GUEST EDITORIAL

Primary care workforce planning: What's happened to the 'Logan' report?

Sue Pullon MPHC (Dist), FRNZCGP, MBChB

Eileen McKinlay MA (Appl), RN

Health care is a labour-intensive business, and a high quality health professional workforce one of its most crucial assets. Even in a small country like New Zealand, best estimates gauge the health care workforce at well over 100 000 people, with about a third (c.35 000) working in primary care.[1-4] Health workforce planning has never been more challenging; significant global shortages of doctors, nurses, midwives, pharmacists, health care managers and others, combined with a lack of ability to train sufficient numbers of health professionals for our own needs, make recruitment and retention of a stable, fit-for-purpose health care workforce particularly challenging.[5]

In primary care, generally the first point of contact with the health system, human resources are particularly important. Primary care health professionals use multiple triage, diagnostic and assessment skills, as well as health education, health promotion and preventive care initiatives, to care for most of the population most of the time, but also to appropriately refer the smaller number of people who on occasion need secondary and tertiary care.[6-8]

There is widespread recognition, within and beyond the health sector, that such a workforce should be well trained and highly competent, not only as individual health professionals but also as effective members of functional health care teams.[9,10] Developing a skilled workforce is a significant investment for any health system, yet it is extraordinarily difficult to find accurate, comparable whole-of-sector workforce data. Without these data, essential workforce planning is at best piecemeal, at worst not done at all—surely an unacceptable situation in the face of an ageing health professional workforce, and continued reliance on overseas graduates.

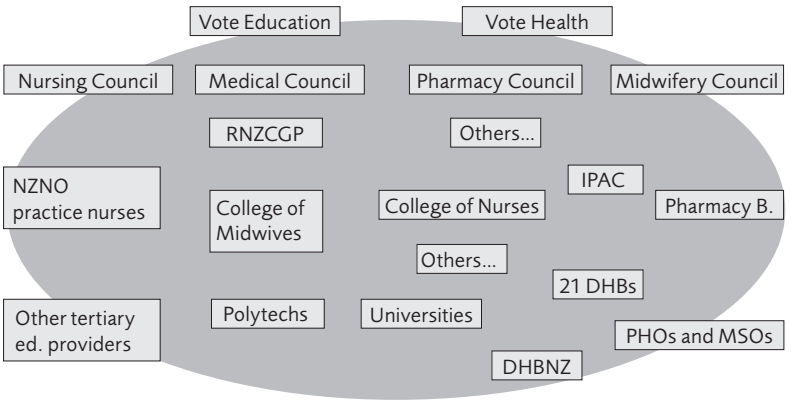
If the primary care sector is to solve some of its ongoing workforce shortages, high quality primary care workforce data must be collected and analysed on a national basis. It is not sufficient to rely on uni-disciplinary professional and regulatory bodies, or the 21 District Health Boards (DHBs), which can only collect their own group's workforce information. These multiple collection processes produce inadequate and non-comparable workforce data; workforce shortages and uncertainties in one professional group or regional area inevitably create difficulties and tensions in several others and undermine the collaborative working so necessary to modern primary care. A prerequisite for workforce planning is the establishment of a whole-of-sector national database where accurate data is systematically collected and made widely accessible to policy makers, employers and professional bodies.

A lack of national direction is well reflected in the many extensive and (no doubt expensive) reports that have been commissioned in the last decade to identify causes and propose solutions for health workforce shortages. There has been little alignment between these reports and scant attention paid to any recommendations, even though many consistently identify significant barriers to workforce effectiveness. The Health Workforce Advisory Committee (2001–2006) came closest to providing a national overview, but since its disestablishment, there has been a notable lack of sustained national leadership, particularly with regard to the primary care workforce. The DHBNZ Future Workforce Group has more recently attempted to take on a national role, and is making headway in some areas, but attention to primary care workforce concerns is variable.

The 'Logan' report[11] is one of the more recent in a long line of reports that has once again identified

CORRESPONDENCE TO:
Sue Pullon
Senior Lecturer, Department of Primary Health Care and General Practice, University of Otago, PO Box 7343, Wellington South 6242, New Zealand
sue.pullon@otago.ac.nz

Figure 1. Workforce planning could be actively fostered by a single representative national organisation



key barriers to primary health care workforce effectiveness, including limitations of funding models, poor organisational structures, lack of professional leadership, insufficient numbers in training, lack of interdisciplinary training, and considerable room for quality improvement.

In the last three years, other similar reports including the 2007 DHBNZ Workforce Group report,[12] the Ministry of Health's *A career framework for the health workforce in New Zealand*,[13] the CTA purchasing intentions 2008/9,[14] the Zurn report (*Health workforce and international migration: Can New Zealand compete?*)[5] and the Medical Training Board's Collation of key discussion papers[15] all reiterate some or all of the same key barriers to PHC workforce effectiveness.

Yet, in truth, the various authors of these reports can do little more without effective national leadership, good quality workforce data to inform decision-making, and some resources to implement a cohesive medium to longer term strategy. Neither of these two elements is currently available in a cohesive body where all health profession stakeholders come together. Such leadership is complex, but a nationally funded independent pan-organisational approach, such as that successfully implemented in Canada,[16] is long overdue. An accountable but independent body representing all stakeholder bodies, such as that shown in Figure 1, with data collection and decision-making ability, as well as the ability to engage with the many stakeholders, would go a long way towards workable, cohesive workforce planning that can be sustained in an era where demand on the health system and the health workforce has never been greater.

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