One job, two jobs, three jobs, four …

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Providing healthcare, managing healthcare, educating new generations of healthcare professionals, and safely delivering new generations of patients into the world and new generations of adolescents into adulthood. Are these all jobs for 21st century primary health care providers? Are they trained, educated, and equipped for the task? Yes and no, is the story our authors tell us in this issue. There are training gaps, promising educational extensions, and we have an exploration of the remnants of a maternity workforce, the fourth job that was but maybe is no longer. Perhaps we can say only one thing for sure: if our health systems are to serve our communities the way health systems are supposed to, they need to continually evolve to match the evolving needs of our changing societies. We cannot deliver this year the same curriculum that was delivered to students of the healthcare arts and sciences last year, and think we are doing OK. We must constantly have an eye on the future, and keep it there while also holding fast to the precious gems from the past. This issue of the Journal offers commentary and research-based insights into healthcare education and health systems, particularly our own.

Our two editorialists explore ideas around the critical healthcare dimension of humanity (of all involved in healthcare).[1,2] While Cunningham makes a plea for respecting the individual values and choices of the distinct and different human beings who make up the health workforce, Gauld argues that every health professional is responsible for two separate jobs – healthcare delivery and healthcare management. The latter is still poorly understood and delivered, largely because the focus in healthcare education and training is on healthcare delivery, to the exclusion of all else.

We have four papers about healthcare education and training. Martel and colleagues report on primary care nurses' need for better preparation to deliver sexual health services to their adolescent clients,[3] Darlow and colleagues describe the challenges and delights encountered by faculty teaching an interprofessional education course,[4] and Blattner and colleagues describe the experiences of New Zealand doctors working in the Cook Islands as part of a reciprocal training programme for generalist doctors in the Cook Islands and New Zealand.[5] Educating subsequent generations of healthcare professionals is a relevant responsibility currently poorly addressed in healthcare professionals' education, and perhaps their third job, to extend Gauld's proposition.

Conversely, one job is lost from medicine. While obstetric care used to be a core part of medical and nursing training and responsibilities, Mason *et al*. have identified a specific set of conditions that support continued engagement in this part of the healthcare job. Key among these is the personal conviction that obstetrics is '*…what good family medicine is all about.*'[6] Cunningham comments that the tide has turned away from this idea for most GPs.[1]

Several authors offer suggestions for further 'tweaks' to the New Zealand health system in this issue. Two papers are about immunisations.[7,8] In their paper about outreach childhood immunisation services, Roberts and colleagues uncover wide variation between District Health Boards (DHBs) in the proportion of children immunised by outreach services. There is also a skewed distribution of costs. This research raises as many questions as it answers, suggesting that perhaps primary healthcare in some regions needs to evolve more quickly than in other places. The research by Turner and colleagues provides further insights into the ways that engagement with families might assist immunisation delivery and reflects again the need to prioritise human interactions over impersonal systems.[8] Maney provides some

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evidence that GPs and pharmacists are becoming better at understanding each other and working together, a positive change, surely.[9]

The systems within which healthcare providers work are still very important. Eggleton reports his work with the Northland DHB to establish a method of measuring access to local general practices.[10] Their paper reports an elegant and replicable process for measuring the time to the third next available appointment in general practice, an international measure of healthcare access. If other DHBs also adopted this process, variations in access nationally could be explored and addressed. Filoche's team also describes an important ecological study into the uptake of DHB funded vasectomies in Counties Manukau, showing how the uptake of this initiative was highest among the most socioeconomically deprived populations, and offering one route to reduced socioeconomic disparities.[11]

Also exploring practice level data, Palapar and colleagues reveal that there were some formal processes used to promote early problem detection in older patients in almost all of the 60 general practices participating in a study relating to the care of older people.[12] Perhaps this is not surprising, given the context of this research, but this study's identification of differences in care practices by area deprivation and rurality suggest the need for more targeted investigations if (in) equality in healthcare delivery is to be better understood. Use of standing orders in general practice also needs to be better understood, according to Taylor.[13]

Finally, but by no means least, Sheary provides an interesting story about a child with eczema who is eventually diagnosed with topical steroid addiction and withdrawal.[14]

Seeing, doing, teaching, and learning together – that is what we address in this issue. However many jobs there are in primary health care, all are important and complement each other.

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