Health Promotion Agency

Statement of Performance Expectations

2015/16

health promotion agency

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New Zealand
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June 2015

CONTENTS

FOREWORD

We are pleased to present the Health Promotion Agency's (HPA's) Statement of Performance Expectations for 2015/16. It outlines HPA's work programme for the next financial year.

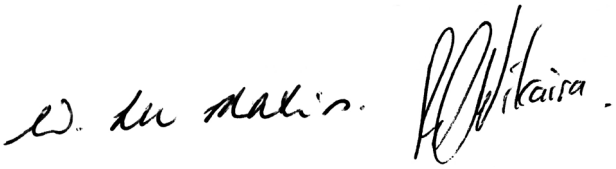
HPA will build on the progress we have already made to ensure New Zealanders are inspired to lead healthier lives. HPA's work spans a range of major issues including alcohol, tobacco control, mental health, immunisation, nutrition and physical activity, rheumatic fever, minimising gambling harm and skin cancer prevention. We also manage the development and distribution of national health education resources. In addition, HPA is often called on at short notice to provide tactical health promotion, communications and marketing support to other government-led initiatives.

We continue to work hard to make a difference, and in times of financial restraint we are mindful of the need to achieve efficiencies in our work. We aim to provide best value for money for the Government by seeking ongoing improvements, focusing our activities where we can make the most impact and working in partnership with government agencies and others.

Over the coming financial year HPA will continue building relationships and partnerships with others in the health sector, maximising our contribution to Government's priority areas and working towards achieving our long-term strategic objectives. HPA is also working in settings such as workplaces and sports and in the education sector to help spread key messages where New Zealanders live, work and play.

We pride ourselves on being responsive to the needs of communities, being able to connect and engage with individuals and groups across the government and non-government sectors, and being innovative in our approaches. HPA will continue to promote health and wellbeing through education, marketing and communications and provide policy advice and research to assist and inform others.

The Board looks forward to another successful year.

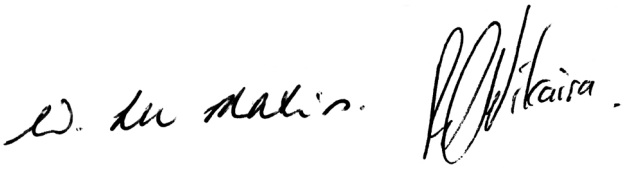


Dr Lee Mathias
Chairman
Health Promotion Agency

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 Performance Expectations for HPA. 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 HPA.



Dr Lee Mathias
Chairman
Health Promotion Agency
26 May 2015

Rea Wikaira
Deputy Chairman
Health Promotion Agency
26 May 2015

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

Dr Monique Faleafa

Katherine Rich

Professor Grant Schofield

Jamie Simpson

The Chief Executive is Clive Nelson.

ABOUT THE HEALTH PROMOTION AGENCY

HPA was established on 1 July 2012. It has a central role in the health sector. HPA continues to build strong relationships with many other organisations providing leadership, acting as a catalyst for change, and encouraging collaboration.

HPA's vision is that New Zealanders realise their potential for good health and improved quality of life and New Zealand's economic and social development is enhanced by people leading healthier lives.

HPA's mission is to inspire all New Zealanders to lead healthier lives.

HPA has a unique position:

- As a small Crown entity HPA seeks to be agile and effective in its work.
- HPA is a multi-disciplinary organisation, with particular skills in marketing and communications.
- HPA is well connected to each of the many sectors it works in. HPA seeks to build strong working relationships with government and non-government organisations, and with many different communities in which New Zealanders live, work and play.

Legislative mandate

HPA is a Crown entity established by the New Zealand Public Health and Disability Act 2000.

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 that 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. In delivering its alcohol-specific functions, HPA must have regard to government policy if so directed by the Minister.

HPA is funded from Vote Health and from a levy on alcohol produced or imported for sale in New Zealand. Levy funding is used for specific purposes.

Contributing to government priorities

As a Crown entity, HPA's planning is guided by the Minister of Health's annual Letter of Expectations. The Letter of Expectations for 2015/16 emphasises the need for a team approach across the health and disability system, and building on the progress that has been made across the state sector to achieve results for New Zealanders. The Minister also notes that the Ministry of Health is planning to update and refresh the New Zealand Health Strategy, and HPA will contribute to this work.

In addition to the 2015/16 ministerial expectations of all health Crown entities, HPA has expectations from the Minister of Health that relate directly to its work. These are that HPA will:

- complete work on HPA's four-year project to deliver against the savings target set by Cabinet, while continuing to contribute to improving health outcomes
- actively work across the sector and with other sectors to maximise HPA's contribution to the Government's priority areas, particularly the health targets, Healthy Families New Zealand and mental health. This will see HPA facilitating strategic relationships to engage with New Zealanders where they live, work and play
- work to identify, as the Crown's preferred provider of health promotion activities, any new areas where HPA can leverage off its strengths to bring value.

HPA will continue to support health sector priorities, including government health targets and in particular the targets of increased immunisation and better help for smokers to quit.

Two of the Government's 10 Better Public Services results areas relate specifically to health and HPA – increasing immunisation and reducing rheumatic fever.[1]

HPA contributes to other cross-government work programmes such as:

- interagency policy work on family violence
- the implementation of a revised national drug policy
- the Ministerial Forum on Alcohol Advertising and Sponsorship
- Healthy Families New Zealand.

HPA aims to ensure financial sustainability by setting tight, realistic budgets and practising careful management.

Reporting

HPA's corporate reporting requirements are to produce:

- a Statement of Intent
- a Statement of Performance Expectations
- four quarterly performance reports of financial and operational performance
- an Annual Report.

HPA meets with, and reports regularly to, the Minister of Health and the Associate Ministers of Health.

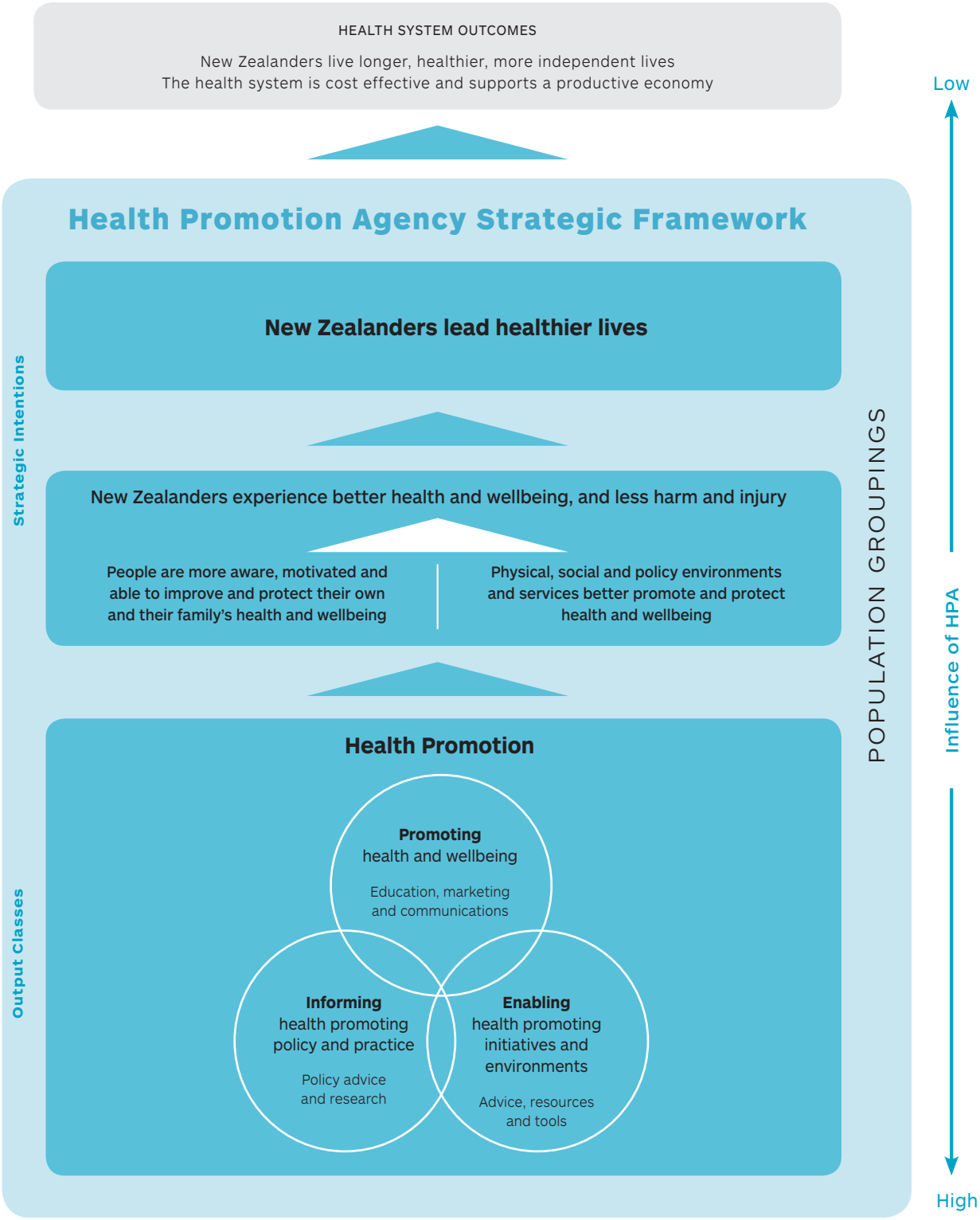
HPA strives to ensure strong working relationships and open communication with its Ministers and with its monitoring agency, the Ministry of Health. This includes maintaining a 'no surprises' policy, where early communication is provided about any material or significant events, transactions and other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

HPA has an Output Agreement with the Minister of Health.

HPA also has a Memorandum of Understanding with the Ministry of Health, which outlines how the parties work together.

1 Available at: http://www.ssc.govt.nz/bps-results-for-nzers

Strategic Framework



The figure above shows HPA's strategic framework. It outlines the strategic intentions that HPA is contributing to and HPA's output classes. HPA will focus its efforts on population groupings disproportionately impacted by harm, injury, illness and disease.

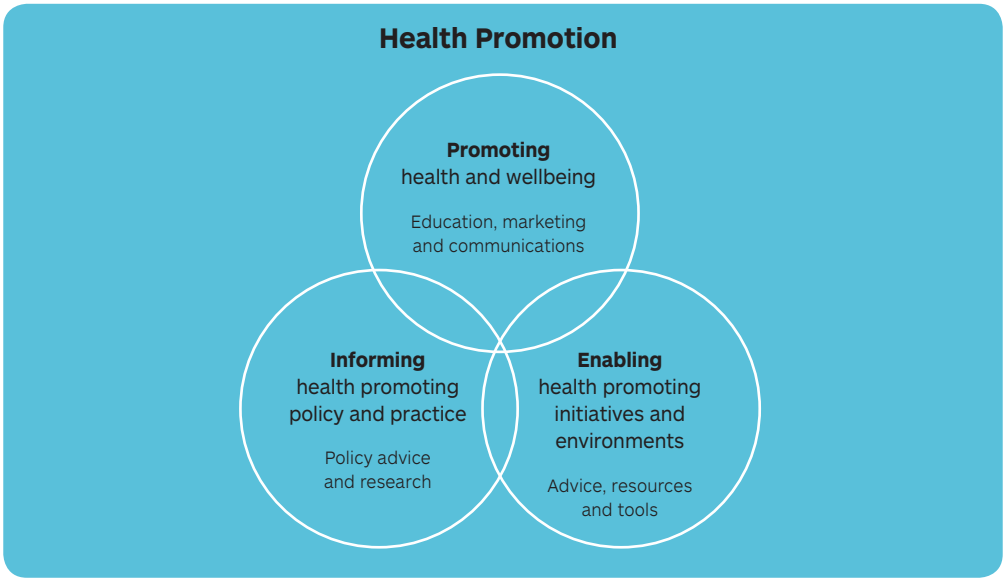
THE STRATEGIC FRAMEWORK

Strategic intentions

HPA aims to contribute to the achievement of national health priorities by helping New Zealanders experience better health and wellbeing, and less harm and injury. HPA works to provide knowledge, motivation and skills, and to help improve the physical, social and policy environments where people live, work and play.

Output classes

HPA has three interconnected output classes. While the nature of the work in each one differs, together the three output classes help achieve HPA's strategic intentions.



Output class one – Promoting health and wellbeing

EDUCATION, MARKETING AND COMMUNICATIONS

HPA designs and delivers a range of education, marketing and communications strategies, including national media campaigns and associated activities and resources.

Communicating health messages to priority audiences and working with particular communities are major parts of the public face of HPA. Some population groups within New Zealand have poorer health outcomes compared with other New Zealanders. Identifying and focusing health promotion activities to help improve the health and wellbeing of these groups, in particular for Māori, Pacific and youth as priority audiences, is a crucial focus for HPA. In some work programmes there are considerable gains to be made by targeting specific populations.

Output class two – Enabling health promoting initiatives and environments

ADVICE, RESOURCES AND TOOLS

Working with and through others greatly extends HPA's ability to inspire New Zealanders to lead healthier lives. HPA provides advice, resources and tools to a wide range of individuals, groups and organisations. To achieve this, HPA:

- works with communities to help them develop local solutions to local problems
- offers specialist knowledge and undertakes work to improve how health promotion is incorporated in workplace, sport and education settings.

Strong partnerships are key to HPA's success. HPA works closely with a large number of organisations, including:

- Ministry of Health
- public health units
- primary health services
- policy makers
- the community and voluntary sector
- central government agencies
- education sector agencies
- media
- district health boards
- primary health organisations
- health professional associations
- non-government organisations
- territorial authorities
- businesses and employers
- academics and researchers.

HPA has Memoranda of Understanding with an increasing number of organisations, both government and non-government.

Output class three – Informing health promoting policy and practice

POLICY ADVICE AND RESEARCH

HPA provides policy advice to inform decision making and policy to improve New Zealanders' health and wellbeing and to reduce injury and other harm. HPA offers specialist knowledge and expertise in developing and delivering successful, nationally integrated health promotion and harm reduction strategies. Policy activities include:

- informing the development of public 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
- advising on best health promotion practice.

Through its research programme, HPA provides in-depth understanding of the population groups that its health promotion initiatives are trying to reach and influence, and advice on strategies that are most effective.

HPA is undertaking research to:

- monitor key health indicators, behaviours and attitudes
- inform and evaluate activities, programmes and initiatives
- gather intelligence and identify emerging health issues.

WORK PROGRAMME

HPA is increasingly working across population groups such as youth and across settings such as workplaces, acting as a catalyst for change spanning a range of major issues including:

- alcohol
- health education
- immunisation
- nutrition and physical activity
- skin cancer prevention
- minimising gambling harm
- mental health
- rheumatic fever
- tobacco.

HPA is often asked by its Ministers and the Ministry of Health to provide tactical health promotion, communications and marketing support to other government-led public health initiatives. It is common for these requests to come at short notice and after the start of the financial year. Examples from previous financial years include the following:

- Rheumatic fever campaigns in October 2013 and May/June 2014 increased awareness about rheumatic fever and the link between sore throats and rheumatic fever.
- Since 2012/13, HPA has been asked to enhance and build on the 2013, 2014 and 2015 influenza campaigns being run by the National Influenza Specialist Group (NISG).

While it is difficult to predict exactly what will be requested, HPA will report on these additional activities in its annual report.

Alcohol

Most New Zealanders drink alcohol and many drink at moderate levels. However, the 2012/13 New Zealand Health Survey found that half of drinkers had drunk to intoxication at least once in the last year and 8% reported drinking to intoxication at least weekly, with those doing so more likely to be in the younger age groups (15 to 34-years-old). Drinkers in these younger age groups were also more likely to experience alcohol-related harm to their physical and mental health and more alcohol-related injuries. About one in five women who were pregnant in the last 12 months had drunk alcohol at some point, with one in six continuing to drink during their pregnancy. More than two-thirds (68%) of pregnant women who had ever drunk alcohol received advice not to drink alcohol during pregnancy.[2]

The national alcohol moderation marketing campaign continues to be developed. Targeted primarily at 18 to 35-year-old risky drinkers who are open to change, it encourages drinkers to ease up and supports those people who choose not to drink. It also contributes to changing social norms around heavy drinking at large events and in other settings and provides a context for community action on alcohol.

The alcohol and pregnancy work programme that commenced in 2014/15 will gather momentum in 2015/16. Marketing and communication activities will primarily target young women who drink moderately to hazardously, while other activities will support health professionals to deliver a routine, consistent and effective response to women about drinking alcohol during pregnancy.

HPA's alcohol work will also include policy advice in areas such as the implementation of a revised national drug policy, the development of the Ministry of Health's Fetal Alcohol Spectrum Disorder (FASD) Action Plan, interagency family violence policy work, and other alcohol-related policy work at the central and local government levels.

2 Ministry of Health. (2015). *Alcohol Use 2012/13: New Zealand Health Survey.* Wellington: Ministry of Health.

Drinking alcohol from a young age is strongly associated with the development of alcohol-related problems later in life.[3] HPA will encourage and support under 18-year-olds to delay drinking alcohol until they are older. This work will be supported by other activities that discourage the social supply of alcohol to under 18-year-olds. Activities will primarily focus on encouraging and supporting community and youth led action with marketing support.

HPA will provide advice, resources and tools to support the effective operation of the Sale and Supply of Alcohol Act 2012. It will also work with stakeholders to encourage the improved management of alcohol at large events and in licensed premises, workplaces, marae and public places.

HPA will continue to work with communities to increase their ability to take action to reduce the alcohol-related harm they see around them. This will include encouraging them to participate in decision making around how alcohol is sold, supplied and consumed in their neighbourhood.

It is important that stakeholders, including the New Zealand public, are provided with evidence-based knowledge and expert advice about alcohol. HPA will provide a range of alcohol-related information, tools and resources that are accessible, usable and up to date.

In line with its statutory responsibilities, HPA will undertake research and monitoring of alcohol use, behaviour, attitudes and associated problems. Interventions will also be evaluated.

Tobacco

Smoking prevalence rates have fallen across most age groups. However, the smoking rates of young adults aged 18 to 24 years are still higher at 23.5% for current smokers (males 26.5%, females 20.6%) than the overall population level of 18% for current smokers and 16% for daily smokers.[4] The latest New Zealand Health Survey (2014) reported a significant drop of 36% in current smoking rates for the 15 to 19 age range; yet for 20 to 24-year-olds this has reduced by only 7%.[5]

Reducing smoking among Māori, particularly Māori females, is a major focus. Current smokers have not significantly shifted over recent surveys between 2006 (42%) and 2012 (39%). For Māori women, current smokers still number 42%.[6] Recent research has placed the percentage of Māori pregnant women who smoke at 42.9%.[7]

HPA is one of many organisations working toward the Government's goal that New Zealand be smokefree by 2025 with a smoking prevalence of less than 5% of the population. HPA will contribute to this change in smoking prevalence by focusing on at-risk population groups, young adults and youth, and providing support to the sector through a range of resources, information and tools eg, hosting regional seminars and providing community grants.

HPA will continue with its Stop Before You Start campaign and other activities that encourage young adults (18 to 24-years-old) to remain smokefree. Other activities targeting youth (12 to 17-years-old) include the sponsorship of Smokefreerockquest and Smokefree Pacifica Beats, partnering with organisations such as the New Zealand School Trustees Association, and supporting events such as the New Zealand Association of Intermediate and Middle Schooling (AIMS) Games.

Minimising Gambling Harm

Harmful gambling occurs when people, and often their families or communities, experience harm or distress because of gambling. It can affect health, relationships, finances, employment and children, and the harms from gambling can extend to the entire community.

The National Gambling Study 2012 showed that, of New Zealanders aged 18-years-old and over, 0.7% (23,504 people) were 'problem gamblers' and an additional 1.8% were identified as 'moderate-risk' gamblers. This represented about 60,000 people in New Zealand who were gambling at levels that were likely to be leading to negative consequences. In addition, 5% of past year gamblers, were classified as 'low-risk' gamblers, indicating that they were already experiencing some low levels of harm and would be potentially at risk of further problems in the future.

3 National Health and Medical Research Council. (2009). *Australian guidelines to reduce health risks from drinking alcohol.* Canberra: NHMRC.

4 Daily smoking rates for 18 to 24-year-olds is 20% (21.9% – males, 18.1% – females).

5 Ministry of Health. (2014). *Tobacco use 2012/13: New Zealand Health Survey.* Wellington: Ministry of Health.

6 Note that differences in smoking prevalence are reported between the New Zealand Health Survey (stated above) and the New Zealand Census, which shows a greater reduction in Māori smoking rates.

7 New Zealand College of Midwives. (2012). Smoking prevalence trends: An analysis of smoking at pregnancy registration and at discharge from a midwife Lead Maternity Carer, 2008 to 2010. *New Zealand College of Midwives Journal,* 49.

Although a relatively small proportion of the population have, or are at-risk of developing, a serious gambling problem, a number of surveys provide indicators of the wider impact of gambling on individuals and their families/whānau:

- Of the population aged 18-years-old and over, an estimated 8% of adults reported that someone else's gambling affected them personally.
- 11.5% 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.
- 8% 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.

People who play Electronic Gaming Machines (EGMs) are at higher risk of harm than those who engage in other forms of gambling. The National Gambling Study 2012 showed that those aged between 25 and 54 were at least twice as likely to be 'problem gamblers' and those in the younger age groups (18 to 44) are more likely to be 'moderate-risk' gamblers. The same survey also shows the burden of problem gambling in New Zealand's main ethnic population groups, with Māori and Pacific adults more likely to be problem gamblers than adults in the total population. For Māori, 6.2% are current problem or 'moderate-risk gamblers' compared with 8% of Pacific Islanders, 3% of Asians and 1.8% of European/Other.[8]

HPA's Choice Not Chance campaign increases awareness of the early signs of harmful gambling and encourages people to seek help and take positive action early, both for themselves and for others they care about. Activities include a range of targeted advertising and messaging across a number of channels including traditional media and online. While these activities focus on the prevention/early intervention end of the spectrum, the messages also reach those who are already problem gamblers, as well as the broader public. HPA also seeks to help create a safer gambling environment, by promoting venue-based messages and supporting venues to meet legal responsibilities and implement best practice.

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 will continue to support the sector in delivering these messages locally and provide them with a range of resources and tools and support for other activities such as Gamblefree Day.

Mental Health

HPA has two mental health programmes.

THE NATIONAL DEPRESSION INITIATIVE

It is common for people in New Zealand to experience mental illness, with 46.6% of the population likely to develop a mental health disorder at some time in their lives. In relation to common mental health disorders, 5.7% of New Zealanders (aged 16 and over) are predicted to experience a depression over a 12-month period and 14.8% of the population are likely to experience an anxiety disorder.[9] Approximately half of the people with a mood disorder and a quarter of the people with anxiety disorder will have both depression and anxiety.

The National Depression Initiative (NDI) works to reduce the impact of depression and anxiety on the lives of New Zealanders by strengthening the individual, family and social factors that help them to recognise and meet the challenge of depression, and to build wellbeing and resilience. The NDI programme consists of national advertising, the depression.org website, which includes information and an online self-help tool (the Journal), a free telephone support line, and other supporting resources. Sir John Kirwan is the ambassador of this programme and is a strong public advocate. The NDI includes a youth-specific programme stream, which consists of thelowdown.co.nz website, and accompanying social media and online support. HPA will enhance these tools and adopt a life-course approach to meet the needs of specific population groups that have higher risk of mental health disorders.

HPA will provide leadership and support for communities to increase their responsiveness to depression and anxiety and increase community wellbeing. Activities will include supporting the integration of NDI with primary health care, promoting mentally healthy workplaces and developing relationships with other organisations to help promote wellbeing.

8 Auckland University of Technology. (2012). *New Zealand 2012 National Gambling Study: Gambling harm and problem gambling.* Auckland: Gambling and Addictions Research Centre.

9 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.

LIKE MINDS, LIKE MINE

The Like Minds, Like Mine programme works towards a socially inclusive New Zealand that is free of stigma and discrimination towards people with experience of mental illness/distress. Strategic development of the programme is supported through a joint agency group comprising the HPA as the national lead agency and the Ministry of Health in the role of 'strategic responsible owner'. Through a combination of a media campaign and community activity, Like Minds, Like Mine promotes inclusive attitudes, behaviours and structures in the New Zealand social environment.

The programme will guide and support community action to increase the capacity of social environments to remove barriers for those who are most excluded. A stream of work to support health professionals in their practice with people who are experiencing mental distress will be established. Through active links with peer programmes internationally, Like Minds, Like Mine will contribute to the body of knowledge for anti-stigma programmes.

Nutrition and Physical Activity

Obesity is one of the most important modifiable risk factors for a number of major diseases, including type 2 diabetes mellitus, ischaemic heart disease, ischaemic stroke and several common cancers. Obesity rates in New Zealand are rising and almost one in three adults (aged 15 years and over) are obese (31%) and a further 34% are overweight. Obesity prevalence of New Zealand children continues to increase, with recent data showing 22% of children are overweight and 11% are obese.[10]

HPA's nutrition and physical activity programme aligns with and supports government initiatives such as the Health Star Rating (HSR) nutrition labelling programme and Healthy Families New Zealand. HPA's nutrition and physical activity programme promotes healthy eating and recreation solutions through a variety of settings such as workplaces and directly to families.

The HSR is a voluntary programme using a star rating scale on packaged foods to identify those with better nutritional value. Foods displaying the HSR are starting to appear on supermarket shelves. HPA will develop and deliver a consumer marketing and education campaign during 2015/16.

Healthy Families NZ aims to improve people's health where they live, work and play. A significant focus for this programme is obesity prevention. HPA will develop an Achievement Programme for Healthy Families NZ during 2015. The Achievement Programme will provide a common framework for evidence-based action in community settings, and provide data on reach and impact of settings-based health promotion initiatives across Healthy Families NZ communities.

During 2015, it is anticipated the Ministry of Health will release updated national Eating and Activity Guidelines. These guidelines provide the evidence base for HPA's nutrition and physical activity programme. HPA will promote the guidelines to the public and health professionals through our programmes and networks.

Skin Cancer Prevention

Skin cancer is by far the most common cancer affecting New Zealanders. It has been estimated that all types of skin cancer account for just over 80% of all new cancers.[11] Melanoma was the fourth most commonly registered cancer in 2010, accounting for all registrations, and the sixth most common cause of death from cancer.[12]

HPA's Skin Cancer Prevention programme is informed by the sector-led New Zealand Skin Cancer Primary Prevention and Early Detection Strategy 2014 to 2017, which aims to reduce the incidence and impact of skin cancer.[13] This strategy guides HPA's activities.

HPA's Skin Cancer Prevention programme aims to encourage New Zealanders to practise sun safe behaviours and reduce excessive exposure to ultraviolet radiation. To achieve this, HPA promotes the Sun Protection Alert (developed in association with MetService and NIWA), which provides daily information that enables New Zealanders to identify the times in their own region when they should use sun protection. HPA is also developing tools and resources and supporting national conferences such as the 2015 Melanoma Summit, to enable primary health care professionals to provide the most appropriate advice on skin cancer prevention to New Zealanders.

10 Ministry of Health. (2013). *New Zealand Health Survey: Annual update of key findings 2012/13.* Wellington: Ministry of Health.
11 O'Dea, D. (2009). *The Costs of Skin Cancer to New Zealand.* Wellington: Cancer Society of New Zealand.
12 Ministry of Health. (2014). *Cancer: New registrations and deaths 2011.* Wellington: Ministry of Health.
13 Available at: http://sunsmart.org.nz

Immunisation

Marketing and communications assistance will be provided to support the Ministry of Health to achieve the aims of increased immunisations to prevent diseases and to achieve high coverage to prevent outbreaks and epidemics.[14] This includes working with the Ministry of Health on strategy and resource development as well as promotions to increase target audience exposure to immunisation messages. Activities include:

- a campaign focused on eight-month-olds being fully immunised on time. As of December 2014, immunisation results continue to progress well, with 93.5% of eight-month-olds fully immunised[15]
- Immunisation Week
- a campaign to remind youth (16 and 17-year-olds) to check that their immunisations are up to date
- developing resources for the Year 7 and Year 8 school immunisation programme
- developing disease-specific resources eg, meningococcal disease and measles.

HPA also supports the development of accurate health education material for the public on immunisation issues.

Health Education Catalogue

Health education resources aim to improve health literacy so that people can manage and improve their health and wellbeing by having free access to preventive public health information. HPA will continue to improve the health education catalogue of resources by implementing enhancements and efficiencies that improve the users' experience and make best use of the budget to meet users' needs. The establishment of a solid platform will ensure the health education catalogue is fully prepared for future technological changes and able to easily adapt and respond innovatively. HPA will work with providers responsible for the development of health education resources produced by the Ministry of Health and other agreed agencies, on a wide range of public health topics and expand the catalogue to fill any health information gaps. The resources are distributed through the health education website and District Health Board Authorised Providers to health service providers and professionals and the general public. HPA's role is to ensure that the health education resources catalogue and website contribute to improved health literacy by being easily understandable, accessible, efficient, and reflect health priorities and any emergent needs.

Research

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.

HPA also 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-old and over, and parents and caregivers of 5 to 16-year-olds. The HLS collects information relating to alcohol, tobacco control, sun safety, problem gambling and healthy eating. The survey has been conducted every two years since 2008.
- 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, and monitors the broad spectrum of risk and protective factors that relate to smoking uptake among young people. The NZYTM comprises the Action on Smoking and Health New Zealand (ASH) Year 10 Snapshot (annual, with approximately 30,000 respondents) and HPA's Youth Insights Survey (YIS) (biennial, with approximately 3,000 respondents). HPA manages the NZYTM as a whole, provides ASH with the Snapshot data, and undertakes analysis and dissemination of the YIS.

14 This includes the Ministry of Health's target of 95% of children being fully immunised by eight months of age.

15 Ministry of Health. (2015). *Infant immunisation progress.* Available at: http://www.health.govt.nz/about-ministry/what-we-do/strategic-direction/better-public-services/infant-immunisation-progress

Output class one performance indicators

PROMOTING HEALTH AND WELLBEING – EDUCATION, MARKETING AND COMMUNICATIONS

Activity	Performance indicators
Alcohol	
Activity: Alcohol moderation initiatives	**1.1** Proportion of target audience helped or encouraged to say 'no' when they didn't want a drink is maintained or improved (17% in 2012/13). Source – Campaign Monitor.
Alcohol and pregnancy	**1.2** Initial alcohol and pregnancy campaign delivered by December 2015 and evaluated. Source – Campaign Monitor.
Tobacco	
Young adult initiatives (17 to 24-year-olds)	**1.3** Develop and implement smoking prevention activities targeting young adults (17 to 24-year-olds) by December 2015.
Gambling Harm	
Choice Not Chance Campaign	**1.4** Develop at least two tools and associated resources to meet the needs of specific audiences eg, online gamblers and electronic gaming machine players.
Mental Health	
National Depression Initiative	**1.5** The number of visitors to and the time spent on the websites thelowdown.co.nz and depression.org.nz are maintained or improved. Baseline collected by June 2015. Source – Google Analytics.

Revenue	$12,098,000	**Expenditure**	$12,098,000	**Surplus/(deficit)**	$0

Output class two performance indicators

ENABLING HEALTH PROMOTING INITIATIVES AND ENVIRONMENTS – ADVICE, RESOURCES AND TOOLS

Activity	Performance indicators
Alcohol	
Resources and advice are provided to individuals, communities and organisations to enable them to take action on alcohol	**2.1** At least 75% of stakeholder respondents who have used the resources or received advice indicate satisfaction (top two categories of a five-point scale) with the resources or advice. Quality and quantity indicator. Source – resource users' survey.
Community-led action on alcohol projects	**2.2** All community-led action on alcohol projects are monitored and reported on in accordance with HPA processes and agreed reporting requirements.
Tobacco	
HPA activities and resources support the Smokefree 2025 goal	**2.3** HPA-led activities in support of Smokefree 2025 are developed and delivered, including delivery of at least two tobacco control seminars.
Gambling Harm	
Supporting host responsibility	**2.4** Resources developed by HPA for Class 4 venues are supported by gambling societies/trusts. Source – Sector survey (Department of Internal Affairs) and administration data.
Mental Health	
Like Minds, Like Mine. Effectiveness of programme activation in communities, organisations and workplaces	**2.5** Establish baseline of New Zealanders' attitudes to stigma and discrimination by December 2015. Source – HPA monitoring tools.
Nutrition and Physical Activity	
Promoting healthy family meals, beverage options, first foods and family recreation solutions	**2.6** New or updated online and print resources produced and distributed supporting the Ministry of Health's Eating and Activity Guidelines and aligning with government priorities including prevention of childhood obesity and Healthy Families New Zealand.
Skin Cancer Prevention	
Skin Cancer Prevention activities	**2.7** Activities are undertaken to increase knowledge of risks and benefits from ultraviolet radiation among the public, health professionals and policy makers.

Revenue	$12,949,000	**Expenditure**	$12,949,000	**Surplus/(deficit)**	$0

Output class three performance indicators

INFORMING HEALTH PROMOTING POLICY AND PRACTICE – POLICY ADVICE AND RESEARCH

Activity	Performance indicators
Research	
Attitudes and Behaviour towards Alcohol Survey	**3.1** Alcohol attitudes and behaviour information is collected through a nationally representative survey. Reports for the 2014/15 Attitudes and Behaviour towards Alcohol Survey are published in 2015/16.
New Zealand Smoking Monitor (NZSM)	**3.2** Data from the NZSM is reported to the Ministry of Health.
New Zealand Youth Tobacco Monitor (NZYTM)	**3.3** Data collection for the 2014 Youth Insights Survey is completed (approximately 3,000 respondents), the dataset is retained for analysis, and ongoing analysis is disseminated. **3.4** Data collection for the 2014 ASH Year 10 Snapshot is completed (approximately 30,000 respondents), and the dataset is provided to ASH.
Health and Lifestyles Survey	**3.5** Reports for the 2014/15 Health and Lifestyles Survey are produced in 2015/16.

Revenue	$2,961,000	**Expenditure**	$2,961,000	**Surplus/(deficit)**	$0

FORECAST FINANCIAL STATEMENTS

PROSPECTIVE STATEMENT OF COMPREHENSIVE REVENUE AND EXPENSE

BUDGET 2015 – 2018

SPE Budget 2014/15 $000	Estimated Actual 2014/15 $000		Budget 2015/16 $000	Budget 2016/17 $000	Budget 2017/18 $000
		Revenue			
11,698	11,698	Alcohol levy	11,510	11,510	11,510
14,100	19,909	Funding from the Crown	16,098	16,098	16,098
200	240	Interest	200	200	200
–	–	Other	200	0	200
25,998	**31,847**	**Total revenue**	**28,008**	**27,808**	**28,008**
		Expenditure			
65	65	Audit fees	61	63	65
172	162	Board	172	176	180
118	78	Depreciation	100	102	105
435	384	Equipment, supplies & maintenance	367	375	383
515	498	Occupancy	699	713	728
607	931	Other operating	757	773	789
7,700	8,614	Personnel	8,778	8,945	9,115
16,386	21,115	Programmes	17,074	17,416	17,765
25,998	**31,847**	**Total expenditure**	**28,008**	**27,808**	**28,008**
0	**0**	**Surplus/(deficit)**	**0**	**0**	**0**

Notes:

1 Projected revenue including funding from the Crown will vary as programmes of work change in response to government health targets and priorities. Other revenue includes conference registrations.

2 Projected revenue in 2015/16, 2016/17 and 2017/18 is estimated on programmes of work currently confirmed.

3 Expenditure reflects the savings target set by Cabinet and included in HPA's 2015/16 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	506,000
FY 2013/14	1,466,000
FY 2014/15	2,366,000
FY 2015/16	2,806,000
	7,144,000

5 Personnel costs will vary as programmes of work change in response to government health targets and priorities.

PROSPECTIVE STATEMENT OF COMPREHENSIVE REVENUE AND EXPENSE

BUDGET 2015 – 2018

SPE Budget 2014/15 $000	Estimated Actual 2014/15 $000		Budget 2015/16 $000	Budget 2016/17 $000	Budget 2017/18 $000
		Alcohol			
		Revenue			
11,698	11,698	Levy	11,510	11,510	11,510
50	60	Interest	50	50	50
0	0	Other	100	0	100
11,748	**11,758**	**Total revenue**	**11,660**	**11,560**	**11,660**
11,748	**11,758**	**Total expenditure**	**11,660**	**11,560**	**11,660**
		All other			
		Revenue			
14,100	19,909	Funding from the Crown	16,098	16,098	16,098
150	180	Interest	150	150	150
0	0	Other	100	0	100
14,250	**20,089**	**Total revenue**	**16,348**	**16,248**	**16,348**
14,250	**20,089**	**Total expenditure**	**16,348**	**16,248**	**16,348**
25,998	**31,847**	**Grand total revenue**	**28,008**	**27,808**	**28,008**
25,998	**31,847**	**Grand total expenditure**	**28,008**	**27,808**	**28,008**
0	**0**	**Surplus/(deficit)**	**0**	**0**	**0**

PROSPECTIVE STATEMENT OF CHANGES IN EQUITY

Budget 2015 – 2018

SPE Budget 2014/15 $000		Budget 2015/16 $000	Budget 2016/17 $000	Budget 2017/18 $000
2,658	Balance at 1 July	2,658	2,658	2,658
0	Total comprehensive revenue and expense for the year	0	0	0
2,658		**2,658**	**2,658**	**2,658**

PROSPECTIVE STATEMENT OF FINANCIAL POSITION

Budget 2015 – 2018

SPE Budget 2014/15 $000		Notes	Budget 2015/16 $000	Budget 2016/17 $000	Budget 2017/18 $000
	Assets				
	Current assets				
430	Cash and cash equivalents		430	430	430
4,950	Investments	1	4,000	4,250	4,000
1,267	Receivables	2	2,050	2,000	2,025
6,647	**Total current assets**		**6,480**	**6,680**	**6,455**
	Non-current assets				
282	Property, plant and equipment	5	133	107	81
282	**Total non-current assets**		**133**	**107**	**81**
6,929	**Total assets**		**6,613**	**6,787**	**6,536**
	Liabilities				
	Current liabilities				
3,971	Payables	3	3,610	3,779	3,523
300	Employee entitlements	4	345	350	355
4,271	**Total current liabilities**		**3,955**	**4,129**	**3,878**
2,658	**Net assets**		**2,658**	**2,658**	**2,658**
	Equity				
2,361	Contributed capital		2,658	2,658	2,658
297	Accumulated surplus/(deficit)		–	–	–
2,658	**Total equity**		**2,658**	**2,658**	**2,658**

Notes:

1 Represents the balance of funds on term deposit. All deposits will mature within 12 months. Current term deposits are deposited with ANZ, ASB, BNZ and Westpac.

2 Includes levies collected by NZ Customs.

3 Includes payables, accrued expenditure, salary accrual and taxes.

4 Includes annual and long service leave.

5 Represents net book value, i.e. cost less provision for accumulated depreciation.

NOTES TO THE PROSPECTIVE FINANCIAL STATEMENTS

Reporting entity

HPA is a Crown entity as defined by the Crown Entities Act 2004 and is based in New Zealand, with offices in Wellington, Auckland and Christchurch. The relevant legislation governing HPA's operations includes the Crown Entities Act 2004 and the New Zealand Public Health and Disability Act 2000. 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 (PBE) for financial reporting purposes.

Basis of preparation

The prospective financial statements have been prepared on a going concern basis, and the accounting policies have been applied consistently throughout the period.

STATEMENT OF COMPLIANCE

The prospective financial statements of HPA have been 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 prospective financial statements have been prepared in accordance with Tier 1 PBE accounting standards.

The prospective financial statements comply with PBE accounting standards.

These prospective financial statements are the first financial statements presented in accordance with the new PBE accounting standards. There are no material adjustments arising on transition to the new PBE accounting standards.

PRESENTATION CURRENCY AND ROUNDING

The prospective financial statements are presented in New Zealand dollars and all values are rounded to the nearest thousand dollars ($000).

In May 2013, the External Reporting Board issued a new suite of PBE accounting standards for application by public sector entities for reporting periods beginning on or after 1 July 2014. HPA has applied these standards in preparing these prospective financial statements.

In October 2014, the PBE suite of accounting standards was updated to incorporate requirements and guidance for the not-for-profit sector. These updated standards apply to PBEs with reporting periods beginning on or after 1 April 2015. HPA will apply these updated standards in preparing its 30 June 2016 prospective financial statements. HPA expects there will be minimal or no change in applying these updated accounting standards.

Summary of significant accounting policies

REVENUE

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

Interest
Interest revenue is recognised using the effective interest method.

Funding from the Crown
HPA is primarily funded from the Crown. This funding is restricted in its use for the purpose of HPA meeting the objectives specified in its founding legislation and the scope of the relevant appropriations of the Ministry of Health.

HPA considers there are no conditions attached to the funding and it is recognised as revenue at the point of entitlement.

The fair value of revenue from the Crown has been determined to be equivalent to the amounts due in the funding arrangements.

Alcohol levy
HPA is also funded from a levy imposed for the purpose of recovering the costs it incurs:

- in addressing alcohol-related harm
- in its other alcohol-related activities.

This levy is collected by New Zealand Customs acting as HPA's agent.

GRANT EXPENDITURE

Discretionary grants are those grants where HPA has no obligation to award on receipt of the grant application and that are recognised as expenditure when approved by the Grants Approval panel and the approval has been communicated to the applicant.

LEASES

Operating leases
An operating lease is a lease that does not transfer substantially all the risks and rewards incidental to ownership of an asset to the lessee.

Lease payments under an operating lease are recognised as an expense on a straight-line basis over the lease term.

HPA leases office equipment and premises.

CASH AND CASH EQUIVALENTS

Cash and cash equivalents includes cash on hand and deposits held on call with banks with original maturities of three months or less.

RECEIVABLES

Short-term receivables are recorded at their face values, less any provision for their impairment.

A receivable is considered impaired when there is evidence that HPA will not be able to collect the amount due. The amount of the impairment is the difference between the carrying amount of the receivable and the present value of the amounts expected to be collected.

INVESTMENTS

Bank term deposits
Investments in bank term deposits are initially measured at the amount invested.

After initial recognition, investments in bank deposits are measure at amortised cost using the effective interest method, less any provision for impairment.

PROPERTY, PLANT AND EQUIPMENT

Property, plant and equipment consists of the following asset classes: artwork, leasehold improvements, furniture and fittings, 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.

In most instances, an item of property, plant and equipment is initially recognised at its cost. Where an asset is acquired through a non-exchange transaction, it is recognised at its fair value as at the date of acquisition.

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 reported net in the surplus or deficit.

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 surplus or deficit as they are incurred.

Depreciation

Depreciation is provided on a straight-line basis on all property, plant and equipment, 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%
Office Equipment	5 years	20%
Artwork		0%
Computer Equipment	3 years	33%
Leasehold Improvements*	3 years	33%
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 is reviewed, and adjusted if applicable, at each financial year end.

INTANGIBLE ASSETS

Software acquisition and development

Acquired computer software licences 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 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's website 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 financial year is recognised in the surplus or deficit.

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

Acquired computer software	3 years	33%

IMPAIRMENT OF PROPERTY, PLANT AND EQUIPMENT AND INTANGIBLE ASSETS

HPA does not hold any cash-generating assets. Assets are considered cash-generating where their primary objective is to generate a commercial return.

Non-cash-generating assets

Property, plant and equipment and intangible assets held at cost 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 service amount. The recoverable service amount is the higher of an asset's fair value less costs to sell and value in use.

Value in use is determined using an approach based on either a depreciated replacement cost approach, restoration cost approach or a service units approach. The most appropriate approach used to measure value in use depends on the nature of the impairment and availability of information.

If an asset's carrying amount exceeds its recoverable service amount, the asset is regarded as impaired and the carrying amount is written down to the recoverable amount. The total impairment loss is recognised in the surplus or deficit.

The reversal of an impairment loss is recognised in the surplus or deficit.

PAYABLES

Short-term payables are recorded at their face value.

EMPLOYEE ENTITLEMENTS

Short-term employee entitlements

Employee entitlements that are due to be settled within 12 months after the end of the period in which the employee renders the related service are measured 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.

A liability for sick leave is recognised to the extent that 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 that it will be used by staff to cover those future absences.

A liability and an expense are recognised for bonuses where there is a contractual obligation or where there is a past practice that has created a constructive obligation and a reliable estimate of the obligation can be made.

Long-term employee entitlements
Employee benefits that are due to be settled beyond 12 months after the end of period in which the employee renders the related service, such as long service leave have been calculated on an actuarial basis. The calculations are based on:

- likely future entitlements accruing to staff, based on years of service, years to entitlement, the likelihood that staff will reach the point of entitlement, and contractual entitlement information
- the present value of the estimated future cash flows.

Presentation of employee entitlements
Sick leave, annual leave and vested long service leave are classified as a current liability. Non-vested long service leave expected to be settled within 12 months of balance date is classified as a current liability.

SUPERANNUATION SCHEMES

Defined contribution schemes
Obligations for contributions to KiwiSaver and ASB Group Master Trust are accounted for as defined contribution superannuation schemes and are recognised as an expense in the surplus or deficit 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.

PROVISIONS

A provision is recognised 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 an outflow of future economic benefits 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 expenditure expected to be required to settle the obligation.

EQUITY

Equity is measured as the difference between total assets and total liabilities. Equity is disaggregated and classified into the following components:

- contributed capital
- accumulated surplus/(deficit).

GOODS AND SERVICES TAX (GST)

All items in the prospective 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, 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.

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 provision has been made for income tax.

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 Prospective Statement of Comprehensive Revenue and Expense.

COST ALLOCATION

HPA has determined the cost of its three output classes using the cost allocation system outlined below.

Direct costs are those costs directly attributed to an output class. Indirect costs are those costs that cannot be identified in an economically feasible manner with a specific output class.

Direct costs are charged directly to output classes. Indirect costs are charged to output classes based on cost drivers and related activity or usage information. Personnel and other indirect costs are assigned to output classes based on the proportion of direct programme costs within each output class.

CRITICAL ACCOUNTING ESTIMATES AND ASSUMPTIONS

In preparing these prospective 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 Prospective Statement of Comprehensive Revenue and Expense, and carrying amount of the asset in the Prospective 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.

Revenue
Projected funding from the Crown will vary as programmes of work change in response to new government initiatives, health targets and priorities.

Projected revenue in 2015/16, 2016/17 and 2017/18 is based on programmes of work currently confirmed with Ministry of Health.

Personnel costs
Personnel costs will vary as programmes of work change in response to government health targets and priorities.

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 Prospective 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 its lease arrangements are operating leases.

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hpa health promotion agency

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