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Two heads are better than one?

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Welcome to the first issue of the Journal of Primary Health Care under the co-editorship of Professors Tim Stokes and Felicity Goodyear-Smith. It's a first for the JPHC to have co-editors, we are enjoying working together as a team, and we'd concur with C. S. Lewis that 'two heads are better than one, not because either is infallible, but because they are unlikely to go wrong in the same direction.'[1] We have been busy in our first 3 months on the job and have made some important changes. We aim for the JPHC to become one of the most respected and well-cited primary health care journals in the world.

We have revised the journal scope to publish research that is conducted in, or highly relevant to, New Zealand, Australia and Pacific nations, and which has a strong focus on Indigenous Māori and Pacific health issues. The long-standing columns *Cochrane Corner* and *Potion or Poison?* continue, with the latter reverting to its original name *Charms and Harms* with the return of Jo Barnes, its founding author. We are keen to get submissions from our primary health care colleagues in Aotearoa New Zealand, and we promise robust and timely reviews. The JPHC publishes original scientific papers, quality improvement reports and viewpoints, and we welcome letters to the editor from our readers. Please do send us suggestions you may have about our future direction.

Not content with just 'two heads being better than one' we have reinstated an Editorial Advisory Board to firstly advise, support, and provide us with strategic input on the JPHC's scope and focus going forward, and to secondly act as champions, promoting the JPHC to their colleagues and students as a good place to publish. Primary health care incorporates both first contact person-based primary care, including general practice, and also population-level care including public health, health promotion, disease prevention and community-based social services. We therefore wanted representation from a broad range of disciplines and populations across New Zealand universities and other institutions. We are delighted that a wonderful group of eminent New Zealand academics have agreed to grace our Board: Prof Peter Crampton (public health), Dr Kyle Eggleton (rural health, GP), Dr Linda Bryant (pharmacy), Assoc Prof Tim Tenbensel (health systems), Assoc Prof Matire Harwood (Māori, GP), Prof Sue Crengle (Māori, GP), Prof Colin Simpson (epidemiology), Assoc Prof Ben Darlow (physiotherapy), Dr Rawiri Keenan (Māori, GP), Prof Jenny Carryer (nursing), Dr Garry Nixon (rural hospital medicine), Assoc Prof Sir Collin Tukuitonga (Pacific, public health) and Dr Debbie Ryan (Pacific, health policy).

With the recent liquidation of the New Zealand Medical Association, the fate of their New Zealand Medical Journal (NZMJ) is unknown, with calls for another organisation to take on its publication. The NZMJ is our best-known medical journal and has been important in publishing papers focused on improving health care and public health.[2] While the JPHC is well-placed to pick up this role, we do not cover secondary care disciplines and the demise of the NZMJ will leave a huge gap.

In this issue our guest editorial by Abbott and colleagues discuss the surgical backlog of joint replacements for people with osteoarthritis. They propose an increase in publicly funded physiotherapy and other community-based allied health care which would both decrease the need for surgery and inequity of access and outcomes for Māori.[3] Many of the original scientific papers in this issue also look at primary care with an equity lens from different disciplines. Eggleton and colleagues audit of Māori health provider nurses' consultations found they dealt with a broad range of conditions but the medicalisation of the electronic health records precluded documenting problems from a nursing and Māori health provider perspective.[4] Van Houtte and colleagues have developed a patient risk

stratification tool which will assist in the identification of high-risk patients who do not frequently attend primary care services.[5]

Pacific health inequities are addressed in Neville and colleagues' study of barriers to older Pasifika's participation in the healthcare system,[6] Tafea and colleagues' Pasifika barriers to immunisation against vaccine-preventable diseases,[7] and a protocol by Dewes and colleagues to investigate the impact of chronic conditions on Tokelauan families.[8] A study on pre-diabetes found that general practitioners and nurses had uncertainty about the sustainability of interventions to address this, but Māori and Pasifika women were keen to promote lifestyle changes.[9]

Practice change requires a collective response. A case study of quality improvement in rural, urban and Kaupapa Māori general practice settings by Cullen and colleagues found that successful implementation was linked to the organisational culture, distributed leadership and teamwork.[10] Gurung and colleagues' study of the Health Care Home found that successful implementation required having a change management plan and ensuring whole of practice engagement.[11] McGonigle and colleagues evaluated the Canterbury Health initiative to deliver intravenous infusions of drugs and blood products in patients' homes. This was successfully implemented by a nurse-led programme with medical oversight, although initially it proved difficult and resource-intensive to ensure stakeholder engagement and good governance.[12]

Other research includes a survey of Waikato general practitioners found that most would wait for their patients with obesity to first raise the issue around weight loss, and that there were socioeconomic inequities in access to bariatric surgery,[13] a study on potential risk of drug interactions in patients seeking anti-depressants through an Australian call centre,[14] and a literature review of the STarT Back Tool, which screens people with low back pain, found that its use generally enhances clinical practice by both general practitioners and physiotherapists.[15]

The pandemic features this issue with a Cochrane Corner on the accuracy of presenting symptoms and signs in diagnosing COVID-19,[16] and a viewpoint from Italy on primary care involvement in COVID-19 management in their first two waves of infection.[17] Finally, we have Barne's *Charms and Harms* on the potential benefits and harms of saffron.[18] Generally safe, saffron is toxic if total daily doses reach 5 g. Given that it is the world's most expensive spice, primary care practitioners are unlikely to ever see any cases of saffron over-dose.

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Conflicts of interest. Felicity Goodyear-Smith and Tim Stokes are Editors in Chief of the Journal of Primary Health Care.

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