Components of care

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Our lead paper this issue identifies that depression in older people living in the community is both under- and over-treated.[1] Dr Cristín Ryan, our guest editorialist from Queen's University Belfast, recommends that medication reviews should be conducted, in conjunction with assessment of the patient's depressive symptoms and reference to diagnostic criteria.[2] The study by Schäfers et al. serves as another example of the need to carefully assess prescribing for older people, including deprescribing on occasion. Unnecessary prescribing has financial costs, both to the government and to patients, as well as possible health-related harms.

A study by Tordoff et al. found that general practice consultation and medication costs are considered expensive by 40% and 17% of older people respectively, which may impact on medication adherence.[3] Low adherence of needed drugs is also problematic and may result in poorer outcomes. A review of over 72 000 general practice adults found that Māori with cardiovascular disease risk had lower levels of antihypertensive adherence than non-Māori. Those who did adhere had lower blood pressure, total-to-HDL cholesterol levels and HbA1c than non-adherers.[4] In a *Viewpoint* paper, Janes and Titchener challenge the concept of 'non-adherence', offering a patient-centred clinical framework to address patients' barriers to better health.[5]

In a randomised trial, trained health promoters delivering a family-centred intervention to improve nutrition and physical activity in at-risk adults found that patients often prefer a more holistic approach and have priorities other than diet and exercise, such as help with mental health or other lifestyle issues.[6] Pacific patients in particular often failed to engage with the programme, despite agreeing to participate. This illustrates the importance of a patient-centred approach, engaging stakeholders at the outset about the nature of interventions that might work for them, and whether and what changes they might wish to make.

Ethnic disparity gaps persist throughout primary health care in New Zealand. A review of over 81 800 pregnant women found that, overall, 70% register with a midwife Lead Maternity Carer within the first trimester, but only 51% of Māori and 44% of Pacific pregnant women.[7] With the virtual demise of the general practitioner obstetrician, this means that many may be receiving no general medical nor antenatal care in those first 14 weeks of gestation. This is concerning, given that Māori and Pacific have higher rates of smoking and perinatal mortality, and lower uptake of antenatal Down syndrome screening than the overall population. Team-based midwifery, embedded within a primary care service, is one possible solution. This approach is used by Newtown Union Health Service, where a small study found that high-needs, socially deprived women, often from ethnic minorities, reported satisfaction with such a model of care.[8]

Māori and Pacific people also have lower rates of childhood immunisation in New Zealand, while Asian people have the highest rates. Rather than focusing on the barriers for Māori and Pacific, Pal et al. explore the enabling factors that might explain why Asian parents achieve such high rates for their children.[9]

In our *Back to Back* series this issue, Eileen McKinlay and Sue Pullon argue for interprofessional education, with co-teaching of medical, nursing and other undergraduate health professional students.[10] Campbell Murdoch argues equally strongly that there is little evidence that this approach contributes much to graduates' ability to practice.[11] In his view, the priority is to address the imbalances in overcrowded undergraduate medical curricula in favour of general practice and patient-centred care, and away from traditional specialist disciplines.

J PRIM HEALTH CARE
2014;6(4):266–267.

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Finally, auditing of practices and review can lead to improvement in various components of care. A study involving the assessment of general practitioner and nurse referral letters, scored using a nine-point checklist, demonstrated that written feedback led to improvement in their subsequent letter quality.[12] An audit of five practices by general practice registrars identified 55 cases of polycystic ovary syndrome, with considerable variability of diagnostic criteria, investigations and management in use.[13] Such reviews may lead to more consistent and evidence-based care being adopted.

The components of care provided in primary and community health settings are countless and varied. Findings from research presented in this issue, along with the distilled evidence in our regular columns (*Nuggets of Knowledge*, *Cochrane Corner*, *String of PEARLS*, and *Potion or Poison?*), provide ample opportunities for improvement in quality of care.

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A very big thank you to our reviewers

Peer reviewers are fundamental to improving scholarship and enhancing the quality of the *Journal of Primary Health Care*. Many thanks to the following people who have served voluntarily as peer reviewers for the Journal in the past year from November 2013 through to October 2014:

Anneka Anderson; Bruce Arroll; Toni Ashton; Sally Baddock; Jo Barnes; Gillian Bartlett; Stuart Birks; Fiona Blyth; Rhiannon Braund; Elizabeth Broadbent; Linda Bryant; Stephen Buetow; Janine Bycroft; Jenny Carryer; Simon Chapple; David Codyre; Peter Crampton; Barbara Daly; Ben Darlow; Kieran Davis; Karen Day; Ofa Dewes ; Fiona Doolan-Noble; Tony Dowell; Kyle Eggleton; Karen Falloon; Janet Fanslow; Jeffrey Gage; Veronique Gibbons; Wayne Gillett; Ben Gray; Chris Gregg; James Green; Karen Hoare; Ben Hudson; Stephen Jacobs; Chrys Jaye; Ngaire Kerse; Ian Laird; Christopher Lash; Ross Lawrenson; Bev Lawton; Mathijs Lucassen; Lynn McBain; Eileen McKinlay; Dee Mangin; Stewart Mann; Bob Marshall; Nataly Martini; Graham Mellsop; David Menkes; Jane Morgan; Pat Neuwelt; Pauline Norris; Nicola North; Tony O'Brien; Hamish Osborne; Sue Pullon; Suzanne Purdy; Sally Rose; Elaine Rush; Nicola Russell; Lesley Salkeld; Peter Sandiford; Ruth Savage; Shane Scahill; Jo Scott-Jones; Fred Sundram; Lynn Taylor; Jocelyn Tracey; Nikki Turner; Jim Vause; Jenny Visser; Tom Wang; Jim Warren; Susan Waterworth; Amanda Wheeler; Michelle Wise.

Many thanks also to the *Journal of Primary Health Care* Editorial Board, Graphic Designer Robyn Atwood and Managing Editor Anne Buckley.