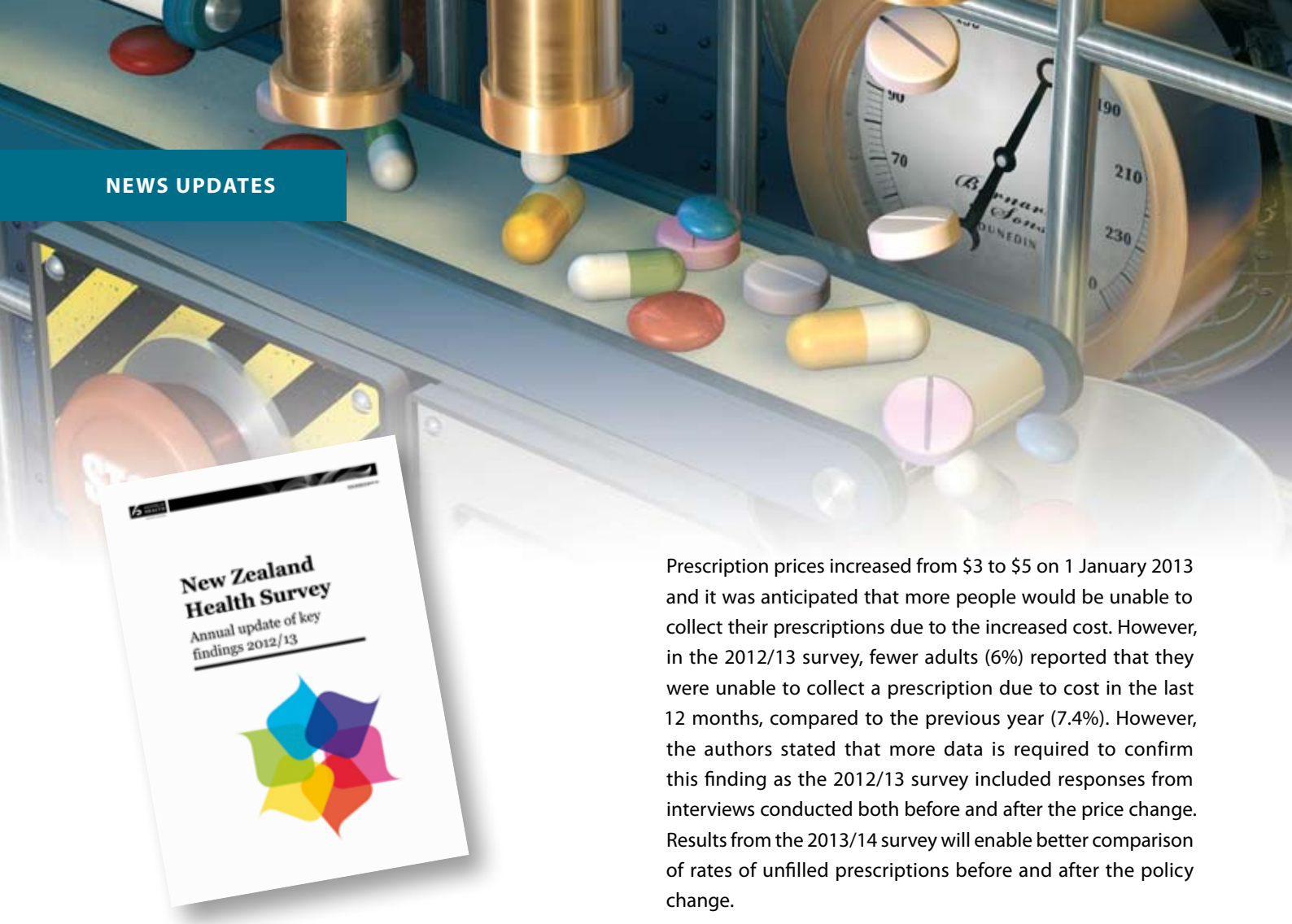

Annual update of the New Zealand Health Survey reveals declining smoking rates but increasing rates of obesity

Statistics New Zealand carries out the New Zealand Health Survey as part of a programme to develop and coordinate official social statistics. These statistics provide relevant health information to help formulate and evaluate policy. In the most recent update of the New Zealand Health Survey covering 2012/13, 13 009 adults and 4485 children were surveyed.[1]

In the latest update released in December 2013, it was reported that daily smoking rates in adults are continuing their downward trend dropping from 16.4% in 2011/12 to 15.5% in 2012/13. Smoking rates in young people have also declined from 24% of people aged 18-24 years smoking daily in 2011/12 to 20% in 2012/13. However, smoking rates among Māori and those living in the most deprived areas are still high; 36% of Māori adults and 28% of adults living in the most deprived areas smoke daily.

Current survey results show an increase in the incidence of obesity in adults. In New Zealand, 31% of the adult population are now obese. This is an increase from 29% in 2011/12 and 26.5% in 2006/7. Rates of obesity are significantly higher among those living in socioeconomically deprived areas.

Prescription prices increased from $3 to $5 on 1 January 2013 and it was anticipated that more people would be unable to collect their prescriptions due to the increased cost. However, in the 2012/13 survey, fewer adults (6%) reported that they were unable to collect a prescription due to cost in the last 12 months, compared to the previous year (7.4%). However, the authors stated that more data is required to confirm this finding as the 2012/13 survey included responses from interviews conducted both before and after the price change. Results from the 2013/14 survey will enable better comparison of rates of unfilled prescriptions before and after the policy change.

Of concern, people living in more deprived areas have poorer health and report greater unmet need for health care. Significantly higher levels of all health risks, including smoking, hazardous drinking, inadequate fruit and vegetable intake, low physical activity and obesity are reported by those living in the most socioeconomically deprived areas. This group have a higher incidence of most health conditions, with rates of diabetes and psychological distress being particularly high in comparison to rates in people living in the least deprived areas. Cost was a major barrier to seeking health care for adults and children living in the most deprived areas. In particular, children living in the most deprived areas were seven times more likely than children in the least deprived areas to have unfilled prescriptions due to cost in the past year.

For more findings from the 2012/13 New Zealand Health Survey update see: **www.health.govt.nz/publication/new-zealand-health-survey-annual-update-key-findings-2012-13**

References

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Further roll-out of the Community Pharmacy Anticoagulation Management Service

Following a successful pilot in 2010, the Community Pharmacy Anticoagulant Management (CPAM) Service was rolled out to a further 50 pharmacies in 2013. Currently, 125 pharmacies throughout New Zealand are offering this service to over 2000 patients.

The CPAM Service is a new model of care which involves accredited community pharmacies providing point-of-care INR testing (by finger prick sample) and adjusting warfarin doses "on the spot" with the aid of a decision support system (INR Online). The General Practitioner retains overall responsibility for the patient's management and is automatically informed of each test and the recommended dose, is consulted on tests that fall out of range, and can intervene at any time.

So far the service has been well received and has had some positive outcomes. In the latest evaluation (1 September, 2012 to 31 May, 2013) it was reported that INR test results for patients enrolled in the CPAM service were in the Therapeutic Treatment Range (TTR) 74 – 78% of the time.[1] TTR is a widely used measure of the quality of anticoagulant control. International guidelines recommend maintaining the results in the TTR 60% of the time or more in order to maximise the benefits of warfarin and to limit adverse effects. Studies of the usual model of care in New Zealand, where general practices arrange venous blood sampling, testing is carried out by a community laboratory, and results are received and communicated back to the patient, have reported TTRs less than 60%.[2]

Patients using the CPAM service were compliant with INR testing, with over 80% of patients getting their tests on or before the due date.[2]

Patients, Pharmacists, General Practitioners and Practice Nurses were surveyed on their opinions of the CPAM service during the pilot study and following the initial roll out. Pharmacists were overwhelmingly positive about the service and supported its continuation. Most patients found the CPAM service convenient and accessible, and had confidence in the pharmacist's ability to perform the service. A small proportion of patients expressed a preference for receiving care from their General Practitioner. Overall General Practitioners and Practice Nurses trusted the Pharmacists to provide this service, and felt that it freed up time for them and was more convenient for their patients. Some were concerned about communication of results and possible fragmentation of services. However, most believed the service should continue and be more widely available.[2]

Pharmacies are funded through DHBs to provide this service and it is provided free of charge to the patient. General Practitioners can work with pharmacies to identify patients suitable for the service. Some patients will still require management by the practice and others may be referred back. Patients can opt-out of CPAM at any time.

For further information, contact a local pharmacy or general practice involved in the Community Pharmacy Warfarin Service. A list of some pharmacies offering the CPAM service is available from: **http://beehive.govt.nz/sites/all/files/Community_Pharmacy_List.pdf**

For background information on CPAM, see: "INR point of care testing in community pharmacies – is this the future?", BPJ 31 (Oct, 2010).

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Sodium valproate in pregnancy – potential for long-term neurodevelopmental effects in children

Infants born to mothers who have taken antiepileptic medicines during pregnancy have a two- to three-fold increased risk of major congenital malformations compared to the general population.[1] This risk is further increased when mothers have taken more than one antiepileptic medicine during pregnancy. Despite this risk, in most cases the benefit of treating epilepsy outweighs the risks of having a child with abnormalities because uncontrolled epilepsy is dangerous for both the mother and foetus.[2]

While the link between antiepileptic medicines and congenital malformations is well established, more evidence is accumulating to suggest that there is also a risk of long-term neurodevelopmental effects in children following maternal use of sodium valproate during pregnancy. These effects include developmental delay, particularly of verbal IQ and of autism spectrum disorders.[3, 4, 5, 6] These risks are independent of maternal confounding factors. The risk appears to be higher with sodium valproate than with other antiepileptic drugs and also appears to be dose related. In some studies the outcomes for children exposed to lower doses of sodium valproate (<1000 mg/day) did not differ from children exposed to other antiepileptic medicines, however, higher doses of sodium valproate resulted in neurodevelopmental delays.[6]

A large European review is underway to re-evaluate the balance of benefits and risks of sodium valproate in pregnancy. In New Zealand sodium valproate is contraindicated in pregnancy (TGA pregnancy category D),[2] however, there may be a few women whose epilepsy can only be controlled by sodium valproate, who are therefore using this medicine throughout pregnancy.[6] In 2009 bpac^{nz} advised that lamotrigine or carbamazepine are the preferred initial treatment choices for women of child bearing potential with epilepsy.

The UK Medicines and Healthcare Products Regulatory Agency (MHRA) are advising Health Professionals that:

- Sodium valproate should not be used in pregnancy or in women of child-bearing potential unless clearly necessary
- Sodium valproate is a poor first choice for women of child-bearing potential and treatment with it should only be initiated in these women following specialist neurological or psychiatric advice as appropriate
- If sodium valproate is used in women of child-bearing potential explain the risks adequately and provide and/or counsel about effective contraception
- If sodium valproate is being used for bipolar disorder, it may be appropriate to cease treatment if there is an effective alternative
- If sodium valproate is to be used during pregnancy, it should be at the lowest effective dose, and doses should be divided throughout the day to avoid rapid peaks in plasma valproate levels
- High-dose folic acid supplementation (5 mg, once daily) is recommended, ideally for one month pre-conception and 12 weeks post-conception if sodium valproate is to be used during pregnancy

For further information, see: BPJ 24 "Prescribing issues associated with anticonvulsant medications for epilepsy", BPJ 24 (Nov, 2009).

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