Controversies and inequities

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Last issue our *Back to Back* column dealt with fluoridation of water.[1,2] The *Back to Back* series are designed to stimulate debate. This one certainly did, culminating in a request that the original 'against' argument be retracted from the electronic databases.

While original scientific papers and viewpoints are peer reviewed, the *Journal of Primary Health Care* does not peer review *Back to Back* column contributions. These are written by invited authors who give their opposing opinions on a moot. In this context peer reviewing is inappropriate. Similarly, we have decided that the *Journal of Primary Health Care* will request retraction of a research paper where incorrect or falsified data is identified but not of an opinion piece. While one side may have misinterpreted the science, or used inappropriate evidence to bolster their case, the other side may also have over-emphasised points or drawn conclusions on insufficiently strong underlying evidence. The 'truth' may lie in between. In this case, the evidence for fluoridation is certainly towards the side of significant benefits with little harm, but these may be not as great nor as definite as the 'for' side presents. Our readers can make up their minds for themselves. The topic of water fluoridation is now closed.

The *Back to Back* this issue also may be seen as contentious. Former President of the Royal College of General Practitioners, Dr Iona Heath, argues that while breast screening may have led to a small reduction in death from breast cancer, this is at the price of considerable over-diagnosis and treatment, and on balance, screening causes more harm than good.[3] In opposition, Professor Stephen Duffy maintains that the benefits outweigh the harms.[4] Evaluate their evidence and decide whether or not you will continue to advise your patients, friends and family to participate in the screening programme.

There is a strong theme of health inequity in this issue. Getting care to people in need and addressing disparities can be problematic. An editorial discusses the barrier that prescription charges can pose for the poor and the sick to getting appropriate health care.[5] Our lead research paper outlines that the high needs group of patients with serious mental illness also frequently have poor physical health and general practice may not be their first port of call.[6] Guest editor Dr Nease identifies that a similar challenge to providing health care to this population exists in the United States.[7]

A study in South Auckland shows a significant non-attendance in a treatment programme for Pacific people diagnosed with depression,[8] and another demonstrates the suboptimal management of gout, especially in Maori and Pacific patients, in this region.[9] Immigrants from Asia may suffer from unrecognised tuberculosis (TB), particularly if it is extra-pulmonary. They may have a normal chest x-ray, highlighting the need to consider TB sputum testing in patients where this is suspected.[10] Children are another vulnerable group. A case review describes the increasing problem of the ingestion or insertion of button batteries by young children, the need for a high level of suspicion in primary care, and rapid removal or referral.[11]

Gains are being made. Norris et al. find that statin use in New Zealand matches the pattern of need, in contrast to previous studies where people of low socioeconomic position were undertreated.[12] Our *Vaikoloa* column addresses the high incidence of rheumatic heart disease in Pacific nations, and describes a screening and prevention programme in Samoa.[13]

Addressing disparities requires accurate data. Pilot evaluation of a tool for collecting ethnicity data is promising, and this could assist in more

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exact measuring of possible health service inequalities.[14] A practice-based audit of the primary immunisation series by Reynolds and colleagues shows that the National Immunisation Register is not capturing all immunisation events.[15] The audit tool finds that New Zealand immunisation rates actually exceed World Health Organization goals, and may help identify populations (especially Pacific and Maori children) where targeted services are needed.

There are a number of variables associated with recovery from low back pain. We are still a long way from predicting those at higher risk of long-term chronicity, but a study of prognostic variables highlights that job availability and a graduated return to work can lead to positive outcomes.[16]

Finally, the New Zealand aim is for 50% of our medical graduates to choose general practice as a career,[17] but sadly we are far from achieving that goal. A qualitative study of final year medical students in Christchurch finds that feeling welcomed, involved, valued and having a useful role in general practice attachments can have a positive influence on students' attitudes towards this career choice.[18] Grassroots general practice has a big role to play in growing our future workforce.

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