FWS / ESSAY OF REFLECTION AND PROPOSALS

DEMOCRATIZING HEALTHCARE IN AFRICA

Making Access to Healthcare a Reality for All

Cheick Boucadry Traore

"The health of an economy depends on the health of its citizens."

A society may possess natural resources, expanding markets, and ambitious projects without ensuring that its people have dignified access to healthcare. When illness forces a family into debt, when distance delays an essential consultation, or when the quality of treatment depends on income, the problem extends beyond the organization of a public service: it concerns social justice, institutional capability, and the future of development.

Democratizing healthcare means transforming access to care from an opportunity reserved for some into a reality for all. It involves rights, but also the practical means of exercising them: essential services close to communities, qualified personnel, available medicines, equitable financing, patient protection, and public accountability.

Africa does not have a single healthcare system. Resources, institutions, geographical constraints, and achievements differ across countries. The principles proposed here therefore call for nationally adapted approaches, not a uniform prescription. Nevertheless, they share one starting point: the human person must be both the source and the ultimate purpose of public action.

01 Health as a Requirement of Citizenship

Illness does not ask about a household's income before it strikes. Yet access to a consultation, an examination, a procedure, or a medicine may still depend on that income. The formal freedom to seek treatment is insufficient when financial or geographical barriers make that freedom illusory.

Recognizing the right to health does not mean promising that everyone will always be healthy. It means affirming that no one should be unjustifiably excluded from a system of prevention and care that respects human dignity. This principle is grounded in international and African human rights instruments [1]. Where useful, it may be strengthened by a constitutional guarantee; everywhere, above all, it must be translated into laws, budgets, administrative responsibilities, and effective avenues for redress.

Democratization therefore requires four inseparable guarantees. Services must be available; they must be accessible, financially and geographically; they must be acceptable, with respect for individuals and their consent; and, finally, they must be of good quality. A facility that is open but has neither medicines nor staff does no more to secure a genuine right than a competent hospital that low-income households cannot reach or afford.

This requirement is especially important for those whom general policies too readily leave behind: poor families, rural residents, pregnant women, newborns, children, persons with disabilities, older people, and displaced populations. Their circumstances should not be treated as an afterthought in national programs. They should be a measure of those programs' seriousness.

Citizenship also entails informed participation in collective life. Patients must be able to understand their treatment, know the costs charged to them, give informed consent, receive care without humiliation, and report abuses. Communities must have ways to make their needs heard. Such participation, however, never releases the state or providers from their own obligations: a patient's poverty must not become a pretext for blaming that patient for the shortcomings of the system.

Public healthcare must therefore be understood neither as a privilege nor as a favor granted to the population. It is a concrete condition of dignity and of people's ability to learn, work, raise a family, and participate in national life.

02 Bringing Healthcare Within Real Reach of Communities

Territorial inequalities are among the hardest to accept. In some rural communities, obstacles accumulate: distant facilities, inadequate transport, the cost of travel, limited availability of medicines, the absence of permanent staff, and difficulty securing prompt attention in an emergency.

The answer is not to build a fully equipped hospital indiscriminately in every locality. Such a promise could spread resources too thinly without guaranteeing quality. What is needed is a coherent network: primary healthcare services close to residents; referral centers adequately equipped for diagnosis, maternity care, and emergencies; hospitals capable of handling complex cases; and transport and communications linking these levels.

A primary healthcare center must be able to receive and guide patients, provide prevention and vaccination, monitor pregnancies, support the management of chronic diseases, recognize danger signs, and arrange safe transfers. Community health teams can contribute to prevention and follow-up under professional supervision, without becoming permanent substitutes for qualified healthcare workers. This primary-care-centered approach is consistent with World Health Organization guidance [2].

The location of services must be determined by where people actually live, not only by administrative boundaries. Travel time, road conditions, seasons, water supply, electricity availability, the needs of women and children, and local health risks must all inform planning. Every community must know where routine care is available, which facility to contact in an emergency, and how to reach it.

Healthcare professionals must also have lasting reasons to serve outside major cities: regular pay, suitable housing, security, working equipment, training opportunities, career progression, and dignified working conditions. Mandatory postings, where they exist, cannot by themselves replace a genuine staff-retention policy.

Telemedicine can help obtain specialist advice, organize follow-up care, and reduce some journeys. But it requires electricity, reliable connectivity, data protection, and access to a physical examination whenever one is needed. It should bring medicine closer to patients, not justify abandoning local healthcare infrastructure.

An area is genuinely covered only when people can receive appropriate care when they need it—not merely when a facility appears on a map.

03 Training, Employing, and Retaining Healthcare Professionals

No healthcare system can be stronger than the capabilities of the women and men who sustain it. Buildings, equipment, and legal reforms become useful only when accompanied by skills, effective organization of work, and demanding professional ethics.

The WHO's 2026 report on the health workforce in its African Region projects a shortfall of approximately 5.85 million health workers by 2030. It also highlights a paradox: trained personnel remain unemployed or underemployed even as many services lack sufficient staff [3]. The problem is therefore not simply the number of graduates. It also concerns financing capacity, recruitment, geographical distribution, skills, and retention.

National policies should connect health training institutions, population projections, staffing budgets, facility needs, and changing patterns of disease. Training professionals without offering useful employment is a waste of human and financial resources. Recruiting teams without preparing them for clinical and social realities is another form of neglect.

Work in public hospitals must be organized to respect both patients' time and healthcare workers' time. Emergency departments need appropriate triage, reliable protocols, continuous operations, and rapid referral of cases better handled by other services. Local facilities must meet standards of quality, hygiene, record-keeping, and supervision suited to their actual functions.

The coexistence of public and private practice requires clear rules. It must not result in public-sector patients being neglected in favor of private consultations. Working hours, obligations, conflicts of interest, fees, and oversight mechanisms must be transparent, in accordance with national frameworks and fair remuneration. Patients must be protected against abuses without disrupting services or discouraging indispensable skills.

Quality care also requires a human relationship: listening to patients, explaining diagnoses, acknowledging uncertainty, respecting confidentiality, and avoiding unnecessary procedures. Effectiveness is not measured solely by the number of consultations or prescriptions. It is also measured by appropriate treatment, patient safety, outcomes, and the trust an institution inspires.

Holding healthcare staff accountable ultimately also requires holding administrators accountable: timely payment, availability of equipment, continuing education, fair complaint procedures, and decisions based on the needs of the population.

04 Financing Healthcare Without Impoverishing Families

The cost of care can trap households in an impossible choice: postpone treatment, sell assets, interrupt a child's education, or take on debt. Reducing precisely this risk is one of the purposes of universal health coverage. The WHO and World Bank's 2025 global monitoring report emphasizes the need to strengthen public and prepaid financing, reduce patients' direct out-of-pocket payments, and prioritize protection for poor or vulnerable people [4].

According to the WHO's regional analysis published for 2025, direct payments by households account for approximately 36% of health expenditure in the WHO African Region [5]. This is a regional estimate, not a rate that applies identically to every country. Nevertheless, it reminds us that a considerable share of the burden may still fall on families at the very moment illness strikes.

The preferred approach is to pool resources before health risks arise: public taxation, solidarity-based insurance or risk-pooling arrangements compatible with national capacities, targeted subsidies, and protection mechanisms for the most vulnerable households. Guaranteed benefits must be explicit and genuinely financed. Insurance that exists only in name, while leaving patients to pay for medicines, tests, or transport, may create a false sense of security.

In 2001, the Abuja Declaration set a political target of allocating at least 15% of national budgets to improving the health sector [6]. This percentage refers to governments' annual budgets, not 15% of gross domestic product. It remains a useful rallying point, but no numerical threshold removes the need to examine spending effectiveness, actual needs, and fairness in resource allocation.

Equitable financing must go hand in hand with integrity in management. Procurement must be traceable, prices and contracts open to scrutiny, stocks monitored, accounts audited, and sanctions enforceable in cases of fraud. Combating corruption and waste does not mean condemning healthcare professionals indiscriminately; it means building institutions in which resources intended for patients actually reach services and are used for their stated purpose.

Medicines are a decisive issue. Pooled procurement where appropriate, quality standards, the availability of essential medicines and diagnostic tools, price information, action against falsified products, and regulation of distribution channels must form a coherent policy [7]. Supporting regional manufacturing capacity can strengthen this strategy when quality, cost, and supply conditions are met.

Spending more is not enough. We must finance the right care, for the right populations, at the right time—and account for the results.

05 Preventing Illness, Providing Care, and Preparing for the Future

Health does not begin at the hospital door. It is shaped in childhood, at school, at work, through nutrition, water quality, the environment, and families' ability to recognize risks. A system devoted exclusively to treating illnesses at a late stage will remain vulnerable, both humanly and financially.

Prevention must be a routine part of public services: vaccination; care during pregnancy and for newborns; nutrition; prevention of malaria and other communicable diseases as appropriate to local conditions; and screening and management of hypertension, diabetes, and cancers amenable to early detection. Sexual and reproductive health services, including information about family planning, must respect people's free and informed decisions.

Chronic diseases require continuity of care that services organized around isolated episodes cannot always provide. Patients need reliable diagnoses, a continuing supply of medicines, appointments they can keep, and adequately coordinated medical records. Older people, persons living with disabilities or long-term conditions, and families affected by mental health disorders must be included in that continuity.

Mental health must no longer be consigned to silence or treated only when a crisis occurs. Prevention, listening, referral, and appropriate care must be available in general healthcare facilities, with access to specialized professionals when necessary. Addiction, violence, and psychological distress require coordinated health and social responses—not stigmatization.

Environmental health requires action beyond ministries of health: safe drinking water, sanitation, air pollution, housing, occupational risks, food safety, and adaptation to climate events. A policy that treats illnesses without examining some of the conditions that produce them risks perpetuating the same suffering.

Africa must also invest in its scientific capabilities: research institutes, laboratories, reliable health data, medicine safety monitoring, specialized training, balanced scientific partnerships, and innovation adapted to local realities. Traditional medical practices should neither be dismissed out of hand nor exempted from evaluation. Any role they play in public policy requires rigorous assessment of quality, safety, and effectiveness.

Research should not be reserved for major crises or depend exclusively on priorities established elsewhere. It is a national capability to understand problems, evaluate solutions, and prepare for future needs.

06 A Pact of Responsibility and Results

Democratizing healthcare does not mean announcing yet another reform. It means building a public commitment precise enough to be monitored, evaluated, and corrected. Credible transformation can be organized around six complementary obligations.

1. Guarantee a foundation of essential care. Each country should define a clear package of prevention and primary healthcare services, supported by referral arrangements for emergencies and specialized interventions. Effective protection for poor and vulnerable people must begin with implementation.

2. Plan services according to people's needs. Services, personnel, and medical transport must be deployed according to population patterns, distances, conditions of access, and risks. Rural areas must not be treated as administrative margins.

3. Make the health workforce an investment priority. Training must be linked to funded positions, dignified working conditions, clinical quality, and careers that enable professionals to serve all regions over the long term.

4. Make spending and medicines subject to scrutiny. Budgets, essential purchases, prices, stockouts, and audit findings must be open to examination by oversight institutions and, in an intelligible form, by citizens.

5. Recognize patients' voices and dignity. Information, consent, confidentiality, channels for complaints, and meaningful community participation must be part of quality healthcare.

6. Measure changes in people's lives. Each year, authorities should publish verifiable indicators on geographical access, out-of-pocket household spending, the availability of essential medicines, workforce distribution, patient safety, and health outcomes, while clearly identifying the limitations of the data.

This pact does not assume that countries begin from the same position or advance at the same pace. It does require them to announce priorities, allocate credible resources, make public both progress and shortcomings, and enable accountability. Responsibility must exist at every level: the state, local authorities, healthcare facilities, professional bodies, insurers, suppliers, and partners.

International cooperation remains necessary. It is useful when it strengthens national institutions, transfers skills, aligns with clearly defined priorities, and leaves countries able to continue delivering services beyond a cycle of external financing. It becomes fragile when it multiplies parallel programs without building lasting public capacity.

Conclusion — Health as a Measure of Progress

A society cannot claim sustainable progress when access to basic healthcare remains the privilege of those who can pay or who live close to major urban centers. Inequality in the face of illness is not merely private suffering; it undermines trust, restricts human opportunity, and compromises the nation's economic and social capacities.

Democratizing healthcare therefore requires a principled decision and disciplined implementation. We must place the human person at the center of our choices; organize care as close to communities as possible; finance solidarity; respect healthcare professionals while demanding accountability; prevent illness as well as treat it; and examine publicly the results achieved.

No single reform will suffice. But a succession of coherent decisions, sustained over time and corrected in light of the evidence, can change what a family expects from the healthcare system and what it has a right to receive.

Health is not a reward of prosperity. It is one of the conditions for building it.

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