

Time for a change of guard

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New Zealand needs to spend our limited health budget wisely. Lessing et al. show that it is safe to switch from originator brand olanzapine to a generic brand.¹ Guest editor Professor Steven Morgan describes how the substantial savings generated from generic substitution could be invested for better health outcomes for our population.² Wallis discusses the issue of polypharmacy and explains how judicious deprescribing for patients on multiple medications also can potentially lead to large cost savings and reduced harms.³ This could be one way of funding removal of the prescription dispensing fee, which Norris and colleagues identify as a barrier to accessing needed medications for those living in poverty.⁴

Even small practice co-payments may be a barrier to health care. A free health centre has been shown to meet the needs of the socially vulnerable patients enrolled with their service.⁵ Gu and colleagues outline how improved health literacy and health care access through a patient portal may help to reduce inequalities.⁶ With respect to this we do have some way to go, however, before this potential is realised: first for everyone to have internet access, and then for individuals to be able to understand the information available via the portal and to make appropriate health decisions.

One socially disadvantaged group are mental health services users. Wheeler and colleagues found that these patients have a poorer health-related quality of life than the general population, particularly those mental health service users aged under 25 years. New Zealand youth have difficulty accessing services, and there is a lack of early intervention and poor interservice collaboration—all issues that need to be addressed to assist in recovery from mental illness and in achieving a satisfactory quality of life for these individuals.⁷

Chronic pain is a challenge both for patients and for the clinicians who care for them. A study by Bhana and colleagues addresses assisting patients to have realistic expectations regarding their hope for a cure.⁸ Our *Back to Back* this issue tackles the issue of whether medicinal cannabis should be available for management of chronic pain. Two pain clinic specialists present opposing views. Hardy argues that there is incontrovertible evidence that cannabis and cannabinoids are effective for neuropathic pain and, therefore, that medicinal cannabis should be made available on ethical grounds, with appropriate regulation.⁹ Aamir counters that the current strength of evidence to treat chronic pain is limited, and counsels against its use.¹⁰ Certainly, there are patients who find prescribed analgesics inadequate or who are wary of taking them, and who may seek Complementary and Alternative Medicines (CAM). Jakes and Kirk identify the growing CAM use in New Zealand, and explore some of the drivers for patients turning to acupuncture for chronic pain relief.¹¹

Dealing with unexplained fatigue is another challenge for GPs, highlighting the need to tolerate uncertainty once serious pathology has been excluded. Morgan and colleagues find that Australian GP registrars order twice as many investigations, compared with established GPs, underlining that this presents an important area for training.¹²

Other papers in this issue include disclosure rates by women of intimate partner violence revealed through screening,¹³ and the vulnerability of midlife or older women to sexually transmitted infection when re-partnering following separation.¹⁴ Lovell and colleagues explore the rapid turnover of the health promotion workforce, with possible compromise resulting to the institutional memory of organisations working in this area.¹⁵

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This is my final issue as Editor-in-Chief of the *Journal of Primary Health Care*. I was asked to take over editing the *New Zealand Family Physician* in 2008. This had been The Royal New Zealand College of General Practitioners' journal for 35 years. I agreed to be Editor on the understanding that the *New Zealand Family Physician* would be retired, and a new journal launched, with the aim of getting the journal Medline-listed. Medline listing is important for a peer-reviewed journal because being indexed in the major databases means published research papers can be found in literature searches. Authors are therefore keener to submit their work to an indexed journal.

Hence the *Journal of Primary Health Care* was born. Creating a new journal 'from scratch' was an exciting challenge. It needed to achieve the look of an academic publication. College graphic designer Robyn Atwood and I embarked on this journey together. We moved from full colour with photographs, to shades of black and orange. We made hundreds of decisions about layout and style, such as size and type of font, numbers of columns per page and design of the cover. Robyn was pivotal in shaping the look of the Journal. I expressed my vision, and she materialised it. I sent her a badly scribbled koru for the *Pounamu* column, and she created an elegant logo. I also prepared instructions for authors and reviewers, templates for submissions, and numerous other documents.

And then, of course, there is the content. The Journal aims to be multidisciplinary, encompassing general practice, primary health care nursing and community pharmacy research, including Māori, Pacific and Asian health issues, health care delivery, health promotion, epidemiology and public health of interest to a primary health care audience. The *Journal of Primary Health Care* also provides distilled knowledge for clinicians about the latest evidence and best practice. Debate is stimulated in the *Back to Back* section, with two experts presenting opposing views on a wide range of health and social issues. Ethics columns and viewpoints also provide 'food for the mind'.

I asked my academic colleagues to trust that I would get the Journal Medline-listed, and to

submit their research. They did. The Journal received its Medline listing after the first year of publication. In the past six and a half years, over 1000 authors have published in the Journal. More than 300 people have voluntarily given their time to review papers, often on multiple occasions. Together, they have made the *Journal of Primary Health Care* what it is. While most are New Zealand-based, we also have had a number of international contributors.

Research papers continue to flow in. The consequence of this is a substantial amount of editorial work. I started the *Journal of Primary Health Care* using a manual system, anticipating moving to an electronic editorial management system to cope with the submission, review and revision processes. Two years ago Anne Buckley took on the Managing Editor role, to assist with manuscript management, editing and proof-reading and so reduce my workload. She has contributed to the quality of the Journal, particularly through her communications with authors to achieve print-ready final proofs.

When I started, I agreed to be Editor for two years or until the *Journal of Primary Health Care* achieved Medline status, whichever came first. It is certainly time to move on, and for a new Editor to stamp her mark. I wish my successor, Susan Dovey, all the best. The Journal is in good shape. At the time of writing there are 12 research papers in press, and a further 24 under consideration; a healthy state for the Journal to be in.

All that remains is for me to thank everyone who has helped the *Journal of Primary Health Care* become a success. My sincere appreciation to Robyn Atwood and Anne Buckley, and to all those who have contributed to the Journal and who have reviewed for it. Lastly, I would like to acknowledge the past and present members of my Editorial Board, who have stood up firmly for the Journal and provided me with so much wise counsel and personal support. Thank you Kurt Stange for inspiring me to take it on, Tony Dowell for all your editorial support and sage advice, Peter Crampton for serving as my sounding board, Eileen McKinley for assisting in overseeing the review process when needed, and the other Board members, Jenny Carryer, Ofa Dewes,

Bruce Arroll, Pauline Norris, Jo Scott-Jones and Shane Reti. Your support has been invaluable. Thank you.

What makes a journal—he tangata, he tangata, he tangata, it is the people, it is the people, it is the people.

Noho ora mai rā.

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Erratum: *Back to Back* column in our March 2015 issue

In *Lead maternity care needs to be embedded in general practice—the 'yes' case*,¹ it was stated that 'The LMC [Lead Maternity Carer] is paid the same amount for every pregnancy, apart from a small subsidy for mileage for postnatal visits.'

The LMC fee for a first birth is actually higher than for subsequent births.² We regret this error.

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