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Why there is an inverse primary-care law in Africa

Many low-income and middle-income countries are now pursuing ambitious plans for universal primary care, but are failing to deliver adequate care quality because of intractable human-resource problems¹—eg, in Uganda in 2009, 44% of health-worker posts were vacant in urban health centres and 57% were vacant in smaller rural health centres.²

Between July, 2011, and April, 2012, we did a series of semi-structured interviews to explore the reasons why migrant health workers from sub-Saharan Africa had not taken up vacant posts to deliver primary care or first-contact care in their own countries, but had instead migrated to Europe (interviewees in Belgium, the UK, or Austria) or to southern African countries (interviewees in South Africa, Botswana). We interviewed 65 health workers (26 nurses and 39 doctors) from 18 countries, and analysed transcripts thematically. The interviewees' stories explain in stark human terms why such an intractable gap exists between government aspirations and the actual provision of effective primary-care services in sub-Saharan Africa.

The three main reasons given for choosing not to work in primary care were a poor working environment, difficult living experiences, and a poor career path. Respondents described a shortage of basic medicines and equipment in both primary-care and first-contact care facilities ("It's really, there is nothing...no antibiotics, nothing", said a doctor from Gabon), an unmanageable workload ("You see the queue, you don't see the people", said a doctor from Nigeria), and poor professional support ("You end up being alone...and it is definitely affecting the quality", said a doctor from the Democratic Republic of Congo).

Many respondents had concerns about personal security in primary-care

settings ("You're exposed to so much, you know, so much danger", said a nurse from South Africa), difficult living conditions for them and their families ("There are no big schools", said a doctor from Guinea), and no opportunities to earn a good salary ("What would encourage me to do it? Good hours, having a good lifestyle with it and proper resources... unfortunately I suppose money as well", said a doctor from South Africa).

Primary care was seen as being of a lower status than was hospital medicine ("Primary care...is looked at as inferior care", said a doctor from Zambia), with no specialist training opportunities ("The seminars that take place, continuous education, all those things happen in the cities, and nearly never in rural areas...over there, they are forgotten", said a doctor from Guinea), and increased exposure to corruption.

Although the difficulties described by our respondents are not restricted to the primary-care sector, they affect primary care most acutely. This concentration is because health workers actually living and working in deprived communities are necessarily those most exposed to poor social opportunities, personal insecurity, and the poor working conditions endemic to those areas.

This problem is neither new, nor restricted to Africa. When universal health coverage was introduced in the UK 50 years ago, the overt failure to provide effective primary care in the areas of greatest health need was famously described in *The Lancet* as the "inverse care law".³ The main driver of inverse care was a supply-side failure—the failure to train, recruit, and support good doctors and nurses. Some working conditions in primary care at the time were described as likely to "change a good doctor to a bad doctor within a very short time".⁴

The recent experiences of health-care reform in India and China similarly show that successful financial and payment mechanisms are not enough to achieve effective

universal health coverage—a good-quality clinical workforce is needed that has access to diagnostic and treatment facilities, and is incentivised to work where it is most needed.^{5,6} In low-income and middle-income countries, this need is invariably greatest in primary care and first-contact care, both because of the nature of the health services that most need to be delivered, and the importance of primary care for health-system cost-effectiveness.

The inescapable and unrecognised implication of what our respondents said is that, in most of sub-Saharan Africa, effective primary care is not going to happen. Clinicians will not work in the conditions they experience in primary care, and these conditions are getting progressively worse as the need for effective primary care increases—thus the situation could be called the inverse primary care law. The policy discourse on universal health care in Africa now needs to focus on how to provide the necessary human resources to staff and deliver primary care effectively. Demand-led payment systems, such as payment by results, cannot drive up care quality unless there is a supply of well trained and well supported clinical staff to meet the demand. Innovative supply-side solutions could address poor working environments and career paths in primary care. Until these solutions are prioritised and implemented, the global poor are condemned to receive poor care or no care at all.

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