation Scale developed in 1911), income or education. Each of these classification schemes can prove problematical when attempts are made to impose it on non-industrialised societies or societies without the equivalent experiences of the industrialised west or when it is used to try to establish social hierarchies in poor communities. As Ichoku (9) has argued, fundamental historical transformations have taken place in African societies and these have created a dualism whereby cash dominated economies exist side by side with traditional subsistence economies. The balance of each of these varies between and within countries and even within regions and ethnic groups. The complexities of this situation are exacerbated for researchers by the fact that households may choose to spread their risks across the two economies. Thus a qualified teacher may also be a trader, or a taxi driver. A professional on the staff of a bank may earn a large salary, live in a rented apartment in a city and have no land inheritance in any village. His counterpart living in the village may have no bank account but large herds of cattle and own title to a substantial piece of land. Who is wealthier? Who has more power? In such contexts as these, classifying a population according to conventional measures of SES is likely to yield inappropriate and/or incorrect results.

Alternative indicators of power distribution in Africa

If the conventional indicators of social class are inappropriate in Africa and some other developing regions, what can we use for power distribution in place of income inequality or SES? Current studies on SDH have neglected the exploration of the remnants of colonial institutions and their possible impact on power distribution in contemporary African societies. This neglect is probably because historical institutional hangovers may not be amenable to social policy reforms (13). Saying that however merely serves to underscore the need to explore these more durable roots of the causes of SDH. That of course might well lead to the need to consider wider and deeper approaches to social reform and an acceptance of the longer adjustment periods required to correct entrenched social factors that influence
current states of health. The need for such investigation is even more cogent given that while the proximate causes of SDH might change reasonably rapidly, these more fundamental social determinants are more enduring (14) and therefore generate even more enduring social inequalities in health. It is further the case that, given the very poor quality of life in Africa and other underdeveloped parts of the globe, so much more health research and policy energy must be focused on these parts of the world and in turn these issues.

These historical patterns are useful particularly in the context of Africa in dealing with within country geographical disparities in investment in health care infrastructure and ultimately in health outcomes. While a large number of these SDH may be universal, others may be more area- or region- specific. Studies of SDH in general have tended to ignore the role of history in embedding structural inequalities through institutions which continue to generate observed socioeconomic inequalities in health today. These issues are fundamental to understanding inequalities in Africa (6).

Lessons from the institutional economics literature

Our interest here is to demonstrate that historical factors shown in the patterns of colonial settlements and the resulting institutions in Africa have contributed to shaping current socioeconomic inequalities in health outcomes in sub-Saharan Africa (SSA). One lesson that may be learnt in SDH research from developments in the institutional economics literature is the awareness that historical institutions can have profound influences on the patterns of present investments which in turn can lead to differences in productivity and social outcomes. Since history can have a persistent effect on social and economic outcomes, it can then be critical to understanding differential social and economic performance in general and of socioeconomic inequalities in health in particular. For example, one empirical study (15) demonstrates that colonial land revenue systems set up by the imperial British powers in India, about 1860, led to significant differences in historical property rights institutions and to differences in economic outcomes that persist to the present. After the conquest of India, the imperial power set up two major arrangements for land tax in the different provinces. One operated through landlords who paid land tax to the government after collecting taxes from tenants on the land. In the other arrangement, the tenants paid taxes directly to the government. These two systems led to different patterns of agriculture and development in the provinces and vastly different health and educational investments, the outcomes of which have persisted to the present. The average yield of wheat is 23% higher and infant mortality is 40% lower in former “non-landlord” districts than in the “landlord” districts while inequality is higher in the “landlord” districts.

A set of literature, (see for example 16, 17-19) also demonstrates how historical institutions determine current social and economic outcomes. Acemoglu, Johnson and Robinson (17) for example, document the way in which development fortunes in different parts of the world changed as a result of institutional reversals consequent upon European intervention over the last 500 years. Areas that were previously among the richest (e.g. the Mughals of India, the Aztecs and Incas in Latin America) are now relatively poor while areas that were relatively poor (e.g. Australia, North America) are now relatively richer. The underlying factor in these developments, according to this hypothesis, is in the strength of historical institutions left behind by the colonialists. Institutions ensuring secure property rights and contracts for at least the majority of the population are essential for investment incentives and successful economic performance (17). The authors contrast secure property rights institutions with extractive institutions which concentrate power in the hands of a small elite which creates the
risk of expropriation for the majority of the population and therefore discourages investment and development. Furthermore, extractive institutions increase the probability of creating and sustaining a culture of rents capture by groups that hold political power. A similar line of argument is advanced by Acemoglu, Johnson and Robinson (16) who suggested that the adoption of different colonization policies by Europeans is associated with different institutional quality established in the different colonies which has endured over time. In places where the colonisers faced high mortality risks arising from unfavourable disease ecology, (e.g. in tropical Africa where the risk of death from malaria was high) they established extractive institutions that supported the exploitation of the resources in the colonised territory. In contrast, where there were reduced health risks as in countries with temperate conditions, they established enduring institutions that guaranteed strong property rights and the efficient enforcement of contracts which in turn provided incentives for investment and ensured longer term economic development.

Acemoglu, Johnson and Robinson (20) and Bhattacharyya (13) propose a hypothesis for understanding the historical roots of varying institutional qualities and therefore different trajectories of development across Europe. Bhattacharyya (13) and Nunn (21) attempt to formalise this theory in the specific context of Africa by showing that persistent disease ecology has blighted the development of strong institutions in Africa. The long history of epidemics and endemic diseases including malaria, cholera, tuberculosis and more recently, HIV/AIDS have played significant roles in the blight of Africa’s development (22). Consistent with the hypothesis put forward by Acemoglu, Johnson and Robinson (20), it is only to be expected that in such a disease infested ecology and generally harsh geographical environment, the European colonisers established only extractive institutions that enabled them to exploit the resources of Africa without at the same time establishing enduring secure property rights and contract enforcement institutions. While these hypotheses have framed the historical sources of differences in development in general, our focus is to relate this to the SDH in Africa and to demonstrate that this has played a role in generating the current levels of health inequalities in SSA, but particularly within countries in the sub-region.

**Colonial institutions and the social determinants of health in sub-Saharan Africa**

The foregoing discussion provides a basis for examining the historical embeddedness of social determinants of health and inequalities in contemporary SSA. European colonization has had and continues to have a profound impact on every facet of economic, social, political, and cultural development of contemporary Africa. It created new sets of values, institutions and opportunities as well as new power configurations. The new institutions differed markedly from what had existed before, effectively since the 18th century. For the specific purpose of socioeconomic analysis of health inequalities, these new power relations result in the creation of a new set of indicators of socioeconomic status. Certainly these may overlap with conventional western SES but are unlikely to be identical. The conventional indicators of socioeconomic status have limited capacity to reflect the fundamental influence of these historical institutions on health disparities across and within the countries of the region. Yet it is these historical forces which serve to define the strengths, weaknesses and vulnerabilities in much of today’s SSA populations.

Furthermore, the specific styles of the different colonial authorities created fundamentally different social systems (including health systems) with implications for social stratification and inequality. While these different styles is not the focus of this paper, Blanton, Mason and
Athrow (23) have demonstrated that the system of administration of the British, being indirect and decentralised, fostered a legacy of ethnic competition and ultimately conflict between constitutive ethnic groups which continues to today to promote inequalities in socioeconomic outcomes. The British system is in contrast to that of the French which was centralised direct rule leading to the abolition of indigenous institutions and the imposition of French beliefs and practices (24).

Thus while SSA societies, like all human societies, may have had or even still have their traditional social hierarchies, the influence of colonialism on the creation of social inequalities in Africa cannot be over emphasised. It was colonialism which introduced the chief ingredients of social stratification, status and social inequality into the existing subsistence economy that prevailed in Africa prior to the arrival of the Europeans. In South Africa for instance, operating under the apartheid system, different health systems catered for different races (25). This is now reflected in current inequalities in health across racial groups in the country.

Money, the market system and the rise of social inequalities in Africa

How did the new structural SES indicators in Africa come to be? The introduction of a money economy, the use of the market system for the distribution of resources and the use of resources for private profit accumulation were the principal ingredients that set in motion the forces of social inequality and stratification in contemporary SSA. Prior to the arrival of the Europeans on the African continent, the population had an essentially subsistence existence. Subsistence economies differed significantly from those based on the capitalism which colonialism brought. In such economies, there was no accumulation of surplus. People worked not for profit but for survival. Labour was supplied based on kinship and reciprocity. As Chodak (26 p.409) documented:

“With the exception of a few minorities in some areas of Africa people in traditional African societies could hardly be regarded as profit oriented. They did not strive for riches, private property or money gain.”

It is of note that the difference in these economic forms was not only recognised by the colonialists but created problems for them. Chodak (26) notes further that without the instrument of money Africa could not become a satellite economy of Europe. To do so it was necessary to create the desire for money and European goods in the African population. The introduction of money and capitalist values was necessary to generate the demand for European goods. African labour was needed in the mines and the plantations that serviced industrial Europe. However, creating the desire for money among the African population was a formidable task since they saw no reason to abandon living as they had before the arrival of the Europeans. Taxation became the vehicle through which the colonial authorities could achieve several goals at once and which today lie at the heart of social change, stratification and social inequalities in Africa.

To maximise the impact of taxation on Africans and to achieve the intended effects as quickly as possible taxes were levied on a per capita basis. In some places it was initially introduced as a “hut tax” but then turned into a per capita tax for every adult (27). In order to earn the money to pay taxes, Africans had to supply cheap labour by working for the Europeans in the mines and in the plantations. In turn they had to demand money from fellow Africans for things that were previously obtained free or which, like labour, were given in
reciprocal exchange (28). More importantly, this process required a shift from the production of food crops which were non-tradable to cash crops which were tradable. This shift is crucial to understanding not only the change in pattern of food consumption in contemporary Africa but also the phenomenon of malnutrition and the growth in non-communicable disease in Africa (29). As Chodak (26) also notes, people who were not working in the mines or the plantations or who could not sell their products to the Europeans started demanding money in return for goods and services. Labour supply, which under the subsistence economy was based on kinship, now became a market factor of production, based on exchange for money. Thus money penetrated the traditional subsistence economy and the need for capital institutions emerged.

Gradually, money became part of the economic institutions and a platform for economic and social organization. It forced people who previously had lived in rural villages into urban areas where they had the opportunity to supply wage-earning labour. Indirectly and additionally this led to the development of urban centres with not only far reaching implications for traditional institutions but also depressing effect on rural economies.

In the remainder of this paper an attempt is made to provide empirical illustrations of how structural embedding of remote colonial institutions resulted in the current large socioeconomic inequalities, including in health, in SSA. We use specific cases within sub-Saharan Africa including Ghana and Nigeria to show these historical hangovers.

Patterns of urbanization in SSA

Urbanization creates unequal power roles offering different levels of opportunities to different groups. Those in urban areas in general have greater social access and opportunities than those in rural areas. The localities where the Europeans first settled along the coastal regions, administrative centres, the mines, plantations and trading posts for agricultural produce grew to become the urban centres of post-colonial Africa. The routes through which agricultural produce was moved from the hinterland to the seaports became the major transport routes. Yeboah (30) notes that in eastern and southern Africa, urban centres were built exclusively for the male labour force that assisted in resource extraction. In West Africa the colonial authorities relied on the existing settlement patterns which excluded women. The result was that in eastern and southern Africa, the exclusion of women from the labour market in the urban centres meant that they migrated from the farms as agriculture stagnated. They found no jobs in the emerging cities and often ended up taking to one form of prostitution or another. Yeboah (30) argues that this is the reason why today there are relatively more urban women engaged in prostitution in eastern Africa than in the west. This explanation might also shed light on the pattern of HIV/AIDS prevalence in SSA, at least at the early stages of its development.

Migration of the male labour force to urban areas has also important implications for food production, nutrition and health, as colonial economic policy shifted from food crop production to production of cash crops for exports. Turshen (29) traced the extensive malnutrition and persistent ill health in Tanzania to poor diet resulting from this structural distortion. Thus it is easy to see how both the present health systems of contemporary African countries and the health inequalities in these countries are closely linked to the patterns of colonization.
In addition those regions nearest to the colonial settlements, particularly those closer to the sea, had a head-start in development. Yeboah (30) and Oppong and Hodgson (31) document that of the five old regional divisions in Ghana, the then Colony region alone (which was the point of immediate contact with Europeans from the Atlantic Ocean) accounted for 35 (46.7%) of the country’s 75 cities in 1984. The Ashanti region which is contiguous to the Colony region had 17 urban cities (or 23% of the total number of cities) while other more distant regions had far fewer urban areas.

**From historical institutions to health inequalities**

The point to be noted here is that in any analysis of health inequalities it would be misleading to concentrate, in Africa for instance, on occupation, income, conventional SES and other such indicators when examining health inequalities without taking these historical developments into consideration. In Ghana for instance, investment in health infrastructure and human resources follows the same historical patterns as the colonial settlement. Dovlo (32) reports that only 6% of total doctors in Ghana are located in the northern part of the country with a population of 4 million people, whereas Greater Accra along the coast of colonial entry into Ghana with only 12.5% of the population employs half of the total doctors in the country. A similar trend is reported on rural-urban disparities in resource distribution. It was reported that in 1997 about 87% of the general physicians in the country worked in urban areas, even though 66% of the population lived in rural areas. This pattern still persists as it is recently reported that medical staff “especially high-level cadres, are underrepresented in rural areas and areas with high poverty levels” (33 p. 6).

In Nigeria, current large regional inequalities in both health infrastructural investment and the social determinants of health can be explained by the different colonial policies adopted by the British in the country. As in Ghana, the British colonial powers entered the colony through the coastal region (i.e. the south) and gradually penetrated into the hinterland from southwest to southeast and to the north, before in 1914 amalgamating administratively the southern and northern protectorates. The white Christian missionaries who, apart from spreading the gospel, were also the key bearers of education and health services, followed in the footsteps of the colonial powers. The colonial authorities adopted two different administrative styles in the north and south. The authorities assumed direct administration of the provinces in the south but, finding the pre-colonial feudal Islamic political structure in the north congenial for collection of taxes and exploitation of economic resources, they adopted an indirect rule system in the north.

Indirect rule allowed the powerful emirs and village heads to collect taxes from their subjects on behalf of the government while retaining part of the revenue for their own use. To ensure that these native structures were not disrupted the colonial authorities denied the European Christian missionaries access to the core northern regions (34). The missionaries who in addition to their missionary activities established western educational and health facilities could therefore not operate effectively in the north (although they did have some success in parts of the middle belt).

The result of these different colonial policies was the development of institutions in the north and south of Nigeria with different trajectories: the north almost completely moored to the feudal Islamic institutions while the south was heavily influenced by western values. In particular, education and western health systems became entrenched in the south while the north still lags far behind in these sectors. These different institutions resulted in vastly
different social and economic outcomes, creating large social inequalities that have persisted to the present time. For example, Isichei (35) documents that in 1970 about 85% of children in Lagos state in the south of the country went to school as against 48% in Kano state in the north. In 1996 when Nigeria adopted a 36 state federal structure, two states in the south had more first-year university entrants than all the 19 northern states put together (34). Statistics from the Nigerian National Bureau of Statistics (NBS) show that in 2008 youth literacy in Imo state (in the south) was 99.2% as against 48.9% in Bauchi state (in the north). Similarly adult literacy in the southern state of Edo was 91.1% as against 29.6% in Katsina state in the north.

Similar large inequalities are evident in the health sector. Ityavyar (36) documents that:

“Modern health services were mostly provided by missionaries and so the more missionaries in an area the more the health services available. The implication of this was the maldistribution of mission health services between northern and southern Nigeria. Religious and geographical reasons, though not the only factors are nevertheless important in explaining the present inequalities in health services between northern and southern Nigeria” (p. 490).

Figure 1: Regional differences in child mortality rates in Nigeria

![Figure 1: Regional differences in child mortality rates in Nigeria](image)

Source: National Population Commission and ORC Macro (39)

In a similar vein Alubo (37) notes that in the former federal structure of 21 states, five states in the south and Kaduna (which was the seat of colonial government for northern Nigeria) accounted for 80% of total registered health facilities and beds in the country. The UNDP (38) found that life expectancy in the former Bendel state (now split into two – Delta and Edo states) in the south was 18 years higher than in Borno state in the northeast. Figure 1 shows the sharp differences in current child mortality rates between geopolitical regions according to the intensity of colonial and missionary impact. It can be seen that child mortality rate in the northeast is almost double that in the southeast. A child born in the northwest has a 2½ higher probability of dying before age 5 than one born in the southeast. The high mortality rate in the south-south region is also explainable in terms of the very swampy and difficult terrains of the region which made colonial and missionary penetration very difficult. Today, this continues to impede accessibility to and of social services. Similar patterns of structural
inequalities have also been observed in other countries of SSA, including Kenya and Uganda (38).

Figure 2: Regional differences in child mortality rates in Ghana

![Graph showing regional differences in child mortality rates in Ghana.](image)

Source: Ghana Statistical Service, Ghana Health Service and ICF Macro (40)

Figures 1 and 3 clearly illustrate the large inequalities in health between the northern and southern zones of Nigeria. A similar pattern is observed in Ghana as shown in Figure 2. The Greater Accra and Ashanti regions have better health indicators than the northern, upper west and upper east regions. According to the 2003 Nigerian Demographic and Health Survey the southern regions of the country have far better health outcomes in terms of child mortality rates than the north (39). For example, child mortality rate in the northwest is more than 4 times higher than in the southeast. Similarly, the average prevalence rate of child malnutrition measured by severe stunting in the northern regions is 29.3% as against 12.3% in the south while it is more than 3 times higher in the northwest than in the southeast.

Figure 3: Regional inequalities in child nutrition in Nigeria

![Graph showing regional inequalities in child nutrition in Nigeria.](image)

Source: National Population Commission and ICF Macro (41).
These distributions suggest that colonialism significantly influenced the current patterns of health and health care in Africa.

**Conclusion**

In research on social determinants of health and health inequalities, there has been a tendency to exclude historical and cultural factors. This manifests itself in sub-Saharan Africa through an ignoring of the historical institutions that have structurally embedded inequalities in African populations. Closer attention to the institutional dimensions could lead to a better understanding of the proximate social determinants of health and health inequalities. This understanding is especially crucial because the structural factors are more fundamental and enduring. Unlike proximate social determinants of health which change over time, the institutional determinants of health are deeper and require longer term adjustment and deeper policy reforms to address. However, it is only when these structurally embedded factors are grappled with that the proximate causes of social health inequalities can also be adequately addressed.

This paper has also tried to show that the current, in essence, mono-cultural (i.e. western) approach to the study of SDH needs a paradigm shift as well. In this context health economics the sub-discipline and the ‘cheerful face of a dismal science’ seems to have lost its bearing. Health economists have exerted enormous energy on the health care economics, focusing largely on issues of very narrow and limited interest such as obesity, computation of QALY and statistical life, while neglectful of the more urgent problems confronting Africa and other developing countries including problems of hunger and social conditions of the large majority of the human race.

Certainly there is a growing number of voices demanding a paradigm shift in health economics. It is doubtful however whether the present attraction of policy issues that largely focus on western concerns and which generate interest in current health care economics can be overcome completely. We hope nevertheless to have demonstrated in this paper, using Africa as an example, that to broaden out to accommodate health economics conceived as a social and cultural study of the social determinants of health would be a worthy enterprise.

**Footnote**

1 Many African countries now depend, to a large extent, on imported processed food from abroad which is said to be responsible for the high and increasing rate of non-infectious diseases in Africa (29). It has been difficult for many countries on the continent to reverse this demand not only for important processed foods but also for other forms of imported items.

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