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Under pressure

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In the words of Queen '… the terror of knowing what this world is about dares you to change your way of being …/this is ourselves under pressure'.[1] Pressure changes things. Things change anyway, of course, but people under pressure respond in ways that are sometimes unpredictable, even to themselves. A 'terror' that 'dares you to change' has been the global COVID-19 pandemic since the start of 2020, forcing change without preparedness and causing the discomfort of having to make the sorts of changes one might not normally choose to make. In his thought-provoking Viewpoint article, Steven Lillis recognises the positive changes for general practice that have arisen in response to the COVID-19 pandemic, while also warning against subtle external pressures to abandon perhaps the most important core dimension of the specialty – relational continuity.[2]

New Zealand's COVID-19 Response Minister, the Hon. Chris Hipkins, was recently asked to identify the part of the New Zealand health system under the greatest strain at the moment. He responded: 'Primary healthcare, the frontline health workers who deal with people every day, are under enormous pressure…',[3] departing from the 'save the hospitals' discourse that has been a feature of COVID-19 media communication in New Zealand to date. While this new recognition of primary healthcare workers is appreciated, health systems (like any system) work best when there is synergy between individual system parts and they operate as a single, integrated entity focused on their central mission – promoting and maintaining the health of the individual people who comprise the entire population.

Our two Guest editorials in this issue of the Journal have a whole-of-health-system focus. Peter Davis discusses the Pharmaceutical Management Agency (PHARMAC) and the explorations we publish in this issue into delays in registering new drugs for use in New Zealand.[4,5] PHARMAC's decisions affect the whole health system. Sarkisova's research lifts the veil on PHARMAC's complex decision-making processes and compares the quality of PHARMAC decisions with similar decisions made in other countries. By contrast, general practitioner (GP) Graham McGeoch and his District Health Board (DHB) colleagues Carolyn Gullery and Greg Hamilton write about the way they are promoting health system synergy in one region: the Canterbury Initiative is an applied common sense solution to healthcare gaps in Canterbury.[6] As in other regions, there is one health system and one budget for public healthcare in Canterbury and serving patients is the purpose of this health system. The DHB, hospital and primary care sectors have joined together to identify gaps in care and devise solutions that work best for patients. This sounds like an obvious thing to do but no other DHB seems to have mindfully attended to making working together in patients' interests operational. In Canterbury, designing health services that worked best for patients has often meant moving hospital-based services into the community, along with the hospital's funding for those services. From the outset, initiatives developed by the Canterbury Initiative have been documented and published so knowledge of them is not lost, as many other health service innovations are. In this issue we publish a paper about a project to establish a community mental health service for youth with gender identity issues.[7]

There are also pockets of excellence in hospital and primary care communication in other parts of New Zealand. Oakley's team has provided this Journal with several examples in dermatology, including in this issue.[8–10] Providing a stark contrast, we publish an article demonstrating poor intra-system synergy in cancer care. Warren and colleagues investigated routes to bowel cancer diagnosis, ultimately concluding that patients referred by GPs for specialist assessment waited much longer for a diagnosis

than patients who presented to hospital emergency departments or were internally referred from other hospital departments.[11] The GP-hospital referral system used throughout New Zealand is a critical connection between two key parts of our health system. In many places it is broken and needs urgent repair to reduce patient harm.

Ure,[12] Maita,[13] Liberatti-Barros,[14] Yasin[15] and their colleagues share discoveries derived from their clinical practices as GPs in New Zealand, Japan, Brazil, and Turkey. At least some parts of each paper will resonate with any GP, anywhere. Among other things, Ure found that face-to-face consultations should remain the gold standard (even though telephone triage can be useful),[12] Maita's research confirmed that mothers are better at diagnosing influenza in their children than any other carer,[13] Liberatti-Barros *et al.* demonstrate brilliant contemporary use of a tool to promote patient-centredness, designed by the Dr Ian McWhinney over 50 years ago,[14] and Yasin's team report on GPs' mental health and physical workplace challenges in providing adequate primary care during the Covid-19 pandemic.[15] Both Ure[12] and Maita[13] point out that as GPs they routinely care for patients with viral respiratory infections (like COVID-19) and Ure provides some insight into the extra pressure caused by having to treat patients with these other infections as if they had COVID-19.[12] In Turkey, Yasin estimates that the pandemic has resulted in about 90 unpaid hours of extra work per month for every GP.[15]

To round out this issue we have an article reporting a randomised controlled trial of a weight management intervention in Australian general practice,[16] and a further paper reporting doctors' experiences of studying in a University of Otago postgraduate programme while living and working in a Pacific island nation.[17]

It has been my privilege and pleasure to be Editor-in-Chief of the Journal of Primary Health Care for nearly 7 years, but from the next issue Professors Tim Stokes (University of Otago) and Felicity Goodyear-Smith (University of Auckland) will take over that role. I owe a huge debt of gratitude to the many people who have assisted in the task of bringing this Journal to our readers under my watch. I thank our owners, the Fellows and Members of the Royal New Zealand College of General Practitioners, because without you this Journal would not exist: your interest in sharing your experiences with the world and learning from the experiences of people in other countries is special. Very few other medical scientific journals have such open access as this journal, for both readers and authors. I thank every author, editorial writer and reviewer for gifting the Journal their time, insights and talents and regret that we have had to turn down some of your gifts: lack of space and increased interest in the Journal means that our article rejection rate grows, year by year. Our columnists Drs Nataly Martini and Vanessa Jordan have written very widely read articles for almost every issue I have edited: thank you most sincerely. I thank the whole editorial team, especially the Associate Editors, and the editorial assistants and production team of CSIRO Publishing. I thank our readers for their continued interest in what we publish. May you all stay well and the Journal continue to flourish.

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