



## Statement of Intent 2010-2013



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New Zealand Government

## **Statement from the HSC Board**

The Health Sponsorship Council's (HSC's) primary goal is to contribute to the reduction in illness and disease and the consequent burden on clinical health care services. The HSC is a specialist agency with 20 years accumulated experience and expertise in promoting healthy lifestyles. It operates as a national health promotion service provider with a long-term focus on reducing the social, financial and health sector costs of a number of health behaviours. Specifically, HSC aims to improve health outcomes by:

- reducing cancers, heart disease, chronic respiratory disease and stroke by reducing the incidence and prevalence of smoking
- reducing skin cancers (including melanoma) and eye disease by increasing sun safe behaviours
- reducing mental, social and financial harms by reducing the incidence and impact of problem gambling
- reducing obesity and its associated illnesses (diabetes, heart disease, kidney failure, joint deterioration etc) through better nutrition and increased physical activity.

The HSC uses research and evaluation to inform its programmes and initiatives to ensure they are relevant and appropriate to audiences' needs and to monitor progress – ensuring programmes are as effective and efficient as possible.

This Statement of Intent outlines for Parliament the performance HSC has agreed with the Minister of Health to deliver for the period commencing on 1 July 2010 and ending 30 June 2011.

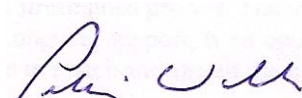
In particular, this document specifies:

- HSC's contribution to government policy
- strategic issues being faced by the HSC and how it intends to address them
- the programme of initiatives to promote healthy lifestyle choices, with performance indicators that the HSC will seek to achieve from 1 July 2010 to 30 June 2011
- the performance the HSC will aim to achieve during this time, specified in terms of financial performance, capability and risk management
- financial forecasts.

This specification of performance will be used as a basis for comparison against our actual performance when our annual report is prepared.



Hayden Wano  
Chairman  
30 June 2010



Prof Peter Walls  
Board Member  
30 June 2010

# **Introduction**

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HSC is a Crown Entity established under the Smoke-free Environments Act 1990 and has prepared this Statement of Intent to meet the requirements of the Crown Entities Act 2004.

The document has three main areas of focus:

Pages 6 to 17 provide a three-year picture of the outcomes HSC is pursuing, how it intends to achieve these outcomes and how it will measure progress. It also includes a summary of the challenges HSC faces and any implications these challenges may have.

Pages 18 to 58 address the HSC's programmes. Each of these is split into two parts. Part 1 outlines the importance of the health issue, what the HSC is aiming to achieve and how this will be done (and demonstrated). Part 2 includes the non-financial measures and standards (Statement of Forecast Service Performance) by which HSC will be assessed in 2010/11.

Pages 59 to 72 include the financial measures and standards by which HSC will be assessed in 2010/11.

The HSC was established by the Smoke-free Environments Act 1990 and is a Crown entity, as defined in Schedule 1 (Crown agents) of the Crown Entities Act 2004.

The HSC is governed by a Board of six members. Current members:

Hayden Wano - Taranaki (Chair)

Dame Susan Devoy – Tauranga (Deputy Chair)

Maree Leonard - Marlborough

Fa'amatuainu Tino Pereira – Wellington

Linda Thompson - Auckland

Professor Peter Walls - Wellington

# **The Next Three Years**

## **HSC's Strategic Direction**

The HSC's function is to "promote health and encourage healthy lifestyles" (section 44 of the Smoke-free Environments Act 1990) resulting in the mission *We promote health and encourage healthy lifestyles* and a vision of *Healthy New Zealanders*. We provide leadership in this area through good practice, working with others and using an extensive range of tools. As outlined in the Strategic Plan 2009-2014, HSC's four strategic goals are:

- Leadership through knowledge – Active development and dissemination of knowledge, including research, evaluation and information, and sharing of knowledge with others.
- Leadership with communities – Improved impact by our work being driven and supported by communities.
- Leadership with others – Provision of leadership and establishment of active and influential alliances with others, and enabling others to increase their ability to have a positive impact on the health of New Zealanders.
- Leadership through innovation and adaptability – Developing an innovative, flexible and responsive organisation, with increased influence on healthy lifestyles.

Long-term (chronic) conditions account for 80% of early deaths in New Zealand and 70% of health costs. Projections are that these long-term conditions will increase.<sup>1</sup> Many of these costly and disabling conditions – heart disease, cancer, diabetes and chronic respiratory diseases – are linked by common preventable behaviours such as tobacco use, inactivity, and prolonged, unhealthy nutrition.

The HSC is contracted to deliver four programmes that make people aware of the consequences of harmful health behaviours and promote healthy lifestyle choices by providing people and communities with the information, motivation and skills they need to be non-smokers, be physically active and eat healthily to maintain a healthy body weight, be safer in the sun and avoid harmful gambling.

The HSC's programmes achieve this by communicating information directly to adults and young people, supporting the work of other frontline service providers, working with

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<sup>1</sup> Ministry of Health. 2008. *Briefing for the Incoming Minister of Health*.

communities, and working with national and regional agencies (see pages 18-20 for further details of this work).

HSC delivers its programmes to all New Zealanders but each programme focuses on encouraging individuals and members of vulnerable and at-risk communities to adopt healthier lifestyles in order to improve their health status and life expectancy. This includes working with Māori and Pacific peoples, as collectively they experience a disproportionate amount of negative health outcomes.

## **The HSC's Approach**

International and national evidence demonstrates that appropriate government and private sector action can improve health. The HSC contributes to this action as a well-established health promotion service provider that provides leadership and expertise. The World Health Organization's Ottawa and Bangkok Charters provide the international framework for health promotion. The Ottawa Charter defines health promotion as “the process of enabling people to increase control over, and to improve, their health...”.

Lifestyle-related illness requires interventions that change the choices people make about behaviours that put their health at risk. Prevention efforts at the individual, community and population level, along with improved primary health care, are key to achieving long-term and sustainable change.

To encourage and enable people to make healthier lifestyle choices, HSC draws on the experience and success of commercial marketing and communication techniques to plan, execute and evaluate its programmes. HSC uses the tried and tested approaches of the commercial sector to improve people's health. This approach is used worldwide and is known as social marketing.

Social marketing is consumer-oriented, responding to individual needs and wants. It is systematic, staged, underpinned by academic and consumer research, and is directly geared to achieving specific and measurable health goals over the short, medium and long term. International evidence suggests that using this approach systematically can “significantly enhance and improve the impact and effectiveness of health promotion” (National Consumer Council, 2006).

## ***Integrating activities***

Working together to integrate activities is essential for successful health promotion and prevention of chronic diseases. The HSC works closely with other providers and organisations to ensure effective and innovative approaches are developed and shared, along with knowledge and information.

The Government gains from this integration by reduced duplication between publicly funded agencies. HSC's partner organisations gain too, by having tools and resources readily available to them to make messages relevant to different people's lives. At the local level, this enables communities to develop solutions that are best for them, while strengthening HSC's work by linking it into activities taking place in communities, schools and workplaces.

The range of organisations the HSC works with is broad, from national agencies such as Agencies for Nutrition Action and the Heart Foundation, to regional organisations such as public health units (within DHBs), Cancer Society divisions and local Māori, Pacific and Asian providers. HSC also works with an increasing number of private sector organisations. This includes media organisations (eg, in 2009/10 several youth-focused media organisations maintained a Smokefree policy for all the material they broadcast), promoters of events (the Big Day Out was 'smokefree' for the second year in 2010), and representatives from gambling industries.

Integrated action with communities, the private sector and across government organisations provides a significant opportunity for health, social and economic gain.

## ***Research and evaluation***

Research and evaluation are key to the HSC's work. Internationally, research and evaluation are acknowledged as fundamental to the implementation of successful public health initiatives (Hastings, 2007; Walsh et al., 1993; World Health Organization, 2008). We cannot hope to help people make healthier lifestyle choices without a thorough understanding of the situation, the people, and the communities involved (Hastings, 2007). We also need to check that the programmes we develop achieve the intended objectives. Research and evaluation, therefore, have a critical role to play in each step of the process.

Examples of research and evaluation the HSC undertakes to develop its programmes, ensure appropriate information and messages are delivered in a meaningful manner to New Zealanders, and that results are monitored and evaluated include:

- Formative research for new programmes. This includes reviews of national and international evidence and New Zealand consumer research to determine and understand people's needs and to establish the best ways to deliver information and support people.
- Robust evaluation and monitoring of existing programmes to ensure they continue to be effective. In this way we are able to adjust our programmes to continue to be relevant to our audiences' needs.
- Leading research to inform the programmes of HSC and others. As part of this work HSC undertakes some long-term research, including the biennial Health and Lifestyles Survey to track the impact of HSC's four programmes, the triennial sun safety monitor (carried out in conjunction with the Cancer Society of New Zealand), and the annual youth tobacco survey that is undertaken with ASH (Action on Smoking and Health), provides youth smoking data for the Ministry of Health, DHBs and the World Health Organization (by including the Global Youth Tobacco Survey).

### ***Commitment to quality***

The HSC is committed to delivering high quality programmes. The HSC has a formal quality improvement process, which uses a tool it developed to assess the quality of its initiatives and programmes (including national and international peer review).

Two HSC programmes have undergone the quality improvement process:

- SunSmart in 2007/08
- tobacco control in 2008/09.

The results show that HSC is delivering programmes to a high standard – in both assessments key stakeholders saw HSC as efficient, effective and responsive. The process also identifies areas for improvement, and these are incorporated into current and future programme development.

The quality improvement process helps ensure both value for money and a continuing focus on improvement. As the tool has potential to improve the effectiveness and efficiency of programmes across the public sector, the HSC has already provided it to the Office of the Auditor General and, in 2010/11, will make it more widely available to other government agencies.

## **Working with others**

Working with others in a collaborative way allows local innovation and can help people achieve their health aspirations. Rather than imposing HSC's approaches on to others it works with them to secure an approach that fits with their requirements. Examples of working in this way include the following:

- Sector reference groups bring together talented people from a variety of professions and communities who can advise HSC on appropriate directions for HSC initiatives. In this way HSC ensures its work is appropriate and applicable. Examples include the Smokefree Schools Group and the Smokefree Working Group.
- The HSC's Māori leadership group was established in 2007/08 to guide, oversee and explore a broad approach to improve the health and wellness of Māori. This group is offering direction to HSC on how to be more effective for Māori.

## **Health equity**

HSC applies an equity lens<sup>2</sup> to its work. What this means in practice is that in the process of planning and implementing programmes, HSC recognises diversity and disadvantage and acts to increase health equity across population groups. In essence this means that HSC targets its programmes towards meeting the needs of those most disproportionately affected in each programme area. For example in tobacco control, Māori have the highest smoking rates and experience a higher burden of disease and ill health from smoking-related conditions.

Therefore, the HSC's tobacco control work specifically targets Māori, and in particular Māori youth, to reduce uptake of smoking among this group. However, in order to assess whether or not HSC's programmes are being effective in achieving this objective, Māori youth smoking rates are compared against all youth smoking rates to ensure that programmes are not inadvertently increasing the disparity between these two groups.

## **Organisational Capability and Capacity**

### **People**

The HSC's success depends on attracting, developing and retaining people with the right skills, abilities and commitment. The HSC implements a number of initiatives to achieve this, including:

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<sup>2</sup> <http://www.moh.govt.nz/moh.nsf/pagesmh/3968>

- continuing to provide learning and development opportunities for staff (professional development plans for individuals are developed as part of the annual performance review process)
- continuing to use the Lominger framework to identify competencies needed for specific roles. Identifying relevant competencies ensures current staff are able to undertake appropriate professional development to fill any gaps in their knowledge and new staff can be recruited who have the skills and knowledge required for each role
- offering exit interviews to staff who are leaving to learn from their experience of working at the HSC
- supporting a diverse workforce so HSC can understand and respond to the socio-cultural aspects of the behaviour of our different audiences.

### ***Good employer practices***

The HSC remains committed to fulfilling its obligations to be a good employer, implementing equal employment opportunities for all. HSC staff are essential to ensure the organisation maintains excellence and a high level of performance and results.

To retain existing staff, attract people to the organisation, and help alleviate workplace stress the HSC has a number of flexible working arrangements, including the following:

- Flexible start and finish times.
- Recognising family needs outside of the workplace by providing reduced working hours, work at home options, and flexible options during school holidays.
- Providing time off in lieu for additional hours worked.
- Supporting staff to be physically active.

## **Operating Environment**

As HSC has four areas of activity (tobacco control, sun safety, problem gambling, and nutrition and physical activity), there is a wide range of consumer and stakeholder audiences. HSC must continue to garner understanding of these groups to ensure it is able to respond to their needs and, most importantly, is able to provide information in ways that are engaging, relevant, and empowering. In this way HSC can assist them to make lifestyle choices that will improve their health, life expectancy, and quality of life.

Rapid changes in technology are transforming the way we live. HSC is committed to understanding and using new technologies in ways that:

- build connections with public and private sector partners
- enable it to work better with communities
- provide up-to-date information to New Zealanders in innovative ways to help them make healthy lifestyle choices.

New Zealanders live in an environment that often supports unhealthy choices eg, tobacco products are freely available from a large number of outlets. Every day we are all exposed to myriad marketing messages (commercial and non-commercial, healthy and unhealthy). These factors mean that HSC competes for attention in an extremely busy market. As a result, and to maintain effectiveness, HSC must continue to communicate in new and exciting ways that capture attention.

The HSC must be sensitive to the impact on our audiences of the economic environment. In these constrained times people will often be preoccupied with the necessities of life (eg, earning enough to pay for power, rent, and getting food on the table), which can lead to unhealthier lifestyle choices. For example, in times of economic hardship problem gambling is known to rise. HSC, therefore, needs to develop further innovative ways to communicate information and ensure messages remain realistic given people's more limited resources.

Demographic trends suggest that the proportion of New Zealanders of Māori, Pacific and Asian ethnicity will increase and these populations tend to have a younger age structure than New Zealanders of European descent. This, and the overall aging population in this country, has a two-fold affect for HSC. At the older end of the population, lifestyle decisions made earlier in life are beginning to impact on quality of life through, for example, increases in the prevalence of obesity, type 2 diabetes, respiratory disease, and heart disease. At the younger end, HSC is focused on motivating young people to choose healthy lifestyle options from an early age, making the need to communicate effectively with younger audiences even more vital.

Economically challenging times require an even greater need for organisations such as the HSC to offer value for money. Promoting good health and preventing ill health can offer very

real value as it can save society millions of dollars in primary health care costs, lost productivity, lost quality of life and early death.

## ***Crown Expectations***

The Minister has expressed the expectations of the Crown as owner of the HSC within the Letter of Expectations 2010/11. This Statement of Intent is consistent with those expectations and includes the following.

### **Fiscal environment**

In this time of fiscal constraint, HSC will continue to manage budgets carefully to provide a strong operating environment focused on financial sustainability. In addition, HSC will continue with its approach of providing appropriate salaries within modest levels.

### **Better services, better value**

The HSC's quality improvement process provides an internationally robust assurance around HSC's programmes.

Formative research and rigorous evaluation provides direction for new activities as well as assessment of the effectiveness of initiatives and highlighting possible improvements.

### **No surprises**

The HSC will meet with the Minister at least six-monthly. Through this process, and its reporting regime, the HSC will ensure that the Minister is kept well aware of any emerging issues, concerns and opportunities.

# Outcomes

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## Health Outcomes

The HSC contributes to the Ministry of Health's high-level health outcomes as follows:

- *Good health is protected and promoted.* HSC is a specialised health promotion agency with 20 years experience in the New Zealand health and social sectors. The HSC's work focuses on providing New Zealanders with information in a way that enables them to make healthy lifestyle choices.
- *A more unified and improved health and disability system.* HSC provides support and leadership in the health sector by working closely with government and non-government organisations and the private sector, developing nationally consistent approaches and messages and bringing together often disparate groups to ensure they communicate with each other and work together to meet individual and shared goals. HSC supports development and implementation of initiatives that support government policy including the active dissemination of research and evaluation, working with communities, and providing resources that assist implementation.
- *People receive better health and disability services.* Evidence shows that national initiatives are most effective when delivered in communities. HSC works with communities to help them decide the most appropriate ways to address health issues. Research undertaken by the HSC ensures we understand priority population needs and are able to design initiatives accordingly to ensure the greatest impact and effectiveness for these groups.
- *The health and disability system and services are trusted and can be used with confidence:* HSC provides reliable, robust evidence for the sectors it works with, allowing local and regional services to implement national programmes with confidence. Similarly, the public can trust that HSC's evidence-informed approaches are best practice.

## Long-term Outcomes and Objectives

Long-term conditions such as heart disease, cancer, type 2 diabetes, obesity and tobacco-related conditions are the leading cause of ill health and early death in New Zealand. These conditions account for 80% of early deaths and disproportionately affect low income earners, Māori and Pacific peoples. Continuing improvements in health promotion and disease

prevention are key to avoiding these diseases developing, slowing the rate of disease progression, improving health, preventing the need for expensive health care, and increasing workplace productivity.

The following describes the HSC's programme goals and the long-term outcomes that contribute to achieving them.

*New Zealanders reject tobacco and live a smokefree lifestyle.* This goal focuses on reducing cancers, heart disease, chronic respiratory disease and stroke by reducing the incidence and prevalence of smoking. The long-term outcomes that contribute to this goal are:

- Reduced uptake of smoking among Māori youth.
- Increased quitting.
- Decreased social acceptability of tobacco.

*Reduce the proportion of New Zealanders who develop and die from skin cancer.* This goal focuses on reducing skin cancers (including melanoma) and eye disease by increasing sun safe behaviours. The long-term outcome that contributes to this goal is:

- Decreased incidence of sunburn among New Zealanders.

*Reduce the incidence of problem gambling and the impact of gambling harms in Aotearoa/New Zealand.* This goal focuses on reducing mental, social and financial harms by reducing the incidence and impact of problem gambling. The long-term outcome that contributes to this goal is:

- Preventing and minimising gambling harm.

*To attain and maintain a healthy weight and reduce the burden of disease through improved nutrition and increased physical activity.* This goal focuses on reducing obesity and its associated illnesses (diabetes, heart disease, kidney failure, joint deterioration etc) through better nutrition and increased physical activity. The long-term outcomes that contribute to this goal are:

- Improved nutrition among 5-16 year old children.
- Improved physical activity among 5-16 year old children.

### ***Objective – supporting the health sector***

The HSC has an objective of supporting the health sector, which focuses on working with the wider health sector eg, other frontline workers, doctors and nurses, and health promoters, to develop their skills and knowledge so they are better able to achieve government health outcomes.

HSC supports the wider sector with the following activities:

- Organising professional development opportunities on health promotion, health issues, research and evaluation eg, the biennial national Smokefree and melanoma gatherings.
- Supporting training opportunities for community health workers eg, evaluation and planning seminars.
- Providing a mechanism for sharing best practice through websites and listserves eg, Melnet (melanoma network).
- Developing linkages with international experts and organisations such as the Cancer Council of Victoria (Australia), the Cancer Institute of New South Wales, the Centers for Disease Control and Prevention (CDC), WHO, and the Global Dialogue for Effective Stop Smoking Campaigns.
- Maintaining and developing relationships with:
  - other government agencies and national organisations such as SPARC and the Ministry of Education
  - DHBs eg, funding and planning units, Smokefree Coordinators
  - members of relevant industry groups.

## Intermediate Outcomes and Interventions

Within the following section the HSC's programmes' intermediate outcomes are outlined on the left-hand side of the Statement of Prospective Service Performance tables (Intermediate outcomes and Intermediate Outcome measures columns). Intermediate outcomes are shorter-term and, when achieved, contribute to long-term outcomes.

Long-term outcome	Intermediate outcomes (3-5 year)	Intermediate outcome measures	Outputs	Performance measures
The state or condition of society we are trying to achieve.	The state or condition of society HSC is hoping to achieve within a 3-5 year timeframe.	The main 3-5 year non-financial measures used to judge performance.	Final goods or services supplied to someone outside the entity.	The main annual non-financial measures used to judge performance.

HSC monitors the contribution of the activities and outputs to its intermediate outcomes with annual performance measures. It also monitors progress towards long-term outcomes by

measuring indicators that show the extent of health gains (including impacts on at-risk communities), increases in knowledge about healthy lifestyle choices, and the adoption of healthy lifestyle behaviours. However, as robust national-level evidence gathering can be expensive and challenging they cannot be undertaken every year. As a result, some of the HSC's monitoring is only undertaken periodically eg, Health and Lifestyles Survey (biennial), Sun Exposure Survey (triennial).

As social and behavioural change can take a long time HSC's performance in the short to medium-term is measured through a combination of proxies and logical indicators. For example, evidence suggests that the number of year 10 students reporting that they have 'never smoked' is a good indicator of progress towards the intermediate and long-term outcomes of reducing smoking initiation.

### ***Development of targets***

The targets that have been developed for this Statement of Intent are derived in two ways. The lower end of the target range represents a conservative estimate of a realistic and achievable target based on current trend data. The higher end of the target range represents an aspirational target, which is higher than would be expected based on current trend data. In some areas, where significant inequalities exist, a larger target band has been developed in recognition that it may be necessary to achieve higher levels of change within that target population in order to reduce the inequalities that exist.

# **HSC Programmes in 2010-11**

## *Output Class One – Marketing Healthy Lifestyles*

HSC's is contracted to deliver services under Output Class One. HSC delivers programmes that contribute to tobacco control (Smokefree and Auahi Kore) sun safety (SunSmart), preventing and minimising the harm caused by problem gambling, and reducing obesity through better nutrition and increased physical activity.

Total Budget for Output Class One 2010/11: \$10,748,000 (ex GST).

To increase the number of people choosing healthy lifestyles, HSC groups its work into five key activities that combine to result in comprehensive, coordinated interventions (which evidence shows are the most successful):

- Communicating information directly to people.
- Supporting the work of other frontline services.
- Working with communities.
- Working with national and regional agencies.
- Research and evaluation.

## ***Communicating information directly to people***

Communicating information directly to New Zealanders:

- inspires them to choose healthy lifestyle options
- makes sure they know what being and staying healthy means and the benefits for them and their families/whānau
- informs them about the help and support available, if they need to change current behaviours.

National communications strategies, which may involve evidence-based, pre-tested, multi-media advertising, public relations activities, and online and social media initiatives have been shown to play a highly effective role in changing behaviour. For example, the United States National Cancer Institute concludes that mass media campaign designed to discourage tobacco use can change youth attitudes about tobacco use, curb smoking initiation and encourage adult cessation. This effect is amplified when mass media campaigns are combined with other strategies in multi-component tobacco control programmes (as are undertaken in

New Zealand). (US National Cancer Institute, *The Role of the Media in Promoting and Reducing Tobacco Use*).

The HSC uses online (web, viral marketing, e-campaigns, social networking) strategies for reaching and building relationships with target audiences and other partner organisations. These strategies build on HSC's work developing connections with audiences and also as a means of further engaging with partners and community workers.

### ***Supporting the work of other frontline services***

HSC supports the work of other frontline service providers such as doctors, nurses, health promoters, educators and counsellors by:

- providing evidence, materials (resources), advice and training to make their work more effective and efficient
- providing a platform for nationwide 'conversations'. For example, the HSC leads the promotion of sun safety messages through the SunSmart programme (run in conjunction with the Cancer Society of New Zealand). This wider promotion of sun safety messages raises New Zealanders' awareness of the impact of skin cancer and melanoma and the harms of sunburn. This supports frontline services by enabling doctors, nurses and other health workers to talk about the issues and undertake early detection work safe in the knowledge that many people will be aware of the implication of their behaviours on their health.

### ***Working with communities***

HSC works directly with communities to help them determine (and implement) the most appropriate ways to address their local health issues.

HSC works collaboratively with identified groups of people connected by special interest, affiliation or identity to help improve their well-being or that of others they care about or their views and actions influence. Working together is based on building respectful relationships that benefit both parties in ways each party values. Working together includes relationship building, information sharing, consultation, involvement, collaboration, empowerment and support. For example, HSC has formed a number of relationships with key community agencies such as DHBs, iwi provider groups, and non-government organisations such as the National Heart Foundation.

## ***Working with national and regional agencies***

As HSC is a national agency based solely in Wellington it relies on delivery mechanisms and networks outside of those it can provide itself. Some of those are available through national and regional organisations eg, Cancer Society of New Zealand, Problem Gambling Foundation, Kohanga Reo while others are available through organisations that are more individual to their community, eg, iwi and community interest groups.

A collaborative working approach ensures HSC's brands and messages are portrayed in a coherent manner, which helps people to better understand the messages and take action, thereby increasing effectiveness and value for money.

National and regional stakeholder relationships enable HSC to:

- gain wider buy-in and ownership of HSC's programmes and initiatives
- support regional and community-based delivery of initiatives
- seek wider input into the subsequent phases of the programmes
- manage expectations and perceptions of key audiences and potential partners
- keep people informed during the delivery and development of the initiatives.

These relationships are essential parts of HSC's work, as demonstrated by the following quote from the *UK Public Health White Paper 2004* "...Once we have a clear message about health, it is important that people can act on it. National and local government, the voluntary and community sectors and industry are beginning to develop new partnerships to communicate more consistent messages on health and ensure that people can follow them up easily."

## ***Research and evaluation***

Research and evaluation play a critical role in every aspect of the HSC's work. It enables HSC to achieve a thorough understanding of the situation, people and communities that it works with (essential for successful health promotion activities), as well as providing a check to ensure that the programmes it develops achieve the intended objectives. In addition, research and evaluation provide guidance and direction for HSC initiatives.

# Tobacco Control

## ***Why is tobacco control important?***

Crucial to increasing life expectancy for New Zealanders is the continuing decline in deaths from cardiovascular disease, the single biggest cause of death in this country. A key driver of this decline over the last 40 years has been a reduction in smoking rates.

Tobacco use is responsible for about 25% of cancer deaths in New Zealand and reducing smoking rates will reduce cancer and the consequent demand on, and cost of, diagnostic, clinical, rehabilitation and palliative services.

## **Costs of smoking**

In 2005, the tangible costs of smoking in New Zealand were estimated to be approximately \$1.7 billion annually, or about 1.1% of GDP. Major components are smoking-caused health care costs, lost production due to premature mortality and lost production due to smoking-caused morbidity (O'Dea and Thomson *et al*, 2007). The intangible costs were estimated to be in the order of 62,800 life-years lost due to smoking-related premature death, and 19,000 quality-adjusted life-years lost due to tobacco-related illness. A reduction in smoking rates, therefore, will reduce financial and resource-related strain on the health system, improve workplace productivity (reducing smokers' breaks and absenteeism), lower the costs to businesses, and improve people's quality of life.

New Zealand smoking rates across all ages and ethnicities have declined significantly since the 1970s. Public education, health promotion, regulation, and help with quitting have all assisted in this reduction in smoking.

However, smoking remains the biggest preventable cause of ill health and early death in New Zealand. It is estimated that smoking is currently responsible for approximately 5,000 deaths per year in this country (including about 350 deaths per year from exposure to second-hand smoke).

In 2008, 23.1% of New Zealanders aged 15-64 years were current smokers<sup>3</sup>. This New Zealand prevalence figure is very similar to that for Australia (19% in 2007 for adults 18 years and over) and the United Kingdom (currently 22% for people 16 years and over).

After adjusting for age, significantly more males (25.7%) were current smokers than females (22.3%). Smoking prevalence was highest among Māori and Pacific peoples, young adults and people living in the most deprived neighbourhoods.

Among Māori, the prevalence of current smoking in 2008 was 45.4% (Ministry of Health, 2009b). After adjusting for age, Māori women were more than twice as likely, and Pacific females were more than 25% likely, to be current smokers than females in the total population. Māori and Pacific males were also significantly more likely to be current smokers than males in the total population.

Smoking prevalence also differs with respect to socio-economic deprivation level. After adjusting for age, adults living in the most deprived neighbourhood areas (NZDep2006 quintile 5) were 1.5 times more likely to be current smokers than adults living in the least deprived neighbourhood areas (NZDep2006 quintile 1) (Ministry of Health, 2009b). In the most deprived neighbourhoods smoking prevalence was 39.4% among men and 37.0% among women, compared with 15.3% among men and 12.9% among women in the least deprived neighbourhoods.

The prevalence of daily smoking in Year 10 students (14- and 15-year-olds) also has decreased dramatically and consistently since 2000, from 16.3% to 7.9% among girls and from 14.0% to 5.8% among boys by 2008 (Paynter, 2009). The decline over this period has occurred among students of all ethnicities, although large relative inequalities persist for both Māori and Pacific youth when compared with European/Other and Asian youth. For example, among girls, smoking rates are highest among Māori (22%) compared to Pacific (11%), New Zealand European (4%) and Asian girls (2%). Decreases in smoking rates from 2003 to 2008 have been larger for girls of all ethnicities, compared with boys, with the exception of Asian youth. Girls still have a higher prevalence than boys.

The proportion of 14- and 15-year-olds that have *never smoked* (that is, never even had one puff of a cigarette) has increased from 33% in 2000 to 60.5% in 2008.

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<sup>3</sup> Definition of current smoker: someone who has smoked more than 100 cigarettes in their lifetime and currently smokes at least once a month. (Ministry of Health, 2009a).

As a consequence, adults and young people who are Māori, and from lower socio-economic backgrounds are priority audiences with consideration given to Pacific within the HSC's tobacco control programme. The responses of these audiences to the messages and the actions promoted are evaluated and given priority when developing and implementing programmes and activities.

## ***What we are seeking to achieve***

The three key objectives of tobacco control activities in New Zealand are to:

- reduce smoking initiation
- increase quitting
- reduce exposure to second-hand smoke.

HSC's work focuses on the first and second of these objectives. Work in recent years has contributed to substantial reductions in exposure to second-hand smoke, particularly in people's homes. HSC has contributed to this reduction through its tobacco control programme and believes these efforts are now best focused on reducing smoking initiation and increasing quitting.

The HSC's tobacco control programme is guided by international and national evidence and best practice. HSC works closely with the Ministry of Health and the wider tobacco control sector to make sure that what we do is integrated with and supports the work of others. The five-year programme plan for tobacco was reviewed in 2009/10 and is now complete. The new plan reflects current priorities as well as incorporating the recommendations from the quality improvement review carried out in 2008.

The new programme goal is:

*New Zealanders reject tobacco and live a smokefree lifestyle.*

Within this new goal the primary focus is on decreasing smoking among young Māori (because of the disproportionate burden on Māori as a result of tobacco use). As young Māori do not live in isolation from the rest of New Zealand society we are confident that HSC's efforts will also benefit other audience groups. However, if we do not focus on young Māori we run the risk of increasing the existing inequality rather than reducing it.

To reduce smoking among young Māori, we need to influence the multiple environments in which they exist. As Māori are influenced by youth culture, increasing Smokefree attitudes among youth generally will also have a positive effect on creating Smokefree identities for young Māori. This means that messaging will not necessarily talk directly to young Māori exclusively but to audiences that influence them, eg. peers, parents and caregivers, whānau, school decision makers, and frontline health workers.

In order to assess the impact of our work on reducing the disparity in smoking rates between young Māori and all youth we need to continue to monitor smoking-related outcomes for both groups.

### ***What we will do to achieve success***

Over the next three to five years, HSC's tobacco control programme will have two key areas of focus – youth and adults.

The **youth** component will:

- provide information and promote messages to young people to increase their anti-tobacco and pro-smokefree attitudes
- denormalise and deglamourise tobacco use by reducing young people's exposure to smoking behaviour
- implement a schools project to effectively address smoking in the school setting.

To achieve these outcomes HSC will promote Smokefree/Auahi Kore directly to young people (especially young Māori) through national activities, which will provide a platform for youth partnerships and events. We will also communicate with those who influence young people.

The **adult** component will provide information and promote messages to all adult New Zealanders in order to:

- provide accurate and credible information about the facts and risks surrounding tobacco use
- increase knowledge about the benefits of tobacco control and a smokefree lifestyle

- maintain public support for tobacco control measures, including support for those people who want to quit.

HSC will continue to deliver adult-targeted national activities to achieve these outcomes. This approach will talk directly to the New Zealand public with tailored messages to specific audience groups. HSC will also encourage use of the messages by frontline workers (at a local level), ensuring nationwide consistency and efficiencies.

Effective tobacco control is not only about encouraging and supporting people to quit but gaining societal support for measures that help people to choose and maintain smokefree/auahi kore lifestyles.

Quitting smoking, for many people, is a journey rather than a one-off event. It takes the average smoker a number of attempts before quitting successfully long-term (Ministry of Health, 2007). Encouraging quit attempts is about taking people further along the journey towards quitting for good.

To achieve both an increase in quit attempts and denormalisation of smoking HSC will continue to promote smokefree/auahi kore environments as ‘the norm’ and support projects such as Auahi Kore Marae (and other Māori settings) and smokefree outdoor areas.

A significant area of work for the HSC is enabling the sector – both the traditional (eg. District Health Boards, public health units, non-government agencies, pharmacies etc) and non-traditional (eg. Plunket, Housing New Zealand etc) tobacco control work force. Relationship building and maintenance is crucial to achieving coherency across the sector. HSC will be responsive to supporting community-based projects that work towards achieving its goal, especially those that aim to reduce smoking by young Māori.

HSC’s long-term outcomes are inter-related and reliant on each other for optimum results, eg. parental cessation is an important protective factor in reducing youth uptake. Similarly, reduced social acceptability of tobacco is linked to successful quitting. As a result, HSC’s outputs are linked to multiple outcomes, so the Statement of Prospective Service Performance should not be viewed simply in a linear fashion.

## ***How we will demonstrate success***

Indicators to measure progress towards achieving intermediate (3-5 year) and long-term outcomes are included on the left hand side of the table on pages 28 to 30. These indicators are measured using data from monitors conducted by HSC and other organisations. As robust national-level evidence gathering can be expensive and challenging it cannot be undertaken every year. The next year evidence will be gathered to measure intermediate outcomes for tobacco control is 2012.

Specific research mentioned on pages 28 to 30 includes the following:

The **New Zealand Youth Tobacco Monitor** (NZYTM) is conducted biennially in partnership with Action on Smoking and Health (ASH) and the Ministry of Health. It is a national survey of 14- and 15-year-old school students.

The **Health and Lifestyles Survey** is a nationally representative quantitative survey of around 1,800 New Zealand adults aged 15+ years that is conducted biennially.

The **HSC Stakeholder Survey** is a small-scale independent piece of qualitative research conducted annually. Key HSC stakeholders are interviewed to provide a 'report-card' of the organisation's performance in the previous year, from a stakeholder perspective, and feedback is used to refine HSC's services.

## ***Progress to date***

Tobacco use is declining in New Zealand. The 2008 New Zealand Tobacco Use Survey showed, after adjusting for age, 23.1% of people aged 15 to 64 smoked (current smokers). The 2006 figure was 24%. While the drop was not statistically significant, it confirms a downward trend in smoking shown by earlier surveys.

The adult survey followed 'impressive reductions' in smoking among secondary school students (see page 22 for the figures).

HSC's work over the last six years has contributed to a decline in exposure to second-hand smoke in homes and cars and an increase in the number of smokefree public and recreational areas outdoors.

While this progress is ‘good news’, for those who continue to smoke the risks are high – it is estimated that half of all long-term smokers will die from a smoking-related disease and those smokers who die from a smoking-related illness lose, on average, 15 years of life. Even small reductions in smoking rates will reduce the huge costs of smoking to individuals, families, communities and the demand on health services. By continuing its tobacco control work HSC will increase its contribution to reducing smoking rates and make it easier for more people to adopt and sustain smokefree lifestyles.

# Tobacco Control – Statement of Prospective Service Performance

*Programme goal: New Zealanders reject tobacco and live a smokefree lifestyle*

Long-term outcome	Intermediate outcomes (3-5 year)	Intermediate outcome measures	Outputs	Performance measures
Reduced uptake of smoking among Māori youth.	<p>Increased proportion of youth (especially Māori youth) reporting:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> anti-tobacco attitudes</li> <li><input type="checkbox"/> pro-smokefree/auahi kore attitudes.</li> </ul> <p>Increased proportion of youth (especially Māori youth) who are <i>never smokers</i>.</p>	<p>By 2012, 70-73% of ALL<sup>4</sup> 14 to 15-year-olds, and 67-71% of Māori 14 to 15-year-olds agree that non-smokers dislike being around people who are smoking. (2008 NZYTM - ALL 66.6%, Māori 60.3%).</p> <p>By 2012, an increase in the percentage of ALL 14 to 15-year-olds, and a greater increase in the percentage of Māori 14 to 15-year-olds, who report that non-smokers should be proud to be smokefree/auahi kore. (to be benchmarked in the 2010 NZYTM).</p> <p>By 2012, 62-64% of ALL 14 to 15-year-olds, and 44-46% of Māori 14 to 15-year-olds, report being <i>never smokers</i>. (2008 NZYTM – ALL 60.5%, Māori 40.8%).</p>	<p>Youth targeted activities implemented to:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> increase anti-smoking attitudes</li> <li><input type="checkbox"/> increase pro-smokefree/auahi kore attitudes.</li> </ul> <p>Activities are is likely to include:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> multi-media advertising, including television</li> <li><input type="checkbox"/> web/online promotion</li> <li><input type="checkbox"/> support of events</li> <li><input type="checkbox"/> public relations activities.</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Participated in at least 25 youth targeted events (impact measured biennially by NZYTM and annually by selected event surveys).</li> <li><input type="checkbox"/> 20% increase in visits to Smoking Not <i>Our</i> Future website during promotion. (Baseline of 1000 visits a month from IP addresses).</li> <li><input type="checkbox"/> Planned TARP<sup>5</sup> levels achieved or exceeded.</li> </ul> <p>Increased awareness of messages and role models promoting smokefree attitudes towards negative social outcomes from smoking, as measured by youth (especially Māori youth) reporting that these messages:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> give them sound reasons for not smoking (2008 ALL 79.7%, Māori 75.4%)</li> <li><input type="checkbox"/> make smoking seem less cool (2008 ALL 65.1%, Māori 62.2%)</li> <li><input type="checkbox"/> put them off smoking (2008 ALL 56.5%, Māori 49%) (measured by 2010 NZYTM).</li> </ul>

<sup>4</sup> ALL 14 to 15-year-olds includes Māori 14 to 15-year olds.

<sup>5</sup> TARPs (Target Audience Rating Points) are a measurement of advertising impacts against a target audience. One TARP is equal to 1% of a target audience being exposed to a message or watching a programme.



Long-term outcome	Intermediate outcomes (3-5 year)	Intermediate outcome measures	Outputs	Performance measures
			Schools Project continues to be implemented to effectively address smoking in the school setting.	Schools Project implemented: <ul style="list-style-type: none"> <li><input type="checkbox"/> School Principals and Boards of Trustees (with a high Māori school roll) report a greater understanding of the importance of integrating a smokefree/auahi kore kaupapa into the school environment (measured by School Trustees Association and Principals Federation post-conference surveys).</li> <li><input type="checkbox"/> 20% increase in 'unique visits' to schools website to seek resources and information. (Baseline of 264 unique visits a month from New Zealand IP addresses).</li> </ul>
Increased quitting.	<p>Increased proportion of smokers (especially Māori smokers) who have made a quit attempt.</p> <p>Increased proportion of smokers (especially Māori smokers) who have made a quit attempt using support.</p>	<p>By 2012, 53-55 % of smokers and 53-55% of Māori smokers, had made at least one quit attempt that lasted 24 hours or longer in the last 12 months (2008 Health and Lifestyles Survey – smokers 51.2%; Māori smokers 51.4%).</p> <p>By 2012, an increase in the percentage of smokers, and a greater increase in the percentage of Māori smokers, report accessing cessation support (to be benchmarked in the 2010 Health and Lifestyles Survey).</p>	<p>Messages and resources developed to support the work of tobacco control sectors providers.</p> <p>Adult targeted activities implemented to:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> inform the public of the harms of smoking</li> <li><input type="checkbox"/> encourage quitting.</li> </ul>	<p>Frontline workers are supported to implement their local tobacco control initiatives as measured by:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Twenty World Smokefree Day regional teams use HSC resources.</li> <li><input type="checkbox"/> A majority of respondents report that HSC resources enhance local World Smokefree Day delivery of smokefree and cessation activities.</li> <li><input type="checkbox"/> The majority of respondents confirm that their work is more effective as a result of using HSC support. (Baseline figure as measured in the HSC Stakeholder Survey).</li> </ul> <p>Adult activities implemented - Planned TARP levels achieved or exceeded.</p>

Long-term outcome	Intermediate outcomes (3-5 year)	Intermediate outcome measures	Outputs	Performance measures
Decreased social acceptability of tobacco.	<p>Increase the proportion of adults (especially Māori) who report anti-tobacco attitudes.</p> <p>Increased public support (especially by Māori) for enhanced smokefree/auahi kore policies.</p>	<p>By 2012, 54-56% of adults, and 53-57% of Māori adults agree that <i>cigarettes and tobacco should not be sold in New Zealand in 10 years time</i>. (2008 Health and Lifestyles Survey - adults 49.8%, Māori adults 47.4%).</p> <p>By 2012, 67-68% of adults and 64-66% of Māori adults, support reducing the availability of tobacco products. (2008 Health and Lifestyles Survey - adults 65.6%, Māori adults 60.3%).</p>	<p>Messages and resources developed to support the work of tobacco control sectors providers.</p> <p>Adult targeted activities implemented to:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> increase public knowledge on the harm caused by tobacco.</li> </ul>	<p>Frontline workers are supported to implement local smokefree and quitting programmes as measured by:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Twenty World Smokefree Day regional teams use HSC resources.</li> <li><input type="checkbox"/> A majority of respondents report that HSC resources enhance local World Smokefree Day delivery of smokefree and cessation activities.</li> </ul> <p>Adult activities implemented - Planned TARP levels achieved or exceeded.</p>

# Sun Safety

## ***Why is sun safety important?***

The incidence rate of skin cancer and melanoma is still increasing and is expected to continue to do so, reflecting the latent nature of skin cancer - the disease often does not manifest until many years after the damaging exposure. The incidence rates we see now are a reflection of the sun worshipping behaviour of the 1970s, 1980s and 1990s, although better detection and registration may account for some of the increase.

The main causal factor for melanoma is episodic sunburn (from exposure to ultraviolet (UV) light), particularly during childhood. Studies have shown that the best avenue for melanoma prevention is by encouraging protection against sunburn, particularly in children and fair-skinned people.

Skin cancer is an enormous health problem in New Zealand. It causes around more than 300 deaths each year (in 2005 269 deaths from melanoma and 102 from non-melanoma cancers) and costs the health system more to treat than any other form of cancer. Yet almost all cases are preventable, through appropriate protection from ultraviolet radiation.

New Zealand has the highest incidence rate for melanoma in the world and rates for both melanoma and non-melanoma skin cancers are higher than the corresponding Australian rates.

## **Costs of skin cancer**

These deaths are the most important cost of skin cancer. It is calculated that were it not for skin cancer New Zealanders would have lived an additional 4,741 life-years in 2006. In addition, these persons if alive would have made an economic contribution through employment of an estimated additional NZ\$66m in 2006. When adding the health care costs of skin cancer and related illnesses to New Zealand (estimated at NZ\$57m for the year 2006) the annual economic costs to New Zealand of skin cancer amount to NZ\$123m. The magnitude of these costs, and of the deaths and ill-health caused by skin cancer, show the importance of maintaining and improving preventive, early diagnosis, and treatment measures (O'Dea, 2009).

Ultraviolet radiation (UVR) exposure also brings benefits as it provides the main source of vitamin D in New Zealand. Adequate vitamin D status is essential for general health, being necessary for bone, joint, muscle and neurological function. Because of this, a balance is required between avoiding an increased risk of skin cancer and maintaining adequate vitamin D levels. Research is currently underway to understand what the optimal balance should be for New Zealanders.

The promotion of sun safety in New Zealand (using the SunSmart brand) is managed through a close strategic partnership between the HSC and the Cancer Society of New Zealand.

### ***What we are seeking to achieve***

The New Zealand Skin Cancer Control Strategic Framework has the goal of *reducing the proportion of New Zealanders who develop and die from skin cancer*. The framework has three strands – prevention, early detection and treatment. HSC’s sun safety activities contribute primarily to prevention. Exposure to UVR before the age of 20 is a particularly strong risk factor for melanoma incidence, so the Skin Cancer Control Steering Committee's Strategic Framework for 2005-2008 identifies children under 13 years old and their caregivers as the target audience. The HSC’s sun safety programme focuses on the parents and caregivers of 8 to 12-year-olds, as this is the age at which children become more independent of their parents, therefore needing parents to reinforce sun safe behaviours. The focus for the prevention aspect of HSC’s sun safety programme is to *reduce the incidence of sunburn in 8 to 12-year-olds* by increasing effective use of sun protection strategies and reducing the time children are exposed to harmful UVR.

### ***What we will do to achieve this***

The overall goal of HSC’s sun safety work for the next three years and beyond is to:

*Reduce the proportion of New Zealanders who develop and die from skin cancer.*

To realise this goal, the sun safety programme has four key outcomes:

- Increase the percentage of parents and caregivers taking steps to protect their 8 to 12-year-olds from getting sunburnt (ie, focusing on the home environment).
- Increase the percentage of organisations and agencies with influence over recreational settings (eg, health promoters, sports organisations, local councils, and event organisers) taking steps to protect 8 to 12-year-olds from getting sunburnt in these settings.

- Increase the percentage of organisations and agencies with influence over the media (eg, health promoters, the MetService, and television and print media) that are taking steps to increase messages that encourage, and decrease messages that discourage, sun protection behaviours.
- Increase the percentage of primary and intermediate schools taking steps to protect 8 to 12-year-olds from getting sunburnt. Note, this objective is the primary responsibility of the Cancer Society.
- The New Zealand Skin Cancer Control Strategic Framework identifies teens or youth as an important secondary audience for the sector. An analysis of the jointly funded HSC/Cancer Society of New Zealand 2010 Sun Exposure Survey will provide benchmark data for the youth audience. To that end, HSC is working with the NSW Cancer Institute to learn the results of the evaluation of their teen campaign – the Dark Side of Tanning.
- Territorial local authorities are key in this area with influence over many sports and recreational spaces, public events and planning and building approvals. HSC will continue working to increase the number of supportive environments where young people may be at risk of sunburn.

The focus for the programme, therefore, is to develop and implement initiatives for each of these settings.

HSC will continue to build on and develop new working relationships with national and international organisations to contribute to the prevention, early detection and treatment of skin cancer. Part of HSC's role is to support the work these intermediary groups and organisations are undertaking at the community level. Traditionally, the key stakeholder group has been limited to Cancer Society health promoters and this has been reflected in the various programme level stakeholder surveys undertaken. HSC is expanding its stakeholder network to include DHB public health units, local government and other organisations concerned with public health and safety.

### ***How we will demonstrate success***

Indicators to measure progress towards achieving intermediate (3-5 year) and long-term outcomes are included on the left hand side of the table on pages 36 to 38. These indicators are measured using data from monitors conducted by HSC and other organisations. As robust national-level evidence gathering can be expensive and challenging it cannot be undertaken every year. Evidence will next be gathered to measure intermediate outcomes for sun safety in 2012 and 2013.

Specific research mentioned on pages 36 to 38 includes the following:

The **Health and Lifestyles Survey** is a nationally representative quantitative survey of around 1,800 New Zealand adults aged 15+ years that is conducted biennially.

The **HSC Stakeholder Survey** is a small-scale independent piece of qualitative research conducted annually. Key HSC stakeholders are interviewed to provide a 'report-card' of the organisation's performance in the previous year, from a stakeholder perspective, and feedback is used to refine HSC's services.

### ***Progress to date***

Evaluation of the sun safety programme undertaken since the mid-1990s shows that the programme and the messages promoted (the 'Slip, Slop, Slap, Wrap' messages) have been successful in raising knowledge, awareness and use of most SunSmart behaviours. However, this has not yet led to a decrease in the incidence of reported sunburn.

Research undertaken in 2006/07 with parents and caregivers of pre-teens found that sun safety messages needed to be consistent with the enjoyment of an outdoor 'New Zealand summer lifestyle'. In consequence, a new national strategy was launched at the start of 2008 that focuses on summer activities but explains the link between sunburn and melanoma and promotes the message to parents and caregivers to 'never let your child get sunburnt'.

Initial evaluation of parents and caregivers' response to the 'Never let your Child Get Sunburnt' message showed that 52.1% had seen the new message and 70.7% of these people said they were a "lot more concerned" about this health issue as a result.

'Never let your Child Get Sunburnt' evaluation has also been undertaken. Analysis of this work will help to inform activities going forward.

Exposure to UVR is the main cause of sunburn and a UV Index (UVI) is in use to make people aware of the level of UVR each day (the UVI is shown in newspapers and some television networks alongside the weather forecast, and broadcast nationally through radio networks, mobile phone and on-line channels). Research undertaken in 2008/09 showed that New Zealanders have a poor awareness and understanding of the current UVI index.

Simultaneously key New Zealand media identified significant issues with the UVI and in some cases discontinued broadcasting the information within weather forecasts. Work will continue through 2010/11 to develop a better way to communicate this important information to the general public.

# Sun Safety – Statement of Prospective Service Performance

*Programme goal: Reducing the proportion of New Zealanders who develop and die from skin cancer.*

Long-term outcome	Intermediate outcomes (3-5 year)	Intermediate outcome measures	Outputs	Performance measures
<p><b>Decrease incidence of sunburn among New Zealanders.</b></p>	<p>Increase proportion of New Zealanders not getting sunburnt</p>	<p>By 2013, 82-84% of adults report they were not sunburnt while outdoors the previous summer weekend (2010 Sun Exposure Survey (SES) – 80.2%) (as measured by the SES 2013).<sup>6</sup></p> <p>Parents and caregivers:                      - By 2012, 10-12% of parents and caregivers report that their child got blisters or was in pain for two or more days the previous summer (2008 Health and Lifestyles Survey – 14%)                      - By 2012, 35-37% of parents and caregivers report that their child got sunburnt the previous summer (2008 Health and Lifestyles Survey – 40%).</p> <p>Youth:                      - By 2013 80-82% of youth (13-24-years) report they were not sunburnt while outdoors the previous summer (2010 SES – 78%) (as measured by SES 2013).</p>	<p>Implement SunSmart activities (informed by research and evaluation) to increase positive sun protection behaviour in targeted population.</p>	<p>SunSmart activities implemented:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Seventeen radio stations run SunSmart promotions.</li> <li><input type="checkbox"/> National and regional news media strategy delivered to news media with the aim of achieving 50 articles.</li> <li><input type="checkbox"/> Planned TARP levels achieved or exceeded.</li> </ul> <p>Formative evaluation report for development of youth-targeted activities is available in 2010/11.</p>

<sup>6</sup> A national survey of 1,250 18-54 year olds undertaken every three years in conjunction with the Cancer Society of New Zealand.



Long-term outcome	Intermediate outcomes (3-5 year)	Intermediate outcome measures	Outputs	Performance measures
	Increase supportive environments that adopt and implement SunSmart policies and practices.	<p>By 2012, assist four more territorial local authorities to implement a specific sun protection policy that refers to activities throughout the council (2006 Territorial Local Authority Sun Protection Survey - 4 of 51 have policies)<sup>7</sup>.</p> <p>By 2012, five more <sup>8</sup> territorial local authorities report they address sun protection as an issue when their council approves, facilitates, sponsors or organises outdoor events and activities during daylight saving months (2006 Territorial Local Authority Sun Protection Survey - 15 of 51)(to be measured by the Territorial Authorities Survey – see footnote 7).</p>	<p>Support territorial local authorities and health promoters to increase the adoption of SunSmart policies and practices by territorial local authorities.</p> <p>Support community organisations/event managers to adopt sun protection policies and practices through community mobilisation strategy.</p>	<p>SunSmart supports staff and representatives of territorial local authorities and health promoters through:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> provision of SunSmart Councils’ Guide and website and other resources</li> <li><input type="checkbox"/> HSC attendance at five event planners workshops/forums and/or local government zone meetings.</li> </ul> <p>Territorial local authority staff and representatives and health promoters report feeling supported (as measured by SunSmart Stakeholder Survey and workshop evaluations).</p> <p>Support organisations and event managers through:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> provision for resource</li> <li><input type="checkbox"/> advising on policy and promoting best practice</li> <li><input type="checkbox"/> Policy and practice demonstrated by 65-75% of supported organisations and event managers (as measured by evaluation conducted by SunSmart).</li> </ul>

<sup>7</sup> A national survey of 73 territorial authorities to be conducted by HSC for the first time in 2012, following on from the previous work (Reeder and Jopson) conducted.

<sup>8</sup> 2006 benchmark survey conducted by Reeder and Jopson reported that 15 of 51 territorial authorities had addressed sun protection as an issue when their council approves, facilitates, sponsors or organises outdoor events and activities during daylight saving months. Due to changing local authority landscape, HSC will seek to assist a targeted number of councils rather than a percentage of councils.

Long-term outcome	Intermediate outcomes (3-5 year)	Intermediate outcome measures

Outputs	Performance measures
<p>Support the skin cancer control sector.</p> <p>Working with New Zealand Guidelines group, frontline health services provide consistent message regarding harms of skin cancer.</p>	<p>Develop and deliver resources that support the work of partners and the sector. Measured by:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> majority of stakeholders feeling supported (as reported by SunSmart Stakeholder Survey)</li> <li><input type="checkbox"/> uptake of resources (benchmark resource efficacy for the user - SunSmart Resource Users' Survey)</li> <li><input type="checkbox"/> facilitating the management of the Melanoma Summit 2011</li> <li><input type="checkbox"/> participate in and host workshops/forums with public health organisations, health professionals and/or health promoters</li> <li><input type="checkbox"/> majority of participating sector reports that they feel supported, as measured by workshop evaluation.</li> </ul>

## **Problem gambling**

### ***Why is preventing and minimising gambling harm important?***

Gambling-related harm is a continuing health issue in New Zealand, with significant health, social and economic implications. While gambling is a popular recreational activity and some communities benefit from funds raised from gambling, for many people and their families gambling has harmful consequences and the effects on the community are far reaching.

Problem gambling occurs when people, and often their families or communities, experience harm or distress because of gambling. Problem gambling can affect health, relationships, finances, employment, and children, and the harms from gambling can extend to the entire community. Problem gambling affects several groups disproportionately, including Māori, Pacific peoples, people of low socio-economic status, and some Asian communities.

The *2006/07 New Zealand Health Survey* (Ministry of Health, 2008a) found that two out of three adults had gambled in the previous 12 months (65.3% of people aged 15 years and over). Of those, the Survey estimated 0.6% of gamblers, 13,000 adults, met the criteria for problem gambling. A further 7.4% of gamblers had also shown signs of risky gambling behaviour.

Almost 3% of adults, 87,000, had experienced problems due to someone's gambling in the previous 12 months. This is consistent with overseas studies that estimate that between five to 10 other people are affected by the behaviour of a serious problem gambler (Productivity Commission, 1999).

### **Costs of gambling**

The social costs of gambling are out of proportion to the numbers of problem gamblers. For example, gamblers may commit crimes to finance their gambling, causing harm to their victims and their families as well as themselves, and incurring costs in the criminal justice sector (Department of Internal Affairs – DIA - 2008).

The *2006/07 New Zealand Health Survey* also shows the burden of problem gambling in New Zealand's main ethnic population groups; with Māori and Pacific adults more than three and a half times more likely to be problem gamblers than adults in the total population.

Problem gambling is overwhelmingly associated with certain forms of gambling, especially gaming machines and casino table games. Around 20% of regular gaming machine players are likely to have a gambling problem (DIA, 2008). Problem gamblers contribute a disproportionate amount to gambling profits.

Although a relatively small proportion of the population have, or are at risk of developing, a serious gambling problem, research in 2006/07 (the *Gaming and Betting Activities Survey (GBAS)* – National Research Bureau, 2007) provides indicators of the wider impact of gambling on individuals and their families/whānau, for example:

- 16% of people surveyed said that there had been some argument about time or money spent on betting or gambling in their wider family or household
- 16% said that someone had had to go without something they needed or some bills were not paid because too much was spent on gambling by another person in their wider family or household.

Māori and Pacific peoples were more likely than people of other ethnicities to say they had experienced both of these consequences of gambling.

Research also shows that New Zealanders are increasingly questioning the social desirability of gambling. A 2005 survey by DIA (DIA, 2008) of participation in, and attitudes to, gambling found that, since the previous survey in 2000, there was an increase in the proportion of people who considered all but one type of gambling *socially undesirable* (telephone or text games or competitions was the exception).

To counter gambling harms, including problem gambling, New Zealand has adopted a public health approach, and the legislation provides for an integrated problem gambling strategy focused on public health (Gambling Act 2003, Part 4, s.317 ) that is funded by a levy paid by gambling operators to the Crown.

The Ministry of Health is responsible, under the Act, for the prevention and treatment of problem gambling. The Ministry's approach is outlined in the draft six-year strategic plan – *Preventing and Minimising Gambling Harm: Strategic plan 2010-2016* (Ministry of Health, 2009).

The Ministry's strategy includes provision for a 'Problem Gambling Education and Awareness Programme' to raise awareness, destigmatise the issue and encourage help-seeking for those in need.

### ***What we are seeking to achieve***

HSC's work focuses on changes both upstream and downstream. Upstream changes include getting society to understand and question the issues around gambling harm, and building public support for measures that prevent and minimise gambling harms and create safer families, safer communities, and safer venues and gambling products. Downstream changes include providing support for frontline workers and community-led responses that range from increasing individuals' help-seeking behaviour to community initiatives to identify and address gambling harms at the local level.

Many of the programme's messages are targeted at all New Zealand adults. At the same time, approaches are being developed with those groups in the population that are disproportionately affected by gambling harms.

### ***What we will do to achieve success***

The overall goal for the problem gambling programme agreed by HSC and the organisations it works with is to:

*Reduce the incidence of problem gambling and the impact of gambling harms in Aotearoa/New Zealand.*

This goal will be realised by:

- continuing to raise general awareness of gambling harms – to create discussion and debate, increase overall understanding, salience and support of the issue
- increasing gamblers' and affected others' understanding of risky gambling behaviours and strategies to prevent and manage them (self-help, family support, use of support services for individuals and families)
- increasing understanding of and participation in activities that prevent and minimise gambling harm in their communities.

## ***How we will demonstrate success***

Indicators to measure progress towards achieving intermediate (3-5 year) and long-term outcomes are included on the left hand side of the table on pages 45 and 46. These indicators are measured using data from monitors conducted by HSC and other organisations. As robust national-level evidence gathering can be expensive and challenging it cannot be undertaken every year. The next year evidence will be gathered to measure intermediate outcomes for problem gambling in 2012.

Specific research mentioned on pages 45 and 46 includes the following:

The **Health and Lifestyles Survey** is a nationally representative quantitative survey of around 1,800 New Zealand adults aged 15+ years that is conducted biennially.

The **HSC Stakeholder Survey** is a small-scale independent piece of qualitative research conducted annually. Key HSC stakeholders are interviewed to provide a 'report-card' of the organisation's performance in the previous year, from a stakeholder perspective, and feedback is used to refine HSC's services.

## ***Progress to date***

The HSC's problem gambling programme was launched in April 2007 with 'Kiwi Lives', which communicates information and messages about the damaging effects of problem gambling in homes and communities and aims to increase awareness and understanding of problem gambling and its impacts. Kiwi Lives also aims to create a supportive environment for frontline health workers and communities.

Evaluation of public response to the first stage of Kiwi Lives showed that, even after a relatively short time, the messages were recalled by a substantial proportion of the target audience; four population groups were surveyed (Māori, Pacific peoples, Asian peoples, and a general population group) and between a quarter and one-half of people in these groups could recall Kiwi Lives when prompted with a description of the advertisement. Feedback also showed that the messages were clearly communicated and were beginning to achieve one of the key aims of promoting debate and discussion about gambling harms and solutions. Between a sixth and a third of respondents in the four groups surveyed said they discussed problem gambling with others after viewing Kiwi Lives.

Māori and Pacific peoples were particularly receptive to the message that problem gambling is a community, not just an individual, issue.

A baseline survey (*GBAS*) to monitor the impact of the programme was completed in 2007. Results from this survey indicate that Kiwi Lives is timely, with potential to increase knowledge and understanding about the harms of gambling and strategies that can be used to prevent and minimise harm.

The second stage of Kiwi Lives was launched in November 2008, using testimonials from an individual, a family and a community about their experience of, and response to, gambling harms and also providing a range of resources to support the work of problem gambling service providers. This second stage of Kiwi Lives aims to continue to increase awareness and understanding of gambling harms and promote strategies that people and communities can use to identify and respond to gambling harms.

The Post Campaign Survey for Stage 2 found almost 8 out of 10 (78%) people said they had seen at least one of the three ads when they were described to them. The stage 2 ads are achieving Kiwi Lives' objectives by increasing knowledge, understanding and concern about problem gambling. When prompted, 38% of those who had seen the ads agreed that they had told them something they didn't know, 68% said they had more understanding of the problem, 55% were more concerned about it than before, and 51% felt better able to respond to problem gambling. These figures were higher for stage 2 than stage 1 of Kiwi Lives, showing that the second stage is building on the achievements of the first stage.

There was a particularly strong response to the ads by Maori and Pacific peoples, people who played a number of "continuous" gambling activities and to people who had seen at first-hand the effects of problem gambling. This demonstrates that the medium are effective for those groups disproportionately affected by gambling harm.

Figures from the Gambling Helpline and other data sources also have shown a positive response to both stages of Kiwi Lives. In the first three weeks of the stage 1 Kiwi Lives' messages being promoted, the Gambling Helpline (whose 0800 number appeared in the radio and television advertising) reported an overall increase in calls of 43%. There was an increase in calls from Pacific peoples of 133%, compared with the same period in the previous year, with corresponding increases of 83% for Māori and 55% for Pakeha. The second three weeks of advertising saw a lower increase in new Helpline clients - of 17% when compared to the same period the previous year. However, May 2007 (just after the time when the advertisements were first shown) saw the highest number of new Helpline clients in two and a

half years and the third highest overall number of referrals in the last three years.

Stage 2 of Kiwi Lives also has shown a notable increase in calls to the Gambling Helpline at the time that the ads were shown on TV. The number of calls from first-time callers in December 2008 and May 2009 was around one-third higher for each of these months than for the previous two months (ie, comparing the December and May figures with the average figure for the respective two previous months).

HSC has also looked at presentations to face-to-face services. While most providers did not report seeing a dramatic change in presentation numbers, information provided by the Ministry's CLIC information database showed increases after stage 1, as follows:

- The number of new presentations\* in March, April and May of 2007 were noticeably higher than the comparable months of 2006. By June, the numbers had returned to normal levels. Looking at trends by gender, there was little difference between male and female clients. Looking at ethnicity, there was no overall effect for Pacific clients, an increase for New Zealand European/Pakeha clients and a substantial increase for Māori clients. (\* numbers were higher whether or not brief and early intervention only clients were included. For this analysis, only clients receiving a comprehensive face-to-face assessment were included.)

## Problem Gambling – Statement of Prospective Service Performance

*Programme goal: Reduce the incidence of problem gambling and the impact of gambling harms in Aotearoa/New Zealand.*

Long-term outcome	Intermediate outcomes (3-5 year)	Intermediate outcome measures	Outputs	Performance measures
Preventing and minimising gambling harm.	Increased proportion of people that understand how problem gambling is harmful to individuals, families and the community	By 2012, 80-85% of people can describe ways that gambling too much can affect the wider community. As measured in 2012 Health and Lifestyles Survey.	Kiwi Lives activities implemented to increase understanding of problem gambling and strategies to prevent and manage it.	Activities implemented: <ul style="list-style-type: none"> <li><input type="checkbox"/> Increase in unpaid media as a result of HSC activity – at least four unpaid media opportunities created during 2010-2011.</li> <li><input type="checkbox"/> Visits to HSC’s problem gambling website (particularly gamblers and concerned others sections) increased to 500 per month (25% increase).</li> <li><input type="checkbox"/> Increase in calls to Helpline during communication activities.</li> <li><input type="checkbox"/> Increase in visits to face-to-face services during media activities.</li> <li><input type="checkbox"/> Planned TARP levels achieved or exceeded.</li> </ul>
	Increase in proportion of people who know of strategies to prevent and manage problem gambling and numbers of people adopting these strategies.	By 2012, 45-50% of people heard advertising or noticed leaflets/posters that explain how gambling can effect you and what you can do. As measured in 2012 Health and Lifestyles Survey.	Frontline problem gambling services are supported by HSC to help implement national activities at a local level.	Frontline problem gambling services are supported by HSC: <ul style="list-style-type: none"> <li><input type="checkbox"/> At least half of all problem gambling services use the HSC E-Bulletin in its first year.</li> <li><input type="checkbox"/> 90% of problem gambling services use the core resources produced by HSC, as reported through HSC online resources</li> </ul>



Long-term outcome	Intermediate outcomes (3-5 year)	Intermediate outcome measures
		<p>By 2012, 75-80% of people can describe at least one sign of someone gambling at a harmful level. As measured in 2012 Health and Lifestyles Survey.</p> <p>By 2012, 80-85% of people can name at least one thing they can do to help someone who is gambling too much. As measured in 2012 Health and Lifestyles Survey.</p>

Outputs	Performance measures
	<p>survey.</p> <ul style="list-style-type: none"> <li data-bbox="1563 343 2105 502">□ Increase in public awareness raising activities as a result of HSC activity and support – at least 10 events organised and five areas engage the media for Gamble-free day.</li> <li data-bbox="1563 507 2105 635">□ The HSC Stakeholder Survey reports that at least 90% of all problem gambling services are better able to do their jobs as a result of HSC support.</li> </ul>

# Nutrition, Physical Activity and Healthy Weight

## ***Why is better nutrition, increased physical activity and healthy weight important?***

When focusing on the top 20 causes of death, by risk factor, the joint effect of diet (which includes cholesterol, blood pressure, body mass index (BMI) and vegetable and fruit consumption) ranks first, with insufficient physical activity also in the top 10 (Ministry of Health, 2003).

The independent and combined effects of poor nutrition, sedentary lifestyles, and obesity on the global increase in non-communicable diseases have been huge. Non-communicable diseases (or chronic diseases), globally, are responsible for 60% of world deaths. Many of these deaths are related to changes in global dietary patterns and lifestyles. Poor nutrition, insufficient physical activity and sedentary time are major and increasing causes of preventable disease, disability and death in New Zealand (Ministry of Health, 2003).

Body weight increases when there is an excess of energy consumed (food) over energy expended. Over an extended time period, this can lead to obesity.

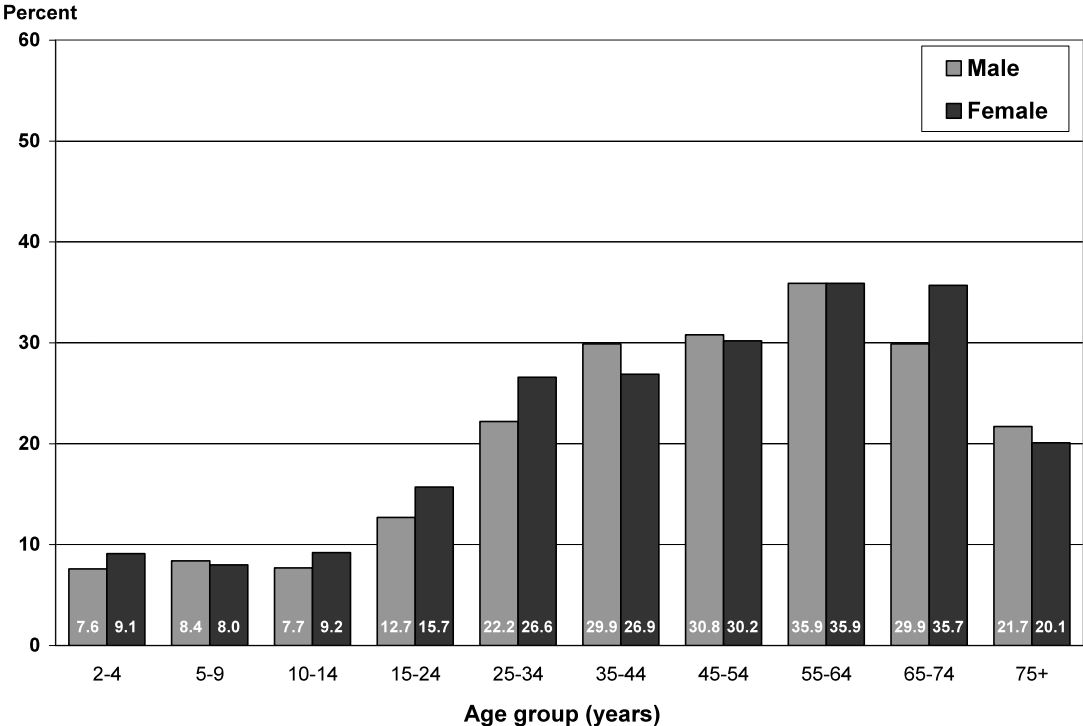
Some health consequences of obesity, such as diabetes, cancer and cardiovascular disease, cause major disability and illness, and require costly, long-term treatment and support.

The Ministry of Health's estimates of the direct health-care costs of obesity suggest costs in the order of NZ\$460 million for the year 2004 (ranging from approximately \$400 to \$500 million) (Ministry of Health, 2008b). Delay in addressing the determinants of obesity at a primary prevention level will lead to further demand for health services in the future. It is forecast that health costs for type 2 diabetes will reach \$1.78 billion by 2021/22 (PriceWaterhouseCoopers, 2007).

The rate of obesity in children, young people and adults is a complex issue that the Government has committed substantial funding towards and is committed to addressing. New Zealand, like many countries, is currently facing what has been coined the 'obesity epidemic', and evidence is accumulating to inform the necessary actions and responses.

In New Zealand in 2006/07, one in five children was overweight (20.9% of 2 to 14-year-olds) and a further one in twelve (8.3%) was obese (Ministry of Health, 2008a). Among adults, one

in three (36.1%) were overweight and a further one in four (26.5%) were obese.<sup>9</sup> There was an increase in the prevalence of obesity for adults from 1997 to 2006/07, but the rate of increase appears to be slowing, with no statistically significant increase from 2002/03 to 2006/07 for both men and women. There was no change in the proportion of school-aged children who were obese over this period, although in less than one generation childhood rates of obesity in New Zealand have tripled (Ministry of Health 2004).



**Obesity for children and adults by age group and gender (unadjusted prevalence)**  
 (Ministry of Health, 2006/07 New Zealand Health Survey)

There are wide ethnic disparities in rates of obesity. Most notably, obesity rates are higher for Māori, Pacific, and low-income families than for other New Zealand groups. Obesity rates have health impacts across the population, with a disproportionate burden falling on Māori and Pacific peoples. This presents an increased risk of chronic diseases such as type 2 diabetes, cardiovascular disease and some cancers for Māori and Pacific peoples.

For South Asian populations<sup>10</sup>, particularly Indian, there are significantly higher cardiovascular disease hospitalisation and mortality rates than the total population. The

<sup>9</sup> People aged 18 years and over were classified as overweight and obese using the World Health Organization's Body Mass Index (BMI) cut-off points. For people 2 to 17 years old the BMI cut-off points developed by the International Obesity Taskforce were used (for details see Ministry of Health, 2008, pages 104 and 105).

<sup>10</sup> South Asian groups include peoples from India, Pakistan, Sri Lanka, Bangladesh, Nepal, Bhutan, Maldives, South Africa, and Fiji Indians.

prevalence of self-reported diabetes is more than three times higher for Indian people than for the total population (Northern DHB Support Agency Ltd, 2010).

Poor and inappropriate nutrition, increased sedentary time, insufficient physical activity, and rising obesity rates are not easy problems to tackle. Improving health outcomes requires coordinated and integrated efforts across multiple sectors and settings to change physical and social environments, targeting high-risk population groups, improving the communication of key educational messages, and developing a skilled workforce.

## ***What we are seeking to achieve***

The overall goal of HSC's nutrition and physical activity work is:

*To attain and maintain a healthy weight and reduce the burden of disease through improved nutrition and increased physical activity.*

The objectives of the HSC's nutrition and physical activity service are as follows:

- To support District Health Boards (DHBs), DHB public health units (PHUs), Primary Health Organisations (PHOs), non-government organisations (NGOs), regional sports trusts (RSTs) and frontline workers by developing and promoting nutrition and physical activity education messages that are consistent with the Ministry of Health's food and nutrition and physical activity guidelines to target populations to promote the benefits of attaining and maintaining a healthy weight and improving nutrition and increasing physical activity.
- To increase public awareness and understanding of the risks of unhealthy weight and the benefits of improved nutrition and increased physical activity and identifying key steps that families can take to improve nutrition and physical activity.

There is a need for national coordination of physical activity and nutrition-related activities in New Zealand through support of those groups and organisations working directly with communities. The aim is to facilitate efficient and consistent communication of messages to the community through the range of stakeholders and frontline workers working with communities. The experience and expertise of the Ministry of Health, DHB HEHA managers,

PHUs, PHOs, NGOs, and RSTs needs to be harnessed to identify themes<sup>11</sup>, materials and community engagement tools that will best support the activities of agencies and communities involved in delivering nutrition, physical activity and healthy weight messages.

Children are a priority group for improving nutrition, increasing physical activity and reducing and preventing obesity, for three reasons:

- Rates of obesity among New Zealand children, and the related incidence of obesity-related conditions, in particular, type 2 diabetes, continue to be of concern.
- There is an established risk of childhood overweight persisting into adolescence and adulthood (Dietz, 1998).
- Once obesity is established, it is notoriously difficult to correct and evidence to support most treatment methods is unclear (IASO International Obesity Taskforce, 2003; Summerbell, Ashton et al., 2006).

However, virtually all reviews have indicated that the prevention of obesity is not only possible but is the most realistic and cost-effective approach for dealing with childhood obesity (IASO International Obesity Taskforce, 2003). Research conducted in the United Kingdom has suggested that prevention efforts should be implemented prior to adolescence, based on the finding that persistent obesity is established before age 11 (Wardle, Henning Broderson et al., 2006).

There is a notable absence of public health nutrition programmes in New Zealand that focus on the role of parents and caregivers as significant influencers on nutrition and physical activity behaviours of children. The parent/caregiver's role is particularly critical for children because parents and caregivers directly shape a child's physical and social environment, and indirectly influence behaviours, habits, and attitudes through socialisation processes and role-modelling (Ritchie, Welk et al., 2005). To the extent that overweight is a function of environment, parents may play a significant role in the prevention of childhood overweight and obesity.

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<sup>11</sup> A theme is a topic that needs to be addressed to bring about needed changes to nutrition, physical activity or healthy weight related attitudes or behaviours. Under each theme key messages will be developed that best communicate the desired changes in attitudes or behaviour.

Finally, HSC has invested significantly in research and formative development in this area over the last four years. This research has enabled us to understand the key factors within New Zealand families and whānau that drive behaviours, and what potential barriers and motivators exist to enable families and whānau to choose healthier behaviours, so that any approaches to improve nutrition and physical activity in NZ families and whānau will be informed by available evidence.

### ***What we will do to achieve success***

HSC's nutrition and physical activity service will deliver resources and identify activities to assist in the delivery of consistent, quality-assured messages around prioritised themes, as well as delivering on a national media plan to increase exposure for messages.

HSC's specific activities for 2010/11 will include:

- Working with the Ministry of Health to develop a coherent and coordinated approach to developing and distributing nationally consistent health promotion messages for healthy weight, physical activity and nutrition via the DHBs' Project Managers, PHUs, PHOs, NGOs, RSTs and other organisations.
- Developing and implementing national strategies that will include identifying themes and associated activities, creating public understanding of the themes, and a resources plan. This work will be informed by an environmental scan and best practice.
- Developing and implementing monitoring and evaluation plans for the nutrition and physical activity service.

### ***How we will demonstrate success***

Since mid-2009 there have been a number of changes in the nutrition and physical activity sector that will require HSC to assess what work is currently being undertaken in this area and what support may, therefore, be required. The performance measures described in this document are based on the belief that HSC will continue to play a role in supporting families to achieve healthier diets and improve physical activity levels for children aged 5-16.

The targets described in the intermediate outcomes section of the table that follows are based on an estimate of possible levels of change. This has been done as the most recent data HSC has collected in this area was during 2007. Further data are being collected in the Health and

Lifestyles Survey (HLS) 2010, which may assist in the refinement of these targets during the course of the 2010-11 financial year.

As robust national-level evidence gathering can be expensive and challenging it cannot be undertaken every year. Evidence to measure intermediate outcomes for nutrition and physical activity will next be collected as part of the HLS scheduled for 2012.

Specific research mentioned on pages 53 to 55 includes the following:

The **Health and Lifestyles Survey** is a nationally representative quantitative survey of around 1,800 New Zealand adults aged 15+ years that is conducted biennially. This survey includes a sample of approximately 700 parents and caregivers.

The **HSC Stakeholder Survey** is a small-scale independent piece of qualitative research conducted annually. Key HSC stakeholders are interviewed to provide a 'report-card' of the organisation's performance in the previous year, from a stakeholder perspective, and feedback is used to refine HSC's services.

### ***Progress to date***

The nutrition and physical activity service that HSC has been contracted to deliver in 2010/11 is a new service and progress regarding its implementation will be reported in HSC's 2010/11 annual report and the 2011/12 Statement of Intent.

# Nutrition, Physical Activity and Healthy Weight – Statement of Prospective Service Performance

*Programme goal: To attain and maintain a healthy weight and reduce the burden of disease through improved nutrition and increased physical activity.*

Long-term outcome	Intermediate outcomes (3-5 year)	Intermediate outcome measures	Outputs	Performance measures
Improved nutrition among 5-16 year old children.	<p>Decrease in the proportion of children aged 5-16 identified as low fruit and vegetable consumers.</p> <p>Decrease in the proportion of children aged-5-16 identified as high-fat consumers.</p> <p>Decrease in the proportion of children ages 5-16 identified as high-sugar consumers.</p>	<p>By 2012, less than 9%<sup>12</sup> of parents/caregivers of children aged 5-16 say that their child does not eat fruit and vegetables at least daily (11% in CFDS<sup>13</sup> 2007). As measured in 2012 Health and Lifestyles Survey.</p> <p>By 2012, less than 22% of parents/caregivers of children aged 5-16 say that their child eats pies or pastries<sup>14</sup> at least once a week (25% in CFDS 2007). As measured in 2012 Health and Lifestyles Survey.</p>	<p>Annual activities developed to:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> identify target audiences for themes, messages and activities</li> <li><input type="checkbox"/> establish two themes and a suite of activities relating to these themes to support activities being undertaken by PHOs, DHBs, PHUS, NGOs and other frontline workers</li> <li><input type="checkbox"/> raise public awareness of the themes and regional activities</li> <li><input type="checkbox"/> identify the need for resources to support regional and local activities</li> <li><input type="checkbox"/> inform other organisations and individuals working in the nutrition and physical activity sector about the themes, messages and activities.</li> </ul>	<p>Stakeholders report that:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> they are using HSC resources to support their work</li> <li><input type="checkbox"/> they find HSC research information useful to assist their planning</li> <li><input type="checkbox"/> national activities developed by HSC have contributed to greater coordination and consistency in nutrition and physical activity messages.</li> <li><input type="checkbox"/> national activities developed by HSC have contributed to greater consistency in nutrition and physical activity messages.</li> </ul>

<sup>12</sup> Intermediate outcomes measures may need to be revised and refined following completion of the HLS 2010.

<sup>13</sup> The Children's Fruit and Drink Survey (CFDS 2007) was undertaken in 2007 and provided baseline data for the Healthy Eating Programme. This has since has been replaced by the Health and Lifestyles Survey (HLS).

<sup>14</sup> Consumption of pies or pastries is used as a proxy marker for consumption of high-fat foods by children aged 5-16.

<sup>15</sup> Availability of juice from concentrate and powders in the household is used as a proxy measure for consumption of empty-sugar foods and drinks by children aged 5-16.

Long-term outcome	Intermediate outcomes (3-5 year)	Intermediate outcome measures
Increased physical activity and decreased sedentary time among 5-16 year old children	Decrease the proportion of children aged 5-16 identified as 'sedentary'.	<p>By 2012, less than 31% of parents and caregivers of children aged 5-16 say that juice from concentrate and powders<sup>15</sup> is available at least once a week (34% in CFDS 2007).</p> <p>As measured in 2012 Health and Lifestyles Survey.</p> <p>Work will need to be undertaken in the 2010-11 period to develop an appropriate benchmark for this measure to be implemented in the 2012 HLS.</p>

Outputs	Performance measures
<p>Support those working to improve nutrition and physical activity in implementing annual activities to:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> support healthy eating health action behaviours among vulnerable population groups, including Māori, Pacific peoples, and low income families</li> <li><input type="checkbox"/> encourage an integrated approach to nutrition and physical activity programmes at grass roots level and assist frontline delivery and community action</li> <li><input type="checkbox"/> provide centrally developed and produced resources to ensure messages are nationally consistent, including with other Ministry of Health resources.</li> </ul> <p>Monitoring and evaluation plan developed and implemented for the support service, including:</p> <ul style="list-style-type: none"> <li>○ resource/product testing with end users</li> <li>○ research with PHOs, DHBs, PHUs, NGOs and other frontline workers to identify the effectiveness of resources and services delivered.</li> </ul>	<p>Resource and product testing completed as required.</p> <p>Monitoring and evaluation plan developed and implemented.</p>

Long-term outcome	Intermediate outcomes (3-5 year)	Intermediate outcome measures
Improved nutrition among 5-16 year old children.	<p>Decrease in the proportion of children aged 5-16 identified as low fruit and vegetable consumers.</p> <p>Decrease in the proportion of children aged-5-16 identified as high-fat consumers.</p> <p>Decrease in the proportion of children ages 5-16 identified as high-sugar consumers.</p>	
Increased physical activity and decreased sedentary time among 5-16 year old children	Decrease the proportion of children aged 5-16 identified as 'sedentary'.	

Outputs	Performance measures
<p>Frontline nutrition and physical activity services are supported by HSC to help implement national activities at a local level.</p> <p>Develop and implement a pilot project with at least one PHO to effectively provide nutrition and physical activity information and support to identified enrolled populations.</p>	<p>Those working to improve nutrition and physical activity report that they are better able to do their jobs as a result of HSC support, as reported in the HSC Stakeholder Survey.</p> <p>Pilot project developed and implemented. including appropriate research and evaluation undertaken.</p>

# Reporting

The Board of the HSC will provide the Ministry of Health, as the Minister's agent, with the following reports during the period. These reports will be presented in a manner that allows the Minister to assess the extent to which the HSC has delivered the performance specified in this agreement.

## ***Quarterly Reports***

The HSC will by the agreed date following the close of the quarter (ie. 9 November 2010, 9 February 2011, 9 May 2011, 9 August 2011) provide a report detailing financial and non-financial performance against performance measures in this Statement of Intent and the Contract. The reports will include comments on progress against the performance indicators and targets due for completion later the year.

## ***Informal Reports***

In addition to the formal reports the HSC will, at any time necessary:

- Alert the Minister of Health and the Ministry of Health to any emerging factors that could preclude the achievement of any Contract obligation that relates to purchase or ownership performance.
- Inform the Ministry of Health of any issue likely to be of significance to the Minister of Health.

## ***Reports to Parliament***

The HSC will prepare the following reports for the Minister of Health to table in Parliament:

- Statement of Intent 2011-2014.
- Annual Report 2010/11.

The content and timing of the production of these documents shall comply with the requirements of the Crown Entities Act 2004.

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# **Financial Statements**

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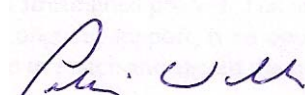
## ***Statement of Responsibility***

The Board and Management of HSC accept responsibility for these prospective financial statements and statement of forecast service performance including the judgements used herein.

The Board and Management are of the opinion that these prospective statements fairly reflect the expected service performance, financial position and operations of HSC for the forecast period.



Hayden Wano  
Chairman  
30 June 2010



Prof Peter Walls  
Board Member  
30 June 2010

## Prospective Statement of Output Costs

The following table outlines the anticipated emphasis and size of the HSC's operations over the next three years.

The programmes are described for the 2010/11 financial year and details of activities are outlined on pages 18 to 58.

### Annual expenditure on programmes by year (ex GST)

	<b>Projected 2010 (\$000)</b>	<b>2011 (\$000)</b>	<b>2012 (\$000)</b>	<b>2013 (\$000)</b>
Tobacco Control	7,851	6,225	5,828	5,896
SunSmart	1,012	1,153	902	982
Nutrition and Physical Activity	513	1,620	1,655	1,555
Problem Gambling	2,090	1,750	1,480	1,480
<b>TOTAL</b>	<b>11,466</b>	<b>10,748</b>	<b>9,865</b>	<b>9,913</b>

## Prospective Statement of Comprehensive Income

	<b>Projected</b>			
	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
	<b>(\$000)</b>	<b>(\$000)</b>	<b>(\$000)</b>	<b>(\$000)</b>
<b>Revenue</b>				
Ministry of Health	11,597	8,917	8,917	8,917
Interest income	130	100	90	80
Other income	201	362	170	363
<b>Total operating revenue</b>	<b>11,928</b>	<b>9,379</b>	<b>9,177</b>	<b>9,360</b>
Community partnerships and sponsorships	1,191	1,173	1,120	1,120
Health promotion resources	470	370	300	300
Media and communications	4,607	3,573	3,260	3,110
Research	991	1,164	922	950
Programme employee costs	1,163	1,324	1,335	1,345
Projects	1,013	1,259	1,038	1,180
Other programme costs	206	195	195	198
Programme support	583	600	590	590
<b>Total programme expenditure</b>	<b>10,224</b>	<b>9,658</b>	<b>8,760</b>	<b>8,793</b>
Corporate services	1,197	1,055	1,070	1,085
Depreciation and amortisation	45	35	35	35
<b>Total expenditure</b>	<b>11,466</b>	<b>10,748</b>	<b>9,865</b>	<b>9,913</b>
<b>Net surplus / (deficit)</b>	<b>462</b>	<b>(1,369)</b>	<b>(688)</b>	<b>(553)</b>
Other comprehensive income	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>Total comprehensive income</b>	<b>462</b>	<b>(1,369)</b>	<b>(688)</b>	<b>(553)</b>

## Prospective Statement of Movements in Equity

	<b>Projected 2010 (\$000)</b>	<b>2011 (\$000)</b>	<b>2012 (\$000)</b>	<b>2013 (\$000)</b>
<b>Balance at 1 July</b>	3,778	4,240	2,871	2,183
<i>Total comprehensive income:</i>				
Net surplus / (deficit)	462	(1,369)	(688)	(553)
<b>Balance at 30 June</b>	<b>4,240</b>	<b>2,871</b>	<b>2,183</b>	<b>1,630</b>

## Prospective Statement of Financial Position

	<b>Projected 2010 (\$000)</b>	<b>2011 (\$000)</b>	<b>2012 (\$000)</b>	<b>2013 (\$000)</b>
<b>Accumulated funds</b>	<b>4,240</b>	<b>2,871</b>	<b>2,183</b>	<b>1,630</b>
<b>Represented by</b>				
<b>Current assets</b>				
Cash and cash equivalents	5,153	3,709	2,976	2,433
GST receivable	102	102	102	102
Debtors and other receivables	200	200	200	200
Inventory	150	150	150	150
<b>Total current assets</b>	<b>5,605</b>	<b>4,161</b>	<b>3,428</b>	<b>2,885</b>
<b>Non-current assets</b>				
Property, plant and equipment	80	75	70	60
Intangible assets	5	5	5	5
<b>Total non-current assets</b>	<b>85</b>	<b>80</b>	<b>75</b>	<b>65</b>
<b>Total assets</b>	<b>5,690</b>	<b>4,241</b>	<b>3,503</b>	<b>2,950</b>
<b>Current liabilities</b>				
Creditors	70	70	70	70
Employee benefit liabilities	150	150	150	150
Other payables	1,230	1,150	1,100	1,100
<b>Total current liabilities</b>	<b>1,450</b>	<b>1,370</b>	<b>1,320</b>	<b>1,320</b>
<b>Total liabilities</b>	<b>1,450</b>	<b>1,370</b>	<b>1,320</b>	<b>1,320</b>
<b>Net assets</b>	<b>4,240</b>	<b>2,871</b>	<b>2,183</b>	<b>1,630</b>

## Prospective Statement of Cashflows

	<b>Projected 2010 (\$000)</b>	<b>2011 (\$000)</b>	<b>2012 (\$000)</b>	<b>2013 (\$000)</b>
<b>Cashflows used in operating activities</b>				
Cash provided from:				
Ministry of Health	11,597	8,917	8,917	8,917
Interest received	130	100	90	80
Other income	205	363	170	363
	11,932	9,380	9,177	9,360
Cash disbursed to:				
Payments to suppliers and employees	11,615	10,794	9,880	9,878
Net goods and services tax	249	0	0	0
	11,864	10,794	9,880	9,878
<b>Net cashflows from (used in) operating activities</b>	<b>68</b>	<b>(1,414)</b>	<b>(703)</b>	<b>(518)</b>
<b>Cashflows used in investing activities</b>				
Cash disbursed to:				
Purchase of property, plant, equipment & intangibles	50	30	30	25
<b>Net cashflows (used in) investing activities</b>	<b>(50)</b>	<b>(30)</b>	<b>(30)</b>	<b>(25)</b>
Net increase / (decrease) in cash and cash equivalents	18	(1,444)	(733)	(543)
Plus projected opening cash and cash equivalents	5,136	5,153	3,709	2,976
<b>Closing cash and cash equivalents</b>	<b>5,153</b>	<b>3,709</b>	<b>2,976</b>	<b>2,433</b>

# Statement of Accounting Policies

## **Reporting Entity**

The HSC is a Crown entity as defined by the Crown Entities Act 2004 and is domiciled in New Zealand. As such, the HSC's ultimate parent is the New Zealand Crown.

The HSC's primary objective is to provide public services to New Zealanders, as opposed to that of making a financial return. Accordingly, the HSC has designated itself as a public benefit entity for the purposes of New Zealand Equivalents to International Financial Reporting Standards (NZIFRS).

## **Basis of Preparation**

### **Statement of Compliance**

These prospective financial statements have been prepared in accordance with Crown Entities Act 2004 and the Smoke-free Environments Act 1990. This includes the requirement to comply with New Zealand generally accepted accounting principles (NZGAAP).

The financial statements comply with NZIFRS, and other applicable Financial Reporting Standards, as appropriate for public benefit entities. This includes New Zealand Financial Reporting Standard No.42: *Prospective Financial Statements* (FRS-42).

The prospective financial statements have been prepared for the special purpose of the 2010/11 Statement of Intent (SOI) of the HSC to the Minister of Health. They are not prepared for any other purpose and should not be relied upon for any other purpose.

These statements will be used in the Annual Report as the budgeted figures.

The preceding SOI narrative informs the prospective financial statements and the document should be read as a whole.

The preparation of prospective financial statements in conformity with FRS-42 requires management to make judgments, estimates and assumptions that affect the application of policies and reported amounts of assets and liabilities, income and expenses. Actual financial results achieved for the period covered are likely to vary from the information presented and the variations may be material.

### **Measurement system**

The financial statements have been prepared on a historical cost basis.

### **Functional and presentation currency**

The financial statements are presented in New Zealand dollars. The functional currency of the HSC is New Zealand dollars.

## **Significant Accounting Policies**

The accounting policies outlined below will be applied for the next year when reporting in terms of section 154 of the Crown Entities Act 2004 and will be in a format consistent with generally accepted accounting practices.

The following accounting policies, which significantly affect the measurement of financial performance and of financial position, have been consistently applied.

### **Budget figures**

These prospective financial statements were authorised for issue by the HSC on 30 June 2010.

The budget figures have been prepared in accordance with generally accepted accounting practice and are consistent with the accounting policies adopted by the HSC for the preparation of the financial statements. The HSC is responsible for the prospective financial statements presented, including the appropriateness of the assumptions underlying the prospective financial statements and all other required disclosure. It is not intended to update the prospective financial statements subsequent to publication of these statements.

### **Revenue**

Revenue is measured at fair value and is recognised as income when earned and is reported in the financial period to which it relates.

### **Revenue from the Crown**

The HSC is primarily funded through revenue received from the Crown, which is restricted in its use for the purpose of the HSC meeting its objectives as specified in this SOI. Revenue from the Crown is recognised as revenue when earned and is reported in the financial period to which it relates.

### **Interest**

Interest income is recognised using the effective interest method.

### **Rental income**

Lease receipts under an operating sub-lease are recognised as revenue on a straight-line basis over the term of the lease in the prospective statement of financial performance.

### **Operating leases**

Leases that do not transfer substantially all the risks and reward incidental to ownership of an asset to the HSC are classified as operating leases. Lease payments under an operating lease

are recognised as an expense on a straight-line basis over the term of the lease in the prospective statement of financial performance.

## **Cash and cash equivalents**

Cash and cash equivalents include cash on hand, deposits held at call with banks and other short-term, highly liquid investments, with original maturities of three months or less.

## **Debtors and other receivables**

Debtors and other receivables are measured at fair value and subsequently measured at amortised cost using the effective interest method, less any provision for impairment.

## **Bank deposits**

Investments in bank deposits are initially measured at fair value plus transaction costs. After initial recognition, investments in bank deposits are measured at amortised cost using the effective interest method.

## **Inventories**

Inventories held for sale are measured at the lower of cost (calculated using the First In First Out basis) and net realisable value.

## **Property, plant and equipment**

Property, plant and equipment asset classes consist of building fit out, computers, furniture and fittings and office equipment.

Property, plant and equipment are shown at cost, less any accumulated depreciation and impairment losses.

The cost of an item of property, plant and equipment is recognised as an asset only when it is probable that future economic benefits or service potential associated with the item will flow to the HSC and the cost of the item can be measured reliably.

Gains and losses on disposals are determined by comparing the proceeds with the carrying amount of the asset. Gains and losses on disposals are included in the prospective statement of financial performance.

Costs incurred subsequent to initial acquisition are capitalised only when it is probable that future economic benefits or service potential associated with the item will flow to the HSC and the cost of the item can be measured reliably.

The costs of day-to-day servicing of property, plant and equipment are recognised in the prospective statement of financial performance as they are incurred.

## Depreciation

Depreciation is provided using the straight line (SL) basis at rates that will write off the cost (or valuation) of the assets to their estimated residual values over their useful lives. The useful lives and associated depreciation rates of major classes of assets have been estimated as follows:

Building fit out	10 years	10% SL
Computers	5 years	20% SL
Office equipment	5 years	20% SL
Furniture and fittings	5 years	20% SL

## Intangibles

### *Software acquisition*

Acquired computer software licenses are capitalised on the basis of the costs incurred to acquire and bring to use the specific software.

Costs associated with maintaining computer software are recognised as an expense when incurred.

Costs associated with the development and maintenance of the HSC website are recognised as an expense when incurred.

### *Amortisation*

Amortisation begins when the asset is available for use and ceases at the date that the asset is derecognised.

The amortisation charge for each period is recognised in the prospective statement of financial performance.

The useful lives and associated amortisation rates of major classes of intangible assets have been estimated as follows:

Acquired computer software	3 years	33% SL
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## Impairment of non-financial assets

Property, plant and equipment and intangible assets that have a finite useful life are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. An impairment loss is recognised for the amount by which the asset's carrying amount exceeds its recoverable amount. The recoverable amount is the higher of an asset's fair value less costs to sell and value in use.

## **Creditors and other payables**

Creditors and other payables are initially measured at fair value and subsequently measured at amortised cost using the effective interest method.

## **Employee entitlements**

Employee entitlements that the HSC expects to be settled within 12 months of balance date are measured at undiscounted nominal values based on accrued entitlements at current rates of pay.

These include salaries and wages accrued up to balance date, annual leave earned, but not yet taken at balance date, and sick leave.

The HSC recognises a liability for sick leave to the extent that compensated absences in the coming year are expected to be greater than the sick leave entitlements earned in the coming year. The amount is calculated based on the unused sick leave entitlement that can be carried forward at balance date; to the extent the HSC anticipates it will be used by staff to cover those future absences.

The HSC recognises a liability and an expense for bonuses where it is contractually obliged to pay them, or where there is a past practice that has created a constructive obligation.

## **Goods and Services Tax (GST)**

All items in the financial statements are presented exclusive of GST, except for receivables and payables, which are presented on a GST inclusive basis. Where GST is not recoverable as input tax then it is recognised as part of the related asset or expense.

The net amount of GST recoverable from, or payable to, the Inland Revenue Department (IRD) is included as part of receivables or payables in the prospective statement of financial position.

The net GST paid to, or received from the IRD (including the GST relating to investing and financing activities), is classified as an operating cash flow in the prospective statement of cashflows.

## **Income Tax**

The HSC is a public authority and consequently is exempt from the payment of income tax. Accordingly, no charge for income tax has been provided for.

## **Output costs**

The output costs as reported in the prospective statement of output costs, report the cost of services for the outputs of the HSC and represent the costs of providing the output.

## **Cost allocation**

The HSC has derived the net cost of service for each significant activity of the HSC using the cost allocation system outlined below.

### *Cost allocation policy*

Direct costs are charged directly to programmes. Indirect costs are charged to programmes based on their pro-rata costs.

### *Criteria for direct and indirect costs*

‘Direct costs’ are those costs directly attributable to a significant activity.

‘Indirect costs’ are those costs that cannot be identified in an economically feasible manner with a specific significant activity. Programme support, corporate services, depreciation and amortisation, and community engagement initiatives/projects, reported as part of project expenditure, are indirect costs.

Programme support comprises activities that are provided to support programmes such as policy development, programme planning and support, project management, quality improvement and in-house researchers/data analysts who work across programmes.

Corporate services include basic infrastructure costs such as rent, power and telecommunications, general office expenditure, core administrative staff such as the Chief Executive, finance and administration, and audit and board costs.

### *Cost drivers for allocation of indirect cost*

The cost of internal services not directly charged to activities is allocated using the pro-rata costs of the programmes.

## **Sponsorship liabilities**

Sponsorship liabilities are recognised when the HSC enters into a contract for sponsorship.

The HSC may in any year commit itself to expend by way of sponsorship, in the next succeeding year, in aggregate up to 25% of the money appropriated by Parliament for the purposes of the HSC for the current year, together with the amount of cash on hand at that point in time (Section 60 of the Smoke-free Environments Act 1990).

## **Critical accounting estimates and assumptions**

In preparing these financial statements the HSC has made estimates and assumptions concerning the future. These estimates and assumptions may differ from the subsequent actual results. Estimates and assumptions are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances. Critical estimates and assumptions are discussed below.

## ***Ministry of Health Funding Agreement***

The income and expenditure figures for the 2011 and 2012 financial years are based on the income figures contained within the existing three-year contract with the Ministry of Health, which commenced on 1 July 2009. An exception to this is in tobacco control, where new, lower, budget figures were advised in April 2010. The 2013 figures assume that funding will continue at the same levels.

## ***Problem Gambling***

The Problem Gambling income figures for the 2011 through to 2013 financial years assume that funding will be in accordance with those published in the Preventing and Minimising Gambling Harm Three-year service plan 2010/11- 2012/13.

## ***General assumption – cost levels***

These figures have been based on the assumption that interest rates and general cost levels, including payroll costs, will remain at similar levels to those at the time of SOI preparation.

## **Property, plant and equipment useful lives and residual value**

At each balance date the HSC reviews the useful lives and residual values of its property, plant and equipment. Assessing the appropriateness of useful life and residual value estimates of property, plant and equipment requires the HSC to consider a number of factors such as the physical condition of the asset, expected period of use of the asset by the HSC, and expected disposal proceeds from the future sale of the asset.

An incorrect estimate of the useful life or residual value will impact the depreciation expense recognised in the prospective statement of financial performance, and carrying amount of the asset in the prospective statement of financial position.

The HSC minimises the risk of this estimation uncertainty by:

- physical inspection of assets
- asset replacement programmes
- review of second hand market prices for similar assets
- analysis of prior asset sales.

The HSC has not made significant changes to past assumptions concerning useful lives and residual values.

## **Financial instruments**

The HSC, as part of its everyday operations, is party to financial instruments that have been recognised in these financial statements. These financial instruments include accounts payable and accounts receivable, cash and short-term deposits.

Revenues and expenses in relation to all financial instruments are recognised in the prospective statement of financial performance.

## **Statement of Cash Flows**

Cash and cash equivalents means cash balances on hand, held in bank accounts, demand deposits and other highly liquid investments in which the HSC invests as part of its day-to-day cash management.

Operating activities include cash received from all income sources of the HSC and records cash payments made for the supply of goods and services.

Investing activities are those activities relating to the acquisition and disposal of non-current assets.

Financing activities comprise the change in equity and debt capital structure of the HSC.

## **Changes in accounting policies**

There have been no changes in accounting policies since the date of the last audited financial statements. The policies have been applied on a basis consistent with the previous year.