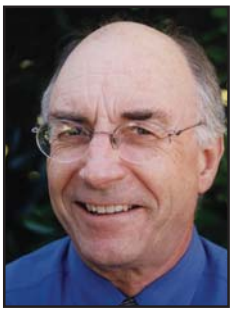
Editorial



Tony Townsend has been a general practitioner for 30 years. Although he has dabbled in medical politics, medical ethics, community-based teaching, university-based teaching, quality improvement and assessment, his passion remains clinical general practice. He is currently a full-time general practitioner in Whangamata.

The stark reality of how far we have to go in improving the health care of our young people became tragically apparent as I was writing this editorial. Two young people were needlessly killed and several others severely injured in Christchurch in a situation involving alcohol, out of control teenagers and cars.

As you will read in our theme papers for this issue, we do not do well in looking after young people in New Zealand compared with other OECD countries. Motor vehicle crashes are the leading cause of death among 16 to 24-year-olds but suicide is second on the list. Twenty-three per cent of the total number of suicides in New Zealand in 1999 (514 suicides) were youth suicides (people aged 15–24 years). Most suicidal behaviour occurs in the context of mental illness (principally depression) and/or substance abuse. Social and educational disadvantage is another risk factor for suicide.[1] We are a small country and, as suicide rates for Maori fluctuate from year to year, because of the small numbers of deaths involved they need to be analysed with caution. Nonetheless, although overall suicide rates were almost identical for Maori and non-Maori in 1999 (at 12.0 and 12.2 per 100 000 respectively), the Maori youth suicide rate was higher than that for non-Maori (30.6 per 100 000 Maori youth compared with 20.5 per 100 000 non-Maori youth).[2]

Sexual health is another concern. Studies suggest that 10–30% of young New Zealanders have had sexual intercourse by the time they reach 15 years of age, and about half have had intercourse by the time they are 16 or 17 years old.[3] Compared with other age groups, young people (aged 15 to 24) are over represented in the rates of sexually transmitted infections. The most commonly reported infections being chlamydia, gonorrhoea, genital warts and genital herpes.[4]

Alcohol, tobacco, cannabis and other drug use is common in this age group. More young men drink alcohol than young women, but more young women smoke tobacco.[5] The consequences of this are well known to those of us who work in general practice.

However, we do not see these young people in our practices very often. As a group they do not have a high prevalence of chronic illness, and the opportunities for illness or accident prevention, or for the promotion of positive health behaviours are few. When we do see them, it is often for crisis management such as suturing wounds after drunken altercations or prescribing the morning after pill when the hangover is still hurting. These are not ideal times to preach the gospel of risk-reducing lifestyle changes. In our practice we have tried to lower the access barrier by not charging a co-payment for school children. Although this seems to help a little, we are still regarded as parental clones. We do not speak the same language. We do not understand them. Why should they talk to us?

There is no shortage of discussion, debate, recommendations or plans. For example, *Youth health: A guide to action* was published by the Ministry of Health in 2002[6] but, for most of us, this is all too difficult. Even reading the 64-page document is difficult, let alone trying to incorporate the action plan into our daily work. This is not a statement of professional nihilism; it is simply the reality of present day general practice.

In response to some of these concerns, youth health centres have been established to try to encourage dialogue and to influence behavior in our young people. We have reports from four of these in this issue. Although each clinic is reporting on relatively small numbers of clients, making the significance of statistical analysis debatable, it appears that improvements in risk taking activities are occurring. It also appears that these centres may act as a stepping-stone, encouraging young people to move from the murky waters of the adolescent health care swamp into mainstream general practice.

In 10 years time I hope that we can look at the data again and find that deaths from suicide and accidental injury in our young people no longer feature at the top of the tables for OECD countries. That we top the tables now is something about which we should feel ashamed.

References

1. http://www.stats.govt.nz/analytical-reports/monitoring-progress/living-stds-health/health.htm. Accessed 15 May 2007.
2. http://www.stats.govt.nz/analytical-reports/monitoring-progress/living-stds-health/default.htm. Accessed 15 May 2007.
3. Ministry of Health Youth Health Status Report 2002.
4. Institute of Environmental Science and Research Limited (2001). Sexually Transmitted Infections in New Zealand: Surveillance Report 2000.
5. http://www.myd.govt.nz/uploads/docs/health.pdf. Accessed 15 May 2007.
6. Youth health: A guide to action. Wellington: Ministry of Health; 2002. http://www.moh.govt.nz