Health Promotion Agency

# *Statement of Intent*

2013–2016

health promotion agency

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**www.hpa.org.nz**

June 2013

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# Foreword

***We are pleased to present the Health Promotion Agency's (HPA) second Statement of Intent. It outlines HPA's high-level outcomes framework for the next three years as well as operating intentions that provide the basis for assessing its performance in 2013/14.***

HPA is committed to inspiring all New Zealanders to lead healthier lives so that we, as a country, experience less harm, injury and disease. HPA does this through enabling people to be more aware, motivated and able to improve and protect their own and their family's health and wellbeing. We also work to encourage supportive physical, social and policy environments and services that better promote and protect health and wellbeing.

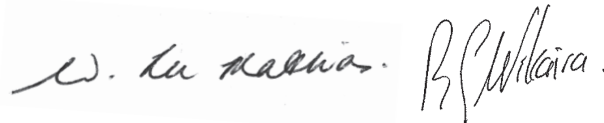
HPA's first year of operating was very much focused on establishing a new, integrated organisation delivering on its objectives. We are proud of the progress made in a short timeframe to deliver programmes of work that inspire New Zealanders to lead healthier lives, alongside the provision of a strong alcohol advisory, policy and research function that has included work to support the implementation of the new Sale and Supply of Alcohol Act 2012.

An important aspect has been developing a strong, identifiable HPA public brand to help build HPA's identity as it worked in its first year to deliver and build on the transferred work programmes of the Health Sponsorship Council and the Alcohol Advisory Council of New Zealand and the new and transferred health promotion initiatives from the Ministry of Health.

Now in its second year, HPA has emerged as a strong and capable organisation valued for its expertise in health promotion practice and able to influence many sectors and environments that contribute to good health and wellbeing and healthy lifestyles. Working across a range of topics, including alcohol, gambling harm, immunisation, mental health, nutrition and physical activity, sun safety and tobacco, HPA is able to see and develop the required linkages internally and in partnership with others to achieve long-term impacts on health and other outcomes. It is also able to respond quickly to emerging issues as they arise.

As an organisation, HPA is working to provide best value for money for the Government by: continuing to make ongoing improvements in the way we work and are governed; focusing our activities where we can make the most impact; working in partnership, wherever possible, with other government agencies; and managing our organisational costs effectively.

We look forward to HPA's future achievements.



*Dr Lee Mathias*
***Chairman***
Health Promotion Agency

*Rea Wikaira*
***Deputy Chairman***
Health Promotion Agency

# Board statement

*In signing this statement, we acknowledge that we are responsible for the information contained in the Statement of Intent for the Health Promotion Agency. This information has been prepared in accordance with the Crown Entities Act 2004 and to give effect to the Minister of Health's expectations of the Health Promotion Agency.*

*Dr Lee Mathias*
***Chairman***
Health Promotion Agency

*Rea Wikaira*
***Deputy Chairman***
Health Promotion Agency

# HPA Board

HPA is governed by a Board appointed by the Minister of Health.

**Board members are:**

Dr Lee Mathias (Chairman)
Rea Wikaira (Deputy Chairman)
Barbara Docherty
Katherine Rich
Professor Grant Schofield
Jamie Simpson

The Chief Executive is Clive Nelson.

# About the Health Promotion Agency

*The Health Promotion Agency (HPA) leads and supports national health promotion initiatives and activities ranging from education, marketing and communications to advice, resources and tools. It also provides an alcohol advisory, policy and research function.*

Working with and through others, our mission is to inspire all New Zealanders to live healthier lives. HPA's vision is for New Zealand to be a country where people realise their potential for good health and improved quality of life and where our economic and social development is enhanced by people leading healthier lives. HPA is an expert organisation in health promotion practice, influencing all sectors that contribute to good health and wellbeing and healthy lifestyles.

## HPA work programme

Achieving health and wellbeing will be harder for some than for others. HPA's work programme will, where appropriate, prioritise populations who are disproportionately impacted by disease, illness or injury and make it easier for these populations to lead healthier lives. Work will be focused where it is most needed and where it can make the most difference.

**HPA undertakes work on a wide range of health issues, including:**

- alcohol
- gambling harm
- health education
- immunisation
- mental health
- nutrition and physical activity
- sun safety
- tobacco.

HPA also undertakes work in other areas when requested to do so by its Ministers or the Ministry of Health.

## Legislative mandate

HPA is a Crown entity under the Crown Entities Act 2004. It was established on 1 July 2012 by the New Zealand Public Health and Disability Amendment Act 2012.

**HPA has an overall function to lead and support activities to:**

- promote health and wellbeing and encourage healthy lifestyles
- prevent disease, illness and injury
- enable environments which support health, wellbeing and healthy lifestyles
- reduce personal, social and economic harm.

**HPA also has alcohol-specific functions to:**

- give advice and make recommendations to government, government agencies, industry, non-government bodies, communities, health professionals and others on the sale, supply, consumption, misuse and harm of alcohol as those matters relate to HPA's general functions
- undertake, or work with others, to research alcohol use and public attitudes to alcohol in New Zealand and problems associated with, or consequent on, alcohol misuse.

As a Crown Agent, HPA is required to give effect to government policy when directed by the responsible Minister. However, in delivering its alcohol-specific functions, HPA must only have regard to government policy if so directed by the Minister.

HPA is funded from Vote Health, from the levy on alcohol produced or imported for sale in New Zealand, and from part of the problem gambling levy. Levy funding is used for specific purposes.

## Reporting

**HPA's corporate reporting requirements are to produce annually:**

- a statement of intent
- an annual report
- four quarterly performance reports of financial and operational performance
- an output agreement.

HPA meets with, and reports regularly to, Hon Jo Goodhew, Associate Minister of Health (its delegated Responsible Minister) and meets, when requested, with Hon Tony Ryall, Minister of Health, and the other Associate Ministers of Health.

HPA strives to ensure strong working relationships and open communication with its Ministers and with the Ministry of Health. This includes maintaining a 'no surprises' policy, where early communication is provided about any material or significant events, transactions and other issues that could be considered contentious or attract wide public interest, whether positive or negative. HPA has a Memorandum of Understanding with the Ministry of Health, which outlines how the parties work together.

# Operating environment

*As a Crown entity, HPA's planning is guided by the Minister of Health's Letter of Expectations 2013/14. Expectations include that HPA contributes to the achievement of government outcomes and priorities.*

Among these are the Government's overall health system and related sector outcomes, the 'Better Public Services' key results, health targets and other government priorities.

HPA contributes to the health system outcomes of:

- New Zealanders live longer, healthier, more independent lives
- the health system is cost effective and supports a productive economy.

It also contributes to other government outcomes including the justice sector's outcomes of 'crime is reduced' and the 'impact of crime is reduced' through its work on reducing alcohol-related harm and problem gambling.

HPA will specifically contribute to the health targets of:

- increased immunisation
- better help for smokers to quit
- more heart and diabetes checks.

HPA contributes to the Better Public Services results areas of 'supporting vulnerable children' and 'reducing crime' through its work to:

- increase infant immunisation rates and reduce the incidence of rheumatic fever
- improve maternal and infant nutrition
- reduce harm from alcohol misuse and problem gambling.

In addition, HPA contributes to a range of other government priority areas and interagency work programmes, including:

- the implementation of the White Paper for Vulnerable Children and the Children's Action Plan
- youth mental health (through the National Depression Initiative)
- the implementation of the Mental Health and Addiction Service Development Plan
- the Drivers of Crime initiative
- the New Zealand Injury Prevention Strategy
- implementation of the Sale and Supply of Alcohol Act 2012 and related policy work
- the revision of the National Drug Policy.

In addition to the 2013/14 ministerial expectation to all health Crown entities, HPA has expectations from the Minister of Health that relate directly to its work. These are that HPA will:

- continue the establishment of HPA including 'right sizing' the business, progressing the integration of systems and work programmes so that forecast benefits and efficiencies are realised, and developing the public brand of the organisation
- deliver on the savings targets set by Cabinet without compromising the contribution HPA and its programmes make to improving health outcomes
- develop a robust model for prioritising work so it is evident that resources are being used where they are most needed and where they deliver the best possible value

- provide evidence to underpin all programmes and activities, and ensure the monitoring of those programmes' effectiveness, even in the initial phases of work
- become an active member of the sector, maximising HPA's contribution to the Government's priority areas of rheumatic fever, tobacco cessation, increasing immunisation, improving mental health, improving maternal and infant nutrition, and better cardiovascular services.

### Responsibly managing finances

HPA is committed to being part of an effective, integrated and innovative health sector that is vital to helping New Zealanders live longer, healthier and more independent lives.

In a time of fiscal constraint, HPA aims to ensure financial sustainability through setting tight, realistic budgets and careful management. During its first year, HPA has identified ways to lift its productivity and contribute to government-wide efficiency and effectiveness gains. HPA will continue to look for opportunities for collaboration, between its own programmes and with other government agencies, to ensure the service delivered to New Zealanders is the best it can be given the tight financial constraints.

### Working with others

As a national organisation focused on promoting health and wellbeing and encouraging healthy lifestyles, HPA provides leadership, acts as a catalyst for change, encourages collaboration, and works in partnership with a broad range of stakeholders, including:

- health sector agencies, particularly the Ministry of Health, district health boards (DHBs), primary health organisations (PHOs), primary health services and health professional associations
- the community and voluntary sector
- central government agencies
- local government
- education sector agencies
- businesses
- the media
- policymakers.

### Promoting health and wellbeing in an environment of social and demographic change

HPA works in an environment of many societal and demographic changes within New Zealand, including growing ethnic diversity and an aging population, as well as technological changes in the way people communicate. Responding appropriately to these changes and challenges requires HPA to be ready and able to respond to a breadth of existing and emerging issues.

HPA contributes to achieving health outcomes through leading and supporting health promotion programmes and activities across a range of health issues. Health promotion is the process of enabling people to increase control over, and to improve, their health. Key internationally recognised health promotion strategies include building public policy, creating supportive health environments, strengthening community action for health, developing personal skills and reorienting health services.[1]

Some population groups within New Zealand are disproportionately impacted by disease, illness or injury and have poorer health outcomes compared with other New Zealanders. Identifying and focusing health promotion action to help improve the health and wellbeing of these groups, in particular for Māori, is a crucial focus for HPA.

[1] World Health Organization. (1986). *Ottawa Charter for Health Promotion*. Geneva: WHO.

# HPA outcomes framework

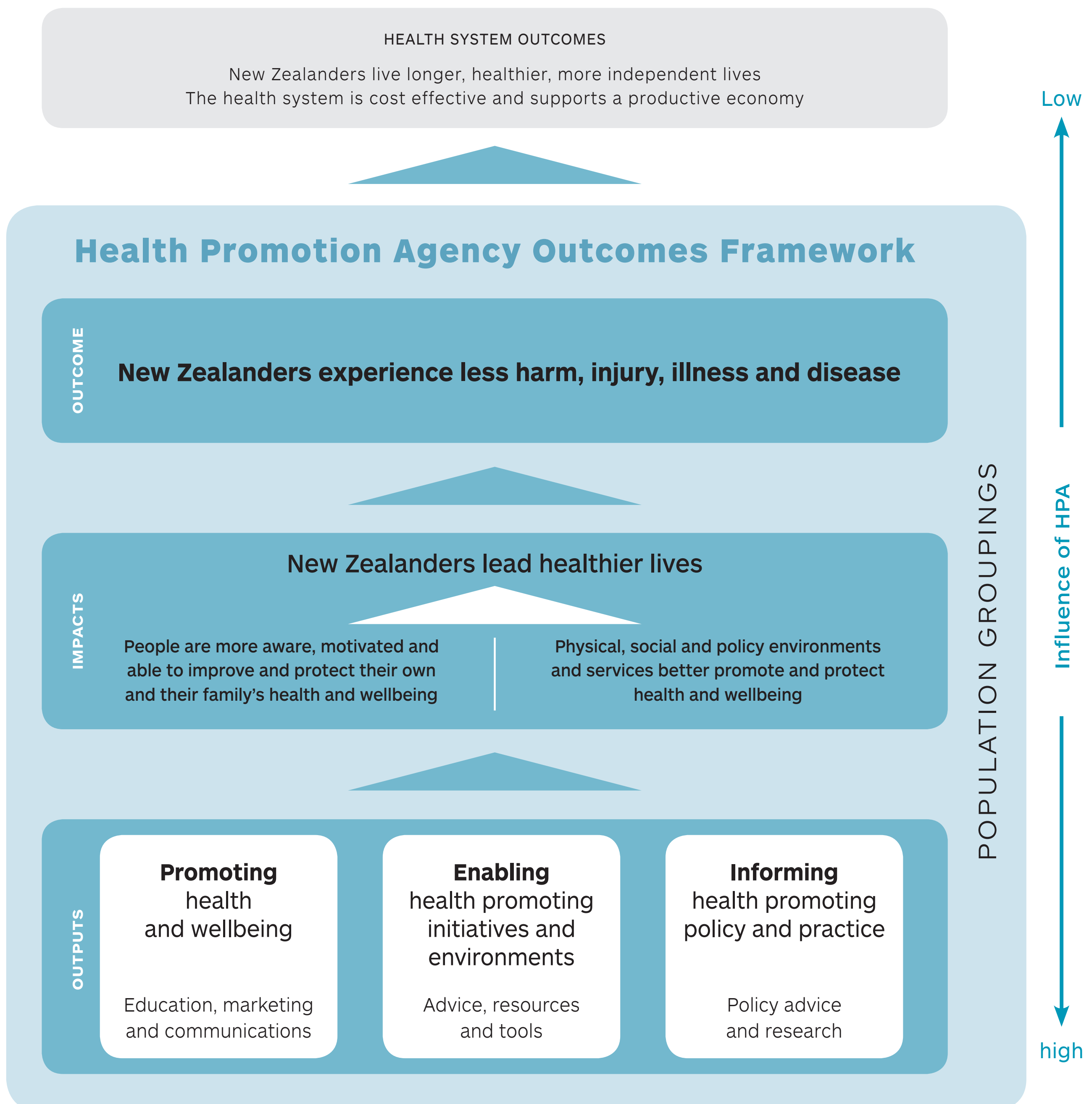



**Figure 1: Health Promotion Agency's outcomes framework**

The outcomes framework in Figure 1 shows the intervention logic for HPA's work. It outlines the outcome, impacts and outputs that HPA is working towards achieving. It also illustrates HPA's intention to focus its efforts on population groupings disproportionately impacted by harm, injury, illness and disease. The three outputs are under one output class.

# Outcome – the change we want to see

OUTCOME

**New Zealanders experience less harm, injury, illness and disease**

## *HPA has one high-level outcome that it is working towards. HPA's work alone cannot, however, achieve this outcome.*

The work and actions of agencies across the health sector as well as in other government sectors and the non-government and community sectors also contribute to successfully achieving this outcome. Working in collaboration and partnership with others is essential, therefore, to HPA's way of working and the effective delivery of its programmes and activities.

Experiencing less harm, injury, illness and disease is essential to New Zealanders leading longer, healthier, more independent lives. Less harm includes personal, social and economic harm.

In recent years there has been some improvement in New Zealanders' overall health:

- Between 1996 and 2006, the number of years a person can expect to live in good health and without an impairment needing assistance increased for males by 2.7 years to 67.4 years and for females by 1.7 years to 69.2 years.[2]
- Non-communicable diseases (NCDs), which are largely preventable, are the leading causes of death in New Zealand. Four NCDs – cancer, cardiovascular disease, diabetes, and chronic respiratory diseases – make up 80 percent of the disease burden for the total population.[3] Lifestyle factors such as smoking, poor diet, physical inactivity and harmful use of alcohol are the main risk factors for NCDs.

Good health is not enjoyed equally across all population groups in New Zealand. The 2011/12 New Zealand Health Survey found there continue to be large disparities across a range of risk factors and health outcomes for Māori and Pacific peoples compared with the total population[4], and also for children and adults living in neighbourhoods of high deprivation compared with those living in neighbourhoods of low deprivation.[5] Some age groups are also at particular risk of poorer outcomes.

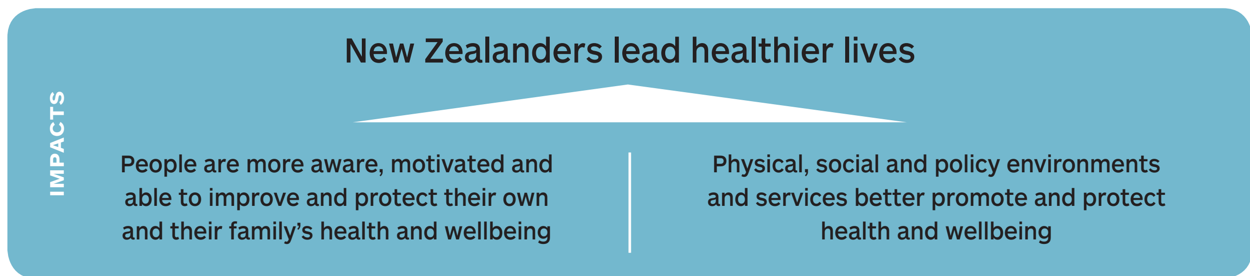
[2] Ministry of Health. (2012). *Statement of intent 2012/13 to 2014/15: Ministry of Health*. Wellington: Ministry of Health.

[3] The World Health Organization identifies the main NCDs as cardiovascular disease, diabetes, cancers, and chronic respiratory diseases.

[4] Ministry of Health. (2012). *The health of New Zealand adults 2011/12: Key findings of the New Zealand Health Survey*. Wellington: Ministry of Health.

[5] Ministry of Health. (2012). *The health of New Zealand children 2011/12: Key findings of the New Zealand Health Survey*. Wellington: Ministry of Health.

# Impacts – the difference we want to make




***In order to experience better health and wellbeing, New Zealanders need to lead healthier lives.***

HPA's work helps them do this by ensuring they have the necessary knowledge, motivation and skills, and by improving the physical and social environment and the services available to them so they are supported in their efforts.

## Impact 1 – New Zealanders lead healthier lives

Although the 2011/12 New Zealand Health Survey found that the majority of New Zealand adults and children are in good health, there were still a considerable number of children and adults who did not meet healthy behaviour recommendations (such as doing regular physical activity, eating well and being smokefree).[6]

While there have been improvements in the health of some New Zealanders as a result of behaviour changes such as reduced smoking, increased immunisation and reduced drink driving, this is not the case for all. For example, in 2009, 21 percent of New Zealanders aged 15-64 years were current smokers. Smoking prevalence was highest among Māori, Pacific people, young adults and people living in deprived neighbourhoods.[7]

## Impact 2 – People are more aware, motivated and able to improve and protect their own and their family's health and wellbeing

While individual factors are not the only determinants of health outcomes, they play a critical role. People need the appropriate knowledge, skills and attitudes if they are to adopt and maintain healthy behaviours, cease behaviours that put good health at risk, and protect themselves and their families from potential risks such as communicable diseases.

The use of a range of strategies helps increase people's awareness of the need to make changes to improve their health and wellbeing, and the motivation and ability to do so. These include national communication activities involving evidence-based, consumer-tested, multi-media advertising, and online and social media to provide information and advice. Community-based activity also helps to reinforce messages and support people to make sustained behaviour change.

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[6] Ministry of Health. (2012). *The health of New Zealand adults 2011/12: Key findings of the New Zealand Health Survey*. Wellington: Ministry of Health; Ministry of Health. (2012). *The health of New Zealand children 2011/12: Key findings of the New Zealand Health Survey*. Wellington: Ministry of Health.

[7] Ministry of Health. (2010). *Tobacco use in New Zealand: Key findings from the 2009 New Zealand Tobacco Use Survey.* Wellington: Ministry of Health.

## Impact 3 – Physical, social and policy environments and services better promote and protect health and wellbeing

Many of the underlying causes of poor health derive from the environmental and social contexts in which people grow, live, work and age. Communities, families and whānau have an important role in influencing and fostering the social norms and environments that promote and protect health and wellbeing. Policy environments, such as legislation to control tobacco sale and supply, or the development of local authority sun safety policies, contribute to creating physical and social environments that support people to lead healthier lives. Health and social services also have a role to play in assessing, supporting and encouraging people to make behaviour change through early intervention activities such as undertaking wellness checks and screening and providing brief advice and intervention.

## Impact measures for work programme areas

This section outlines the rationale and the medium-term measures and targets for HPA's work programmes. The measures have been developed to assess progress towards achieving the three HPA impacts and reflect either the broad or specific population group focus of the work programme areas.

### Alcohol

New Zealand has a high level of acute alcohol-related harms, such as injuries, road trauma, offending, and alcohol poisoning, relative to other countries.[8] These harms are related to drinking large amounts of alcohol on one occasion.

Many high-risk drinkers regularly drink to intoxication, which puts them at risk of acute harms. Many others regularly drink at a level that increases their risk of developing a chronic health condition, such as liver disease, addiction and some cancers. Alcohol is known to be causally related to more than 60 different health conditions and, for almost all conditions, heavier alcohol use means higher risk of disease.[9]

Drinking alcohol moderately results in less alcohol-related harm than heavy drinking. Taking action to change drinking behaviour from heavy to moderate drinking levels is, therefore, key to reducing harm from alcohol. For some people, this change may be not drinking any alcohol. A drinking culture and drinking environments that support moderate drinking, and for some the choice not to drink at all, also contribute to people making changes that last.

Making sustained progress on reducing harm from alcohol requires the use of multi-level strategies involving individuals, communities, organisations and sectors. HPA's alcohol-related work therefore has a broad and comprehensive approach. The measures below capture HPA's progress towards New Zealanders drinking at more moderate levels, changes in attitudes, motivation and behaviour, and improvements in the support and help provided to people seeking to better manage their drinking.

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[8] Baumberg, B. (2006). The global economic burden of alcohol: A review and some suggestions. *Drug & Alcohol Review, 25*(6), 537–551.

[9] Room, R., Babor, T., & Rehm, J. (2005). Alcohol and public health. *The Lancet, 365*(9458), 519-530.

## Impact measures for alcohol

| Measure | Latest measurement | HPA target 2016 | Source |
|---|---|---|---|
| **1. New Zealanders lead healthier lives** | | | |
| **Increase** in proportion of adult (18+ years) non-drinkers and lower-risk drinkers | 74% of adults (aged 18+) are non-drinkers (19%) or lower-risk[10] drinkers (55%) (2012) | 78% | Annual Attitudes and Behaviour Alcohol Survey |
| **Increase** in proportion of adult (18+ years) medium- to high-risk drinkers who report drinking less than the previous year | 45% (2012) | 47% | Annual Attitudes and Behaviour Alcohol Survey |
| **2. People are more aware, motivated and able to improve and protect their own and their family's health and wellbeing** | | | |
| **Increase** in proportion of adults (18+ years) who have thought about cutting back on how much they drink | 35% (2011)<br>32% (2012) | 39% | Annual Attitudes and Behaviour Alcohol Survey |
| **Increase** in proportion of drinkers who got drunk on the last occasion and decided to drink less than they used to | 35% (2011)<br>31% (2012) | 39% | Annual Attitudes and Behaviour Alcohol Survey |
| **Increase** in proportion of adult (18+ years) medium- to high-risk drinkers who report that they sought help | 3% (2012) | 5% | Annual Attitudes and Behaviour Alcohol Survey |
| **3. Physical, social and policy environments and services better promote and protect health and wellbeing** | | | |
| **Increase** in proportion of adults (18+ years) who disagree or strongly disagree that drunkenness was acceptable in some situations | 64% (2011)<br>66% (2012) | 68% | Annual Attitudes and Behaviour Alcohol Survey |
| **Increase** in proportion of adult (18+ years) medium- to high-risk drinkers who report that they received help | 9% (2012) | 11% | Annual Attitudes and Behaviour Alcohol Survey |

[10] Lower-risk drinking is consuming 1-6 standard drinks on the last drinking occasion.

### Tobacco

Smoking remains the single biggest cause of preventable morbidity and mortality in New Zealand. Along with many other organisations, HPA is working towards the Government's goal that New Zealand be essentially smokefree by 2025 (with smoking prevalence less than 5 percent) and the national health target of 'better help for smokers to quit'. Reducing smoking among Māori, particularly Māori females, is the primary focus of HPA's work, as smoking rates are significantly higher among this group (41 percent) than among the general population (18 percent).[11] The measures specified below will help monitor progress toward reduced smoking in New Zealand.

The 2018 targets for smoking prevalence reflect the measurements needed to be reached in order for New Zealand to be on track to achieve the 2025 goal. These measurements align with the Ministry of Health's target to bring prevalence down to around 10 percent of the national population by 2018, and to at least halve the Māori and Pacific smoking rates by then. HPA will apply its resources efficiently and effectively towards the achievement of these targets but progress will be dependent on the combined efforts of government agencies and the wider tobacco control sector.

Further measures are included to track changes in anti-tobacco and smokefree attitudes and motivation to quit. HPA also collects data on the awareness of the Government's Smokefree 2025 goal.

## Impact measures for tobacco control

| Measure | Latest measurement | HPA target 2018[12] | Source |
|---|---|---|---|
| **1. New Zealanders lead healthier lives** | | | |
| **Decrease** in proportion of Year 10 students who are current smokers | 7.4% All (2012)<br>16.5% Māori (2012) | 5% All<br>8% Māori | Youth Insights Survey |
| **Decrease** in proportion of adults aged 15+ years who are current smokers | 18% All (2011/12)<br>38.4% Māori (2011/12) | 10% All<br>20% Māori | New Zealand Health Survey |
| **2. People are more aware, motivated and able to improve and protect their own and their family's health and wellbeing** | | | |
| | | HPA target 2016 | |
| **Increase** in proportion of adults aged 15+ years who agreed that 'Being Smokefree is part of the New Zealand way of life' | 60.3% All<br>51.1% Māori<br>(2012) | 85% All<br>85% Māori | Health and Lifestyles Survey |
| **Increase** in proportion of current smokers or recent quitters (quit in the last 12 months) aged 15+ years who made one or more serious quit attempts in the last 12 months | 53.3% All<br>53.1% Māori<br>(2012) | 65% All<br>65% Māori | Health and Lifestyles Survey |
| **3. Physical, social and policy environments and services better promote and protect health and wellbeing** | | | |
| **Increase** in proportion of adults aged 15+ years who were 'aware that the Government wants New Zealand smoking rates reduced to 5% by 2025' | 42.8% All<br>40.0% Māori<br>(2012) | 80% All<br>80% Māori | Health and Lifestyles Survey |

[11] Ministry of Health. (2012). *The health of New Zealand adults 2011/12: Key findings of the New Zealand Health Survey*. Wellington: Ministry of Health.

[12] This is consistent with the Ministry of Health's target of halving the Māori and Pacific smoking rate by 2018.

### Gambling harm

Gambling-related harm is an important health issue in New Zealand, and has significant negative health, social and economic implications. Evidence suggests that taking action when the early signs of problem gambling appear will prevent the problem getting worse and will reduce the level of gambling-related harm experienced by the gambler and those around them.

HPA's work in this area aims to motivate people to seek help and take positive action early, both for themselves and for others they care about. It also seeks to influence gambling environments to reduce environmental risks so that at-risk gamblers are identified and gambling harm is minimised. The measures below reflect this approach.[13]

## Impact measures for gambling harm

| Measure | Latest measurement | HPA target 2016 | Source |
|---|---|---|---|
| **1. New Zealanders lead healthier lives** | | | |
| **Increase** in proportion of at-risk gamblers and people in close contact with them reporting that they monitor their gambling behaviour | Baseline data to be collected in 2013/14 | | CATI (Computer Assisted Telephone Interviewing) Minimising Gambling Harm Survey |
| **2. People are more aware, motivated and able to improve and protect their own and their family's health and wellbeing** | | | |
| **Increase** in awareness of the early indicators of harmful gambling | Baseline data to be collected in 2013/14 | | Health and Lifestyles Survey |
| **3. Physical, social and policy environments and services better promote and protect health and wellbeing** | | | |
| **Increase** in awareness of the legal requirements of venues to minimise gambling harm | Baseline data to be collected in 2013/14 | | CATI Minimising Gambling Harm Survey |

[13] These measures are slightly different from the impact measures used previously for this programme. The previous measures did not provide the best assessment of progress toward the achievement of the desired changes and were, in the most part, chosen because the data was already being collected. More helpful measures will be used in the future, with baselines established in 2013/14.

### Nutrition and physical activity

Obesity rates in New Zealand have steadily increased since the mid-1990s, and now nearly one million adults in New Zealand are obese.[14] New Zealand has the third-highest obesity rate in the OECD. In 2011/12, 28 percent of adults were obese, and a further 35 percent were overweight, which means only one in three adults in New Zealand has a normal body weight.

Rates of childhood obesity have also increased and, in 2011/12, 10 percent of children aged 2–14 years were obese, and a further 21 percent were overweight. Obesity rates are considerably higher for Māori and Pacific children, with Māori children being twice as likely and Pacific children three times as likely to be obese than their non-Māori and non-Pacific counterparts respectively (after adjusting for age and sex).[15]

Good nutrition, regular physical activity, and a healthy body size are important in maintaining health and wellbeing and for preventing serious health conditions such as cardiovascular disease, diabetes, sleep apnoea, musculoskeletal disorders such as osteoarthritis, and certain types of cancer.[16]

From conception, through infancy and childhood, parents, caregivers and families directly shape a child's physical and social environment, and indirectly influence behaviours, habits, preferences and attitudes. Obesity during pregnancy and excessive weight gain during pregnancy are associated with adverse maternal, neonatal and child outcomes. Early exposure to maternal under- or over-nutrition and infant over-feeding contribute to life-long effects. Early biological and cultural developments play an important role in determining life-long health status. And so it is critical to influence early development and ensure parents and caregivers make the best decisions for themselves and their children.

Until recently, HPA's nutrition and physical activity work has focused on increasing breakfast eating among school-aged children and some activities to support this work will continue into 2013/14. We will also be undertaking new work to improve infant and maternal nutrition and physical activity. The measures below reflect the existing work programme. Appropriate impact measures for the new work will be developed during 2013/14 as HPA's contribution to improving infant and maternal nutrition and physical activity is further defined.

## Impact measures for nutrition and physical activity

| Measure | Latest measurement | HPA target 2016 | Source |
|---|---|---|---|
| **1. New Zealanders lead healthier lives** | | | |
| **Increase** in proportion of parents/ caregivers of 2-14 year old children who report that their child eats breakfast at home every day | 87% All<br>82% Māori<br>83% Pacific<br>(2011/12) | 89% All<br>86% Māori<br>85% Pacific | New Zealand Health Survey |
| **2. People are more aware, motivated and able to improve and protect their own and their family's health and wellbeing** | | | |
| **Increase** in proportion of parents/ caregivers who agree or strongly agree with the statement: "What my child eats affects his/her performance at school" | 87% All<br>75% Māori<br>57% Pacific<br>(2012) | 89% All<br>80% Māori<br>62% Pacific[17] | Health and Lifestyles Survey |

[14] Ministry of Health. (2012). *The health of New Zealand adults 2011/12: Key findings from the New Zealand Health Survey*. Wellington: Ministry of Health.

[15] Ministry of Health. (2012). *The health of New Zealand children 2011/12: Key findings from the New Zealand Health Survey*. Wellington: Ministry of Health.

[16] University of Otago & Ministry of Health. (2011). *A focus on nutrition: Key findings from the 2008/09 New Zealand Adult Nutrition Survey*. Wellington: Ministry of Health.

[17] As there is only one year of data to-date, there is no trend data, and the target will need to be reviewed after analysis of the next Health and Lifestyles Survey.

### Sun safety

More than 400 New Zealanders die every year from skin cancer, with melanoma being responsible for most of these deaths – 326 in 2009.[18] Skin cancer is conservatively estimated to cost the New Zealand health system more than NZ$57 million each year.[19] The vast majority of skin cancers are preventable – more than 90 percent of melanomas in Australasia are attributable to sunlight exposure.[20] HPA sun safety work encourages both young people and wider New Zealand society to practise sun safe behaviours. The youth-focused campaign aims to reduce the pro-tanning attitudes that drive sun tanning behaviour among young people, while other elements provide New Zealanders with tools to enable them to reduce their own and others' risk.

## Impact measures for sun safety

| Measure | Latest measurement | HPA target 2016 | Source |
|---|---|---|---|
| **1. New Zealanders lead healthier lives** | | | |
| Increase the proportion of youth (13-17 years) who reported using at least one sun protection item and/or purposely sought out shade while outdoors the previous summer weekend | 81% (2013) | 83% | Sun Exposure Survey |
| **2. People are more aware, motivated and able to improve and protect their own and their family's health and wellbeing** | | | |
| Reduction in proportion of youth (13-17 years old) who spent 15 minutes or more outdoors during the previous weekend agree with the statement: "Most of my friends think that a suntan is a good thing" | 73% (2013) | 69% | Sun Exposure Survey |
| Increase in proportion of adults who report they have seen the Sun Protection Alert[21] | 50% (2013) | 55% | Sun Exposure Survey |
| **3. Physical, social and policy environments and services better promote and protect health and wellbeing** | | | |
| Increase in the number of territorial authorities that have completed shade audits | 1 (2012) | 12 | Administrative data |

18 Ministry of Health. (2012). *Cancer: New registrations and deaths 2009*. Wellington: Ministry of Health.

19 O'Dea, D. (2009). *The costs of skin cancer to New Zealand*. Wellington: Cancer Society of New Zealand.

20 Armstrong, B. K., & Kricker, A. (1993). How much melanoma is caused by sun exposure? *Melanoma Research,* 3(6), 395-401.

21 The Sun Protection Alert is a visual tool that enables people to identify the times in their own region that they should seek protection from the sun

# Outputs – The work we plan to do – 2013/14

*HPA has three interconnected outputs grouped into one output class. While the nature of the work in each output differs, together the three outputs achieve the impacts and outcomes HPA is seeking.*

## Output 1 – Promoting health and wellbeing – Education, marketing and communications

HPA designs and delivers a range of education, marketing and communications strategies that inform, motivate and enable New Zealanders to lead healthier lives. Significant activities and related performance measures in this output for 2013/14 are outlined below.

### Alcohol

A range of strategies forms part of a national marketing campaign and other communications activity to help New Zealanders make positive decisions about their alcohol use. The latest national marketing campaign, 'Activating Choice', went to air in the fourth quarter of the 2012/13 financial year. It aims to give New Zealanders, particularly risky drinkers, a language they can use to refuse a drink, social permission to refuse a drink, and encouragement to 'back' their mates who are trying to ease up. It builds a social movement in support of moderation. The campaign, which will continue in 2013/14, involves a range of mass media elements. High-profile sportspeople and community partners will also promote complementary messages. Māori are at higher risk of experiencing alcohol-related harm, so specific communications will be developed for this audience.

The enactment of provisions in the Sale and Supply of Alcohol Act 2012 in 2013/14 will make a number of changes to the way that alcohol is sold and supplied. HPA's marketing activities will increase public and stakeholder understanding of these changes and their implications, particularly as they relate to young people under 18 years of age.

Motivating risky drinkers to seek help, particularly through the Alcohol Drug Helpline, is another important element of HPA's alcohol marketing work. Online tools will also be available to help drinkers assess their risk of harm and take action to reduce it.

## Output 1 measures for alcohol

| Activity | Quantity measure | Quality measure | Source |
|---|---|---|---|
| Activating choice marketing campaign | Awareness of the campaign marketing and communication messages will be maintained | At least 50% of the target audience considers the campaign messages are relevant to themselves or someone they care about | Campaign monitor |
| Marketing campaign to improve understanding of the legal requirements in relation to the supply of alcohol to under 18 year olds | At least 60% of adults (18+ years) were aware that it is now a legal requirement that they gain permission from a parent before providing their teenager with alcohol<br>(40% awareness in November 2012) | | Campaign monitor |
| Alcohol helpline marketing | Alcohol-related calls to the Alcohol Drug Helpline increase by at least 15% in 2013/14 compared with 2012/13 | | Alcohol Drug Helpline data |
| Information for the public on reducing alcohol-related harm | New or updated online and print resources for the public on reducing alcohol-related harm, including self-help resources, and uptake of resources<br>Number of visitors to *alcohol.org.nz* is maintained | 75% of resource user respondents indicate satisfaction (top two categories of a five-point scale) with alcohol resources and websites | Resource users survey<br>Administrative data<br>Google Analytics |

### Tobacco

The 'Smoking Not *Our* Future' campaign uses a range of strategies to build anti-tobacco and pro-smokefree attitudes among young people with a particular focus on young Māori females. This is achieved through partnerships with events such as Smokefreerockquest and Pacifica Beats and by building a community of youth who are actively engaged in creating a youth smokefree movement.

The highest level of smoking uptake now occurs between 17 and 24 years of age with the greatest uptake seen among Māori females. HPA has recently undertaken research to better understand why this occurs and to identify potential strategies to address the issue. A marketing and communications strategy, including a stakeholder engagement plan, to reduce late uptake and increase cessation among young adults will be developed and a marketing campaign launched toward the end of 2013/14.

## Output 1 measures for tobacco

| Activity | Quantity measure | Quality measure | Source |
|---|---|---|---|
| Youth targeted strategy (12–16 year olds) | Smokefreerockquest attendance figures are maintained or increased (2012: 630 bands; 291 schools; and 12,500 people in attendance at regional finals)<br><br>Smokefree Pacifica Beats ttendance figures are maintained or increased (2012: 72 bands; 45 schools; and 1,900 people in attendance at regional finals) | | Administrative data (statistics provided by event partners)<br><br>Google Analytics |
| Young adult strategy (17–24 year olds) | A marketing and communications strategy, including a stakeholder engagement plan, developed and campaign launched | | Administrative data |

### Gambling harm

The 'Choice Not Chance' campaign aims to raise awareness of gambling risks and harms and motivate people to seek help and take positive action early, both for themselves and for others they care about. This will include television advertising using the key messages developed for the 'Kiwi Lives' campaign, along with online and other forms of advertising.

While these activities will focus at the prevention/early intervention end of the spectrum, the messages will also reach those who are already problem gamblers, as well as the broader public. Initial research and development for a venue-focused campaign will also be undertaken.

## Output 1 measures for gambling harm

| Activity | Quantity measure | Quality measure | Source |
|---|---|---|---|
| 'Choice Not Chance' campaign | At least 10% of visitors to the 'Choice Not Chance' website use an online self-assessment/ self-help tool | Calls to the Gambling Helpline are 30% higher at times when mass media advertising is running compared with when it is not (29% in 2009/10, 2010/11, 2011/12) | Google Analytics<br>Administrative data (Gambling Helpline records reported quarterly based on a 12-month rolling period) |

### Nutrition and physical activity

'Breakfast-eaters have it better' is currently the primary focus of HPA's nutrition and physical activity work. With the likely refocusing of HPA's nutrition and physical activity work towards maternal and infant health, some aspects of the Breakfast-eaters promotion will be maintained. Additional intervention strategies and output measures that reflect this refocus will be developed during 2013/14 and will be reported on in HPA's 2014 Annual Report.

'Breakfast-eaters have it better' aims to increase the proportion of Māori and Pacific children who consume breakfast daily, by talking to parents and caregivers about the benefits of breakfast, as well as encouraging parental role modelling of breakfast-eating behaviour (as children of Pacific ethnicities are 5.7 times more likely and Māori children 2.5 times more likely to skip breakfast than New Zealand European children or children of other ethnic groups).[22]

## Output 1 measures for nutrition and physical activity

| Activity | Quantity measure | Quality measure | Source |
|---|---|---|---|
| Health eating promotions | Average total reach for all online activity is maintained (average of 1,091,410 per month in 2012) | | Facebook data<br>Google Analytics |

[22] Quigley, R., Taylor, R., & Scragg, R. (2007). *Is consuming breakfast important for academic performance, maintaining a healthy body weight, and improving nutrient intake and lifestyle habits in children?* Wellington: Agencies for Nutrition Action.

### Sun safety

HPA's SunSmart work encourages both young people and wider New Zealand society to practise sun safe behaviours. The youth-focused campaign involves promotions at popular youth events reaching an estimated 35,000 young people, supported by the use of unpaid media and of online tools (including Facebook). Another campaign involves the promotion of the Sun Protection Alert through all major local and regional newspapers, television, radio, online and other channels, including a new smartphone application. The Sun Protection Alert provides daily information that enables New Zealanders to identify the times in their own region that they should use sun protection.

## Output 1 measures for sun safety

| Activity | Quantity measure | Quality measure | Source |
|---|---|---|---|
| Youth-targeted sun safety campaign | At least 2,500 youth engaged directly with sun safety messages through use of UV camera<br>(1,850 in 2012/13) | | Administrative data<br>Youth sun safety campaign pre- and post-campaign evaluation |
| Sun Protection Alert | Development of new Sun Protection Alert smartphone application | | MetService.com |

### Mental health

Positive mental health is an important part of overall health and wellbeing. HPA aims to minimise the impact of mental illness on New Zealanders in the context of a broader approach to wellbeing. According to the World Health Organization, mental health is the foundation for individual wellbeing and the effective functioning of a community.[23] It is common for people in New Zealand to experience mental illness, with 46.6 percent of the population predicted to meet criteria for a disorder at some time in their lives. Depression is one of the main disorders, with 5.7 percent of New Zealanders (aged 16 and over) predicted to experience a major depressive disorder over a 12-month period.[24]

Stigma and discrimination towards mental illness are among the major barriers to a person's recovery. To support societal change, HPA works with organisations contracted to provide and evaluate a variety of national services as part of the 'Like Minds, Like Mine' public education programme. This programme aims to reduce the stigma and discrimination faced by people with experience of mental illness. Work to help reduce the impact of depression on the lives of New Zealanders will be continued through the public health 'National Depression Initiative'. The initiative aims to strengthen individual, family and social factors that protect against depression and improve community and professional responsiveness to depression.

[23] World Health Organization. (2010 September). *Mental health: Strengthening our response*. Fact Sheet (220). Retrieved from *http://www.who.int/mediacentre/factsheets/fs220/en/*

[24] Oakley Browne, M. A., Wells, J. E., & Scott, K. M. (eds). (2006). *Te Rau Hinengaro: The New Zealand Mental Health Survey*. Wellington: Ministry of Health.

## Output 1 measures for mental health

| Activity | Quantity measure | Quality measure | Source |
|---|---|---|---|
| 'National Depression Initiative' marketing campaign | At least 18,000 contacts made with the depression helpline services (excluding the youth-specific 'lowdown' website) (27,261 in 2011; 18,437 in 2012)<br><br>At least 10,000 people register to use the Journal (an online self-help programme) to help them manage their depression (10,711 in 2011; 10,056 in 2012) | | Lifeline Data<br><br>Google Analytics |
| 'Like Minds, Like Mine' marketing campaign | Prompted recall of 'Like Minds, Like Mine' advertising is maintained or improved<br><br>(90% in 2013) | Proportion of people expressing disagreement with the statement "I would feel uncomfortable talking to someone who had a mental illness" is maintained or increased<br><br>(79% in 2011) | 'Like Minds, Like Mine' tracking survey |

### Immunisation

HPA will continue to provide marketing support for the immunisation programme in 2013/14. In 2012/13, marketing and communications assistance was provided to support the achievement of the Ministry of Health's immunisation outcome of 'Good health and independence are promoted and protected'. This included working with the Ministry of Health on strategy and resource development, as well as funding the extension of media schedules to increase target audience exposure to immunisation messages. Work was undertaken on the influenza campaign, immunisation week, the youth reminder campaign, and the development of resources for the Year 7 and Year 8 school immunisation programme and for meningococcal disease.

## Output 1 measures for immunisation

| Activity | Quantity measure | Quality measure | Source |
|---|---|---|---|
| Provide marketing support to national immunisation initiatives | Service is delivered to agreed timeframes, standard and budget | Ministry of Health contact people indicate satisfaction (top two of a five-point scale[25]) with the service provided by HPA | Administrative data<br><br>Survey of Ministry of Health contact people |

[25] Measurement is the level of agreement with the statement "I am satisfied with the service provided by the HPA" (1) strongly disagree; (2) disagree; (3) neither agree or disagree; (4) agree; and (5) strongly agree.

### Health education

Health education resources aim to improve health literacy so that people are better able to find, understand and evaluate health information and to help them manage and improve their health. HPA will work with providers responsible for the development and distribution of nationally available health education resources on a wide range of public health topics.

The resources are distributed through authorised providers to health service providers and the public. HPA's role is to manage the contracts with providers to ensure that health education resources contribute to improved health literacy through a process that is accessible and efficient and reflects health priorities.

## Output 1 measures for health education

| Activity | Quantity measure | Quality measure | Source |
|---|---|---|---|
| Management and monitoring of contracts for production and distribution of nationally available health education resources | Contracts are actively managed according to specifications of each contract | Service specifications are met on time, at agreed cost and to required quality | Administrative data (contract reports) |

### Health promotion and communications support provided for other public health initiatives

As well as the ongoing health promotion programmes that it runs, HPA is regularly asked to provide health promotion, communications and marketing support to other government-led public health initiatives. Sometimes these requests are made after the publication of HPA's Statement of Intent. In 2012/13, this included work related to rheumatic fever, and cardiovascular disease. HPA will continue to be responsive to these requests and will meet the following performance measures in relation to them.

## Output 1 measures for public health initiatives

| Activity | Quantity measure | Quality measure | Source |
|---|---|---|---|
| Provide health promotion, communications and marketing support to other public health initiatives | Service is delivered to agreed standard, within agreed timeframes and within budget | Ministry of Health contact people indicate satisfaction (top two of a five-point scale) with the service provided by HPA | Administrative data<br>Survey of Ministry of Health contact people |

## Output 2 – Enabling health promoting initiatives and environments – Advice, resources and tools

HPA's ability to inspire New Zealanders to lead healthier lives is greatly extended if it works with and through others. To achieve this, HPA provides advice, resources and tools to a wide range of individuals, groups and organisations to enable health (and other relevant) sectors and communities to take action and to help improve environments (physical and socio-cultural) so that these environments better promote and protect health. HPA also promotes best practice.

Working with others enables HPA to meet its ministerial expectation that HPA work with other entities to maximise system-wide efficiency and effectiveness. Key activities and related performance measures in this output for 2013/14 are outlined below.

### Alcohol

A key focus of HPA's alcohol work in 2013/14 is to support the implementation of the Sale and Supply of Alcohol Act 2012. This work will include providing advice and updating existing, and developing new, resources, guidelines and evidence-based tools and practical resources for regulatory agencies, the hospitality industry and settings (such as large events) to meet the requirements of the new Act. Work will also be undertaken to encourage regulatory agencies, the hospitality industry and others to work together, share resources, and focus on the regulatory and non-regulatory aspects of creating drinking environments and cultures that reduce alcohol-related harm.

Health services have considerable involvement in the prevention and treatment of alcohol-related harm. HPA will provide advice and support across the spectrum of alcohol treatment from early intervention to specialist services to help ensure that people who need help with their drinking are identified earlier, their interactions with services are seamless and they receive the help they need. HPA has a particular emphasis on promoting and encouraging the expansion and uptake of alcohol screening and brief intervention in health services, especially through primary health services, as well as increasingly through other sectors, such as the justice and social services sectors.

The Alcohol Drug Helpline receives funding from HPA to provide a telephone and web-based service direct to the public and to support early intervention in a range of health and social sector settings. HPA will be working to promote the Helpline more effectively, as it provides a crucial interface service for many people seeking help with their drinking. Work will also be undertaken to strengthen innovation, linkages and collaboration between primary health and alcohol treatment services, including support for the treatment sector through its annual Cutting Edge national addictions conference.

Community-led action offers many opportunities for influencing New Zealand's drinking culture. HPA will undertake work with a range of community groups and organisations to fund and encourage innovative community action on alcohol issues using local solutions, in particular with populations who experience the highest levels of harm from alcohol. Activity also includes being a partner and broker for regional and local initiatives that support effective regulatory activity and community solutions, such as active community participation in the development of local alcohol policies.

## Output 2 measures for alcohol

| Activity | Quantity measure | Quality measure | Source |
|---|---|---|---|
| Stakeholder magazines and newsletters | Two *AlcoholNZ* magazines and 11 *Ease up* e-newsletters are produced | At least 75% of stakeholder respondents indicate satisfaction (top two categories of a five-point scale) with alcohol magazines and newsletters | Stakeholder or resource users survey<br>Administration data |
| Resources and advice for alcohol legislation requirements | New or updated online and print resources consistent with the new alcohol legislation for regulatory agencies and premises and uptake of resources | At least 75% of stakeholder respondents indicate satisfaction (top two categories of a five-point scale) with resources and advice for alcohol legislation requirements | Stakeholder or resource users survey<br>Administrative data |
| Resources and advice for health professionals and others to better enable them to help people who need help with their drinking | New or updated online and print resources for primary healthcare and other settings and uptake of resources | At least 75% of stakeholder respondents indicate satisfaction (top two categories of a five-point scale) with resources and advice to better enable health professionals and others to help people who need help with their drinking | Stakeholder or resource users survey<br>Administrative data |
| Alcohol Drug Helpline | At least 40% of all Alcohol Drug Helpline alcohol-relevant calls answered receive either an individual or family brief intervention | At least 75% of Helpline caller respondents indicate (top two categories of a five-point scale) that they received the help they were looking for when they called the Alcohol Drug Helpline | Administrative data<br>Annual Helpline Treatment Perception Survey |
| Supporting the Cutting Edge national addictions conference for the addiction treatment sector | | Evaluation results show overall satisfaction with the conference (75% score in top two categories of a five-point scale) | Conference evaluation |
| Community-led action on alcohol projects | All funded community-led action projects are monitored on a biannual basis | At least 90% of community-led action projects funded in 2012/13 meet specified reporting requirements | Administrative data |
| Resources and advice for community action on alcohol | | At least 75% of stakeholder respondents indicate satisfaction (top two of a five-point point scale) with resources and advice for community action on alcohol | Stakeholder or resource users survey |

### Tobacco

HPA undertakes a range of activities to support frontline health promotion workers to be more effective. These include: coordinating and resourcing World Smokefree Day; providing resource materials; promoting smokefree lifestyles; encouraging consistency between national and local action; and encouraging the use of evidence-based approaches. HPA also hosts several sector-wide websites.

## Output 2 measures for tobacco

| Activity | Quantity measure | Quality measure | Source |
|---|---|---|---|
| Sector support | At least 30 communities are supported to implement local World Smokefree Day initiatives | At least nine out of 10 stakeholders confirm that their work is more effective as a result of using HPA support (10 out of 10 in 2012, nine out of 10 in 2011) | Stakeholder or resource users survey |

### Gambling harm

The work of frontline minimising gambling harm services is integral to making progress in minimising harm from gambling. These services are key to delivering HPA's national campaign through their regional and local activities.

HPA has developed positive working relationships with this sector, and will continue to support and up-skill the sector in delivering the messages on the ground. Activities include providing them with merchandise and printed resources, up-to-date information, tips and ideas on message delivery at a local level, and links to relevant research. Support will be also provided to service providers to enable them to undertake a range of awareness-raising activities such as Gamblefree Day.

## Output 2 measures for gambling harm

| Activity | Quantity measure | Quality measure | Source |
|---|---|---|---|
| Supporting frontline services | Health promotion resources and advice are provided to all (21) minimising gambling harm service providers | At least 70% of respondents to a survey of public health minimising gambling harm services indicate (top two categories of a five-point scale) that they are better able to do their job as a result of HPA support 70% in 2012) | Stakeholder or resource users survey |
| Supporting local services | At least 10 regions use tools provided by HPA to support their Gamblefree Day activities in order to raise the profile of gambling harm in their community | At least 50 local gambling-related media stories are generated as a result of community activities supported by HPA (35 in 2012/13) | Administrative data<br>Media monitor |

### Nutrition and physical activity

HPA will be providing resources and information to community groups, Māori and Pacific health promoters, public health units, public health organisations, primary health services, schools, early childhood centres, sports clubs, and the media to support community activities and promotions and to help communicate consistent nutrition and physical activity messages.

HPA will work with the Ministry of Health to identify key areas where HPA can support new and existing providers that are working to improving maternal and infant nutrition and physical activity outcomes. Additional output measures for this new work will be developed during 2013/14 and reported on in HPA's 2014 Annual Report.

## Output 2 measures for nutrition and physical activity

| Activity | Quantity measure | Quality measure | Source |
|---|---|---|---|
| Sector support | Advice and support are provided to at least six Ministry of Health-funded providers working to improve maternal and infant nutrition | At least 85% of resource users indicate (top two categories of a five-point scale) that they are better able to do their job as a result of HPA support | Administrative data<br>Stakeholder or resource users survey |

### Sun safety

HPA contributes to and supports the development of the New Zealand Skin Cancer Control Strategic Framework 2015-2018. The framework focuses on prevention, and to a lesser extent early detection, of skin cancer. HPA will also promote the use of a shade audit tool that is recognised by the Australian Cancer Council as the best way to plan outdoor spaces to minimise the risk of overexposure to ultraviolet (UV) radiation. A shade audit allows organisations to consider the specific needs of individual sites to ensure outdoor spaces at their sites are appropriately and cost effectively protected from UV radiation.

## Output 2 measures for sun safety

| Activity | Quantity measure | Quality measure | Source |
|---|---|---|---|
| Support skin cancer sector planning | New Zealand Skin Cancer Control Strategic Framework 2015–2018 completed | | Administrative data |
| Promotion of shade audits | At least three workshops promoting the shade audit tool are delivered<br>Shade audits completed with at least two territorial authorities | At least 80% of participants attending the workshops report that they would include shade in their long-term council plans | Administrative data<br>Workshop evaluation |

## Output 3 – Informing health promoting policy and practice – Policy advice and research

HPA provides policy advice and research to inform decision making on best practice and policy to improve New Zealanders' health and wellbeing and reduce injury and other harm, including:

- informing the development of healthy public policy/health policy
- providing expert advice on health promotion and harm reduction strategies across a wide range of health issues
- providing advice and making recommendations on alcohol-related public policy
- undertaking research to:
  - monitor key health indicators, behaviours and attitudes
  - inform and evaluate activities, programmes and initiatives
  - gather intelligence and identify emerging health issues.

Key activities and related performance measures for this output are outlined below.

### Expertise and advice on health promotion

HPA will provide leadership in health promotion. It offers specialist knowledge and expertise in developing and delivering successful, nationally integrated health promotion and harm reduction strategies. It can provide an in-depth understanding of the population groups that health promotion initiatives are trying to reach and influence and of what strategies are most effective. HPA will also continue to build on established relationships and partnerships with New Zealand universities, key government and non-government agencies and international organisations so it can provide expert advice to inform health promoting policy and practice.

### Alcohol-related policy advice

HPA has a specific statutory function that allows it to give advice and make recommendations to government, government agencies, industry, non-government bodies, communities, health professionals, and others on the sale, supply, consumption, misuse and harm of alcohol. This involves HPA providing oral and written advice through submissions and interagency meetings and work programmes at the central and local government levels.

With the final provision of the Sale and Supply of Alcohol Act 2012 soon coming into force, HPA will continue to provide an advisory, support and broker role, working with local authorities, Local Government New Zealand and the Ministry of Justice on aspects of implementation, including on the development of local alcohol policies. At the national level, HPA will continue to contribute to other Ministry of Justice-led policy work related to the sale and supply of alcohol.

Other interagency alcohol-related policy work that HPA contributes to includes work on the Drivers of Crime initiative, the implementation of the New Zealand Injury Prevention Strategy and the development of a new injury prevention action plan, and the revision of the National Drug Policy.

## Output 3 measures for alcohol policy advice

| Activity | Quantity measure | Quality measure | Source |
|---|---|---|---|
| Policy advice/ submissions | Number of submissions | Submissions are provided by the specified timeframes | Administrative data |

### Research

HPA undertakes a range of research that is used both internally and externally to inform policy, practice and future research, including the following national surveys:

- The Health and Lifestyles Survey (HLS) is a monitor of the health behaviour and attitudes of New Zealand adults aged 15 years and over, and parents and caregivers of 5-16 year olds. It collects information relating to alcohol, tobacco control, sun safety, problem gambling and healthy eating. The survey has been conducted biannually since 2008 and will be conducted in 2013/14 with an extended module on gambling harm.
- The New Zealand Smoking Monitor (NZSM) is a continuous monitor providing information on smokers' and recent quitters' knowledge, attitudes and behaviour.
- The New Zealand Youth Tobacco Monitor (NZYTM) provides information about adolescents' smoking-related knowledge, attitudes and behaviour.

HPA has a specific statutory function to provide research on alcohol-related issues. Research is undertaken to collect nationally representative information on alcohol attitudes and behaviour in New Zealand. Other research activity includes trend measurement, expansion of the evidence base for alcohol-related harm, support for legislation change requirements, and operational and programme support.

## Output 3 measures for research

| Activity | Quantity measure | Quality measure | Source |
|---|---|---|---|
| New Zealand Smoking Monitor (NZSM) | The NZSM is infield continuously during 2013/14<br>Data from the NZSM is reported to the Ministry of Health monthly, quarterly and annually | Analysis of data is provided to the Ministry of Health's satisfaction | Administrative data |
| New Zealand Youth Tobacco Monitor (NZYTM) | | Preparation for the 2014 Youth Insight Survey is completed to the satisfaction of the Ministry of Health | Administrative data |
| Health and Lifestyles Survey | Development and data collection commenced of a nationally representative survey of more than 2,000 households oversampling Māori and Pacific people with an expanded module for gambling harm<br>Reports for the 2012 Health and Lifestyles Survey are produced in 2013/14 | Dissemination of research findings though reports and other materials delivered on time | Administrative data |
| Research to collect nationally representative information on alcohol attitudes and behaviour | Alcohol attitudes and behaviour information collected through nationally representative surveys<br>Reports for the 2012 Annual Attitudes and Behaviour Survey are published in 2013/14 | Dissemination of research findings though reports and other materials delivered on time | Administrative data |

# Organisational health and capability

During 2012/13, priority was given to creating a high-performing organisation by:

- developing an organisational structure that is fit for purpose
- developing a set of organisational values and a single organisational culture
- identifying opportunities for integration across programmes of work to increase efficiency and achieve savings
- amalgamating the systems and processes of the two former organisations
- ensuring that staff were provided with information on the organisation's structure as it developed and that they were given the opportunity to contribute to decision making
- ensuring that staff were well supported during the transition.

The HPA Board is committed to adhering to the principles of good practice governance. The Board operates according to a governance manual. It will undertake an annual self-assessment to formally assess the performance of individual members, the Chairman, and the Board as a whole.

At the time of the merge, both former organisations had their own sets of organisational policies, and staff continued to use these to enable them to deliver their work programmes. A programme of work to develop a new set of HPA policies and procedures that cover all the Good Employer policy areas began in 2012/13 and will be completed by 30 June 2014. Staff will be closely involved in this process.

# FORECAST FINANCIAL STATEMENTS

**HEALTH PROMOTION AGENCY**
**STATEMENT OF COMPREHENSIVE INCOME**
**BUDGET 2013 – 2016**

| Forecast 2012/13 $ | | Budget 2013/14 $ | Budget 2014/15 $ | Budget 2015/16 $ |
|---|---|---|---|---|
| | **REVENUE** | | | |
| 13,894,000 | Levy income | 13,647,000 | 13,197, 000 | 13,197, 000 |
| 13,797,395 | Crown income | 12,884,395 | 11,884,395 | 11,444,395 |
| 140,000 | Interest Income | 150,000 | 150,000 | 150,000 |
| 415,000 | Other Income | – | 170,000 | 100,000 |
| **28,246,395** | **Total Operating Revenue** | **26,681,395** | **25,401,395** | **24,891,395** |
| | **EXPENDITURE** | | | |
| 61,388 | Audit Fees | 65,000 | 65,000 | 65,000 |
| 170,436 | Board | 170,000 | 173,400 | 177,000 |
| 100,000 | Depreciation | 100,000 | 100,000 | 100,000 |
| 151,720 | Equipment, Supplies & Maintenance | 148,500 | 151,500 | 154,500 |
| 730,765 | Occupancy | 764,000 | 698,000 | 707,000 |
| 598,699 | Other Operating | 521,800 | 544,500 | 555,400 |
| 6,338,862 | Personnel | 6,912,000 | 7,050,300 | 7,191,300 |
| 19,874,525 | Programmes | 18,000,095 | 16,618,695 | 15,941,195 |
| **28,026,395** | **Total Operating Expenditure** | **26,681,395** | **25,401,395** | **24,891,395** |
| **220,000** | **Surplus** | **–** | **–** | **–** |

**Notes:-**

1. Projected revenue including Crown income will vary as programmes of work change in response to government health targets and priorities.
2. Projected income in 2014/15 and 2015/16 is estimated on programmes of work currently confirmed.
3. Expenditure reflects the savings target set by Cabinet and included in HPA's 2013/14 Letter of Expectation. The savings target is to be met without compromising the contribution to improving health outcomes expected of HPA and will be met through a combination of consolidation, production efficiencies and rephasing and reprioritisation.
4. Projected cost savings/efficiency gains are:-

| | $ |
|---|---|
| FY 2012/13 (incl. $286K consolidation and $220K operating surplus) | 506,000 |
| FY 2013/14 | 1,466,000 |
| FY 2014/15 | 2,366,000 |
| FY 2015/16 | 2,806,000 |
| | **7,144,000** |

## HEALTH PROMOTION AGENCY
## STATEMENT OF COMPREHENSIVE INCOME
## BUDGET 2013 – 2016

### RESTATED BY INCOME SOURCE

| Forecast 2012/13 $ | | Budget 2013/14 $ | Budget 2014/15 $ | Budget 2015/16 $ |
|---|---|---|---|---|
| | **ALCOHOL** | | | |
| | Revenue | | | |
| 12,414,000 | Levy | 11,967,000 | 11,517,000 | 11,517,000 |
| 50,000 | Interest | 87,000 | 87,000 | 87,000 |
| 100,000 | Other Income | – | – | 100,000 |
| **12,564,000** | **Total Revenue** | **12,054,000** | **11,604,000** | **11,704,000** |
| **12,564,000** | **Total Expenditure** | **12,054,000** | **11,604,000** | **11,704,000** |
| | **PROBLEM GAMBLING** | | | |
| | Revenue | | | |
| 1,480,000 | Levy | 1,680,000 | 1,680,000 | 1,680,000 |
| - | Interest | 9,000 | 9,000 | 9,000 |
| **1,480,000** | **Total Revenue** | **1,689,000** | **1,689,000** | **1,689,000** |
| **1,480,000** | **Total Expenditure** | **1,689,000** | **1,689,000** | **1,689,000** |
| | **ALL OTHER** | | | |
| | Revenue | | | |
| 13,797,395 | Crown income | 12,884,395 | 11,884,395 | 11,444,395 |
| 90,000 | Interest | 54,000 | 54,000 | 54,000 |
| 315,000 | Other Income | – | 170,000 | – |
| **14,202,395** | **Total Revenue** | **12,938,395** | **12,108,395** | **11,498,395** |
| **13,982,395** | **Total Expenditure** | **12,938,395** | **12,108,395** | **11,498,395** |
| **220,000** | **Surplus** | **–** | **–** | **–** |
| | | | | |
| **28,246,395** | **Grand Total Revenue** | **26,681,395** | **25,401,395** | **24,891,395** |
| **28,026,395** | **Grand Total Expenditure** | **26,681,395** | **25,401,395** | **24,891,395** |
| 220,000 | **Surplus** | **–** | **–** | **–** |

## HEALTH PROMOTION AGENCY
## STATEMENT OF CHANGES IN EQUITY
## BUDGET 2013 – 2016

| Forecast 2012/13 $ | | Budget 2013/14 $ | Budget 2014/15 $ | Budget 2015/16 $ |
|---|---|---|---|---|
| 2,438,000 | Opening public equity | 2,658,000 | 2,658,000 | 2,658,000 |
| 220,000 | Net surplus/(deficit) for the year | – | – | – |
| **2,658,000** | **Closing public equity** | **2,658,000** | **2,658,000** | **2,658,000** |

## HEALTH PROMOTION AGENCY
## STATEMENT OF FINANCIAL POSITION
## BUDGET 2013 – 2016

| Forecast 2012/13 $ | | Notes | Budget 2013/14 $ | Budget 2014/15 $ | Budget 2015/16 $ |
|---|---|---|---|---|---|
| | **CURRENT ASSETS** | | | | |
| 498,000 | Cash and Bank | | 518,000 | 490,000 | 430,000 |
| 4,600,000 | Short Term Deposits | 1 | 4,500,000 | 4,400,000 | 4,400,000 |
| 900,000 | Accounts Receivable | 2 | 900,000 | 900,000 | 900,000 |
| **5,998,000** | **Total Current Assets** | | **5,918,000** | **5,790,000** | **5,730,000** |
| | **LESS CURRENT LIABILITIES** | | | | |
| 3,220,000 | Accounts Payable | 3 | 3,150,000 | 3,030,000 | 2,970,000 |
| 150,000 | Sponsorship | | 150,000 | 152,000 | 152,000 |
| 220,000 | Employee Entitlements | 4 | 220,000 | 225,000 | 230,000 |
| **3,590,000** | **Total Current Liabilities** | | **3,520,000** | **3,407,000** | **3,352,000** |
| **2,408,000** | **NET CURRENT ASSETS (WORKING CAPITAL)** | | 2,398,000 | 2,383,000 | 2,378,000 |
| | **NON-CURRENT ASSETS** | | | | |
| 250,000 | Fixed Assets | 5 | 260,000 | 275,000 | 280,000 |
| 250,000 | **Total Non-Current Assets** | | 260,000 | 275,000 | 280,000 |
| **2,658,000** | **NET ASSETS** | | **2,658,000** | **2,658,000** | **2,658,000** |
| | **ACCUMULATED FUNDS** | | | | |
| 2,438,000 | Accumulated Funds | | 2,658,000 | 2,658,000 | 2,658,000 |
| 220,000 | Net Surplus/(Deficit) | | – | – | – |
| **2,658,000** | **TOTAL ACCUMULATED FUNDS** | | **2,658,000** | **2,658,000** | **2,658,000** |

**Notes:-**

1. Short Term Deposits represent the balance of funds on term deposit. All deposits will mature within 12 months. Current Term Deposits are deposited with ANZ, BNZ and ASB in accordance with HPA's investment policy.
2. Includes levies collected by NZ Customs.
3. Includes Sundry Creditors, accrued expenditure, salary accrual and taxes.
4. Annual and Long Service Leave.
5. Fixed Assets represent net book value, i.e. cost less provision for accumulated depreciation.

# Statement of accounting policies

## Reporting Entity

The Health Promotion Agency (HPA) is a Crown entity as defined by the Crown Entities Act 2004 and is based in Wellington, New Zealand, with offices in Auckland and Christchurch. As such, HPA's ultimate parent is the New Zealand Crown.

HPA has an overall function to lead and support activities for the following purposes:

- promoting health and wellbeing and encouraging healthy lifestyles
- preventing disease, illness and injury
- enabling environments that support health and wellbeing and healthy lifestyles
- reducing personal, social and economic harm.

It also has functions specific to providing advice and research on alcohol issues.

HPA has designated itself as a public benefit entity for the purposes of New Zealand equivalents to International Financial Reporting Standards (NZ IFRS).

## Basis of Preparation

### STATEMENT OF COMPLIANCE

The forecast financial statements of HPA are prepared in accordance with the requirements of the Crown Entities Act 2004, which includes the requirement to comply with New Zealand Generally Accepted Accounting Practice (NZ GAAP).

The forecast financial statements comply with NZ IFRS, and other applicable Financial Reporting Standards, as appropriate for public benefit entities.

### MEASUREMENT BASE

The forecast financial statements are prepared on a historical cost basis.

Functional and presentation currency in the financial statements is New Zealand dollars.

## Significant Accounting Policies

### REVENUE

Revenue is measured at the fair value of consideration received or receivable.

**Interest**
Interest income is recognised using the effective interest method.

### LEASES

**Operating leases**
Leases that do not transfer substantially all the risks and rewards incidental to ownership of an asset to HPA 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 statement of financial performance.

HPA leases office equipment and premises.

### CASH AND CASH EQUIVALENTS

Cash and cash equivalents include cash on hand and deposits on call.

### DEBTORS AND OTHER RECEIVABLES

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

## INVESTMENTS

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.

For bank deposits, impairment is established when there is objective evidence that HPA will not be able to collect amounts due according to the original terms of the deposit.

Significant financial difficulties of the bank, probability that the bank will enter into bankruptcy, and default in payments are considered indicators that the deposit is impaired.

## PROPERTY, PLANT AND EQUIPMENT

Property, plant and equipment consist of artwork, leasehold improvements, furniture and office equipment, and motor vehicles.

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

### Additions

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 HPA and the cost of the item can be measured reliably.

Where an asset is acquired at no cost, or for a nominal cost, it is recognised at fair value when control over the asset is obtained.

### Disposals

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 statement of financial performance.

### Subsequent costs

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 HPA 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 Statement of Financial Performance as they are incurred.

### Depreciation

Depreciation is provided on a straight-line basis on all property, plant and equipment, other than land, 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 are estimated as follows:

| | | |
|---|---|---|
| Furniture and Fittings | 10 years | 10% |
| General Office Equipment | 5 years | 20% |
| Computer Equipment | 3 years | 33.3% |
| Leasehold Improvements* | 3 years | 33.3% |
| Motor Vehicles | 5 years | 20% |

*Leasehold improvements are depreciated over the unexpired period of the lease or the estimated remaining useful lives of the improvements, whichever is the shorter.

The residual value and useful life of an asset are reviewed, and adjusted if applicable, at each financial year-end.

## INTANGIBLE ASSETS

### Software acquisition and development

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

Costs that are directly associated with the development of software for internal use by HPA are recognised as an intangible asset.

Staff training costs are recognised as an expense when incurred.

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

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

### Amortisation

The carrying value of an intangible asset with a finite life is amortised on a straight-line basis over its useful life. 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 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% |
| Developed Computer Software | 4 years | 25% |

### 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.

Value in use is depreciated replacement cost for an asset where the future economic benefits or service potential of the asset are not primarily dependent on the asset's ability to generate net cash inflows and where HPA would, if deprived of the asset, replace its remaining future economic benefits or service potential.

If an asset's carrying amount exceeds its recoverable amount, the asset is impaired and the carrying amount is written down to the recoverable amount. For re-valued assets, the impairment loss is recognised against the revaluation reserve for that class of asset. Where that results in a debit balance in the revaluation reserve, the balance is recognised in the statement of financial performance.

For assets not carried at a re-valued amount, the total impairment loss is recognised in the statement of financial performance.

## 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 HPA expects to be settled within 12 months of balance date are measured at nominal values based on accrued entitlements at current rates of pay.

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

HPA 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.

#### Defined contribution schemes

Obligations for contributions to KiwiSaver and ASB Group Master Trust are accounted for as defined contribution schemes and are recognised as an expense in the statement of financial performance as incurred.

#### Defined benefit schemes

HPA makes contributions to the ASB Group Master Trust Scheme (the scheme), which is a multi-employer defined benefit scheme.

Insufficient information is available to use defined benefit accounting, as it is not possible to determine, from the terms of the scheme, the extent to which the surplus/deficit will affect future contributions by individual employers, as there is no prescribed basis for allocation.

The scheme is therefore accounted for as a defined contribution scheme.

HPA recognises a provision for future expenditure of uncertain amount or timing when there is a present obligation (either legal or constructive) as a result of a past event, it is probable that expenditures will be required to settle the obligation and a reliable estimate can be made of the amount of the obligation.

Provisions are measured at the present value of the expenditures expected to be required to settle the obligation using a pre-tax discount rate that reflects current market assessments of the time value of money and the risks specific to the obligation. The increase in the provision due to the passage of time is recognised as a finance cost.

### TAXATION

#### Goods and services tax (GST)

All items in the financial statements are presented exclusive of GST, except for 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 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 Statement of Cash Flows.

Commitments and contingencies are disclosed exclusive of GST.

#### Income tax

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

### FOREIGN CURRENCY TRANSACTIONS

Foreign currency transactions are translated into New Zealand dollars using the exchange rates prevailing at the dates of the transactions. Foreign exchange gains and losses resulting from the settlement of such transactions are recognised in the Statement of Financial Performance.

### GRANTS AND FUNDING

Contract commitments are recorded on a monthly basis. Specific allocations against future years' revenue are recorded in the Statement of Commitments. Funds are sometimes paid by instalments to meet the cash flow requirement of the programme as determined by the funding agreement.

### BUDGET FIGURES

The budget figures have been prepared in accordance with NZ IFRS, using accounting policies that are consistent with those adopted for the preparation of the forecast financial statements.

## Critical Accounting Estimates and Assumptions

In preparing these financial statements, HPA 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. The estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are discussed below:

### PROPERTY, PLANT AND EQUIPMENT USEFUL LIVES AND RESIDUAL VALUE

At each balance date HPA 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 HPA to consider a number of factors such as the physical condition of the asset, expected period of use of the asset by HPA, 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 statement of financial performance, and carrying amount of the asset in the Statement of Financial Position.

HPA 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.

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

## Critical Judgements in Applying HPA's Accounting Policies

Management has exercised the following critical judgements in applying HPA's accounting policies.

### LEASES CLASSIFICATION

Determining whether a lease agreement is a finance or an operating lease requires judgement as to whether the agreement transfers substantially all the risks and rewards of ownership to HPA.

Judgement is required on various aspects that include, but are not limited to, the fair value of the leased asset, the economic life of the leased asset, whether or not to include renewal options in the lease term and determining an appropriate discount rate to calculate the present value of the minimum lease payments. Classification as a finance lease means the asset is recognised in the statement of financial position as property, plant and equipment, whereas for an operating lease no such asset is recognised.

HPA has exercised its judgement on the appropriate classification of equipment leases and has determined a number of lease arrangements are operating leases.

## Changes in Accounting Policies

The accounting policies set out above are applied consistently to all periods presented in these forecast financial statements.

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health promotion agency

June 2013