Statement of Intent 2009-2012

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New Zealand Government

Statement from the HSC Board

The Health Sponsorship Council's (HSC's) primary goal is to contribute to the reduction in illness and disease and the consequent burden on clinical health care services. The HSC is a specialist agency with 19 years accumulated experience and expertise in promoting healthy lifestyles. It operates as a national health promotion service provider with a long-term focus on reducing the social, financial and health sector costs of a number of health behaviours. Specifically, HSC aims to improve health outcomes by:

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

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

This Statement of Intent outlines for Parliament the performance HSC has agreed with the Minister of Health to deliver for the period commencing on 1 July 2009 and ending 30 June 2010.

In particular, this document specifies:

- HSC's contribution to government policy
- strategic issues being faced by the HSC and how it intends to address them
- the programme of initiatives to promote healthy lifestyle choices, with performance indicators that the HSC will seek to achieve from 1 July 2009 to 30 June 2010
- the performance the HSC will aim to achieve during this time, specified in terms of financial performance, capability and risk management
- financial forecasts.

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

Hayden Wano
Chairman
30 June 2009

Tracey Bridges
Board Member
30 June 2009

Introduction

HSC has prepared this Statement of Intent to meet the requirements of the Crown Entities Act 2004.

The document has two parts:

PART 1 provides a three-year picture of the outcomes HSC is pursuing, how it intends to achieve these outcomes and how it will measure progress. It also includes a summary of the challenges HSC faces and any implications these challenges may have.

PART 2 includes the financial and non-financial measures and standards by which HSC will be assessed in 2009/10.

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

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

Hayden Wano - Taranaki (Chairman)
Tracey Bridges - Wellington
Maree Leonard - Marlborough
Fa'amatuainu Tino Pereira - Wellington
Allison Roe - Auckland
Professor Peter Walls - Wellington

PART 1 – The Next Three Years

HSC's Strategic Direction

The HSC's function is to "promote health and encourage healthy lifestyles" (section 44 of the Smoke-free Environments Act 1990) resulting in the mission *We promote health and encourage healthy lifestyles* and a vision of *Healthy New Zealanders.* As outlined in the Strategic Plan 2009-2014, HSC's four strategic goals are:

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

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

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

[1] Ministry of Health. 2008. *Briefing for the Incoming Minister of Health*.

The HSC's programmes achieve this by:

- communicating information directly to adults and young people to:
  - inspire them to choose healthy lifestyle options
  - make sure they know what being and staying healthy means and the benefits for them and their families/whānau
  - inform them about the help and support available, if they need to change current behaviours
- supporting the work of other front-line service providers eg, doctors, nurses, health promoters, educators and counsellors by:
  - providing evidence, materials (resources), advice and training to make their work more effective and efficient
  - providing a platform for nationwide 'conversations'. For example, the HSC leads the promotion of sun safety messages through the SunSmart programme (run in conjunction with the Cancer Society of New Zealand). The wider promotion of sun safety messages raises New Zealanders' awareness of the impact of skin cancer and melanoma and the harms of sunburn. This supports front-line services by enabling doctors, nurses and other health workers to talk about the issues and undertake early detection work safe in the knowledge that many people will be aware of the implication of their behaviours on their health
- working with communities to help them determine (and implement) the most appropriate ways to address local health issues
- working with national and regional agencies to integrate approaches and services in order to increase effectiveness and value for money eg, Agencies for Nutrition Action and District Health Boards (DHBs).

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

The HSC's Approach

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

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

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

This approach is consumer-oriented, responding to individual needs and wants. It is systematic, staged, underpinned by academic and consumer research, and is directly geared to achieving specific and measurable health goals over the short, medium and long term.

Integrating activities

Working together to integrate activities is essential for successful health promotion and prevention of chronic diseases. The HSC works closely with other providers and organisations to ensure effective and innovative approaches are developed and shared, along with knowledge and information. HSC, like commercial marketers, uses brands (eg, Smokefree, Auahi Kore and SunSmart) to increase people's recognition and understanding of what the programmes offer them. For example, research shows that 96.2% of young people know about the Smokefree brand and 69% of Māori young people know about the Auahi Kore brand. Using brands encourages the integration of activities as other organisations and communities use the brands, ensuring that information is communicated consistently and coherently, so helping people to understand the messages better and, as a result, take action.

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

The range of organisations the HSC works with is broad, from national agencies such as Agencies for Nutrition Action and the Heart Foundation, to regional organisations such as public health units (within DHBs), Cancer Society divisions and local Māori, Pacific and Asian providers. HSC also works with an increasing number of private sector organisations. This includes media organisations (eg, in 2008/09 several youth-focused media organisations adopted a Smokefree policy for all the material they broadcast), promoters of events (the Big Day Out was 'smokefree' in 2009), and representatives from gambling industries.

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

Research and evaluation

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

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

Commitment to quality

The HSC is committed to delivering high quality programmes. In late 2007/08 HSC implemented a formal quality improvement process, developing a tool for assessing the quality of its initiatives and programmes that includes national and international peer review.

Two HSC programmes have undergone the quality improvement process (SunSmart in 2007/08 and tobacco control in 2008/09). The results show that HSC is delivering programmes to a high standard – in both assessments key stakeholders saw HSC as efficient, effective and responsive. The process also identifies areas for improvement, and these are incorporated into current and future programme development.

In these straitened financial times the quality improvement process helps ensure both value for money and a continuing focus on improvement. Accordingly, the HSC has provided the framework to the Office of the Auditor General as it has potential to improve the effectiveness and efficiency of programmes across the public sector.

Māori Leadership

Māori are an important audience for three of HSC's programmes (being among the most vulnerable audiences for the health behaviours of smoking, problem gambling and obesity). To improve the HSC's responsiveness to Māori and improve effectiveness in tobacco control, the HSC has a formal working relationship with Te Reo Marama (Māori Smokefree Coalition), and Te Hotu Manawa Māori (a national non-government organisation concerned with Māori heart health).

Along with these organisations the HSC established a group in 2007/08 to guide, oversee and explore a broad approach to improve the health and wellness of Māori, including concepts such as whānau ora and kaupapa Māori health. It is expected that the group will offer direction to HSC on how to be more effective for Māori.

Organisational Capability and Capacity

People

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

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

Good employer practices

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

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

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

Operating Environment

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

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

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

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

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

Demographic trends suggest that the proportion of New Zealanders of Māori, Pacific and Asian ethnicity will increase and these populations tend to have a younger age structure than New Zealanders of European descent. This, and the overall aging population in this country, has a two-fold affect for HSC. At the older end of the population, lifestyle decisions made earlier in life are beginning to impact on quality of life through, for example, increases in the

prevalence of obesity, type 2 diabetes, respiratory disease, and heart disease. At the younger end, HSC is focused on motivating young people to choose healthy lifestyle options from an early age, making the need to communicate effectively with younger audiences even more vital.

Crown Expectations

The Minister has expressed the expectations of the Crown as owner of the HSC within the Letter of Expectations 2009/10. This Statement of Intent is consistent with those expectations and includes the following.

Better services, better value

The HSC's quality improvement process provides an internationally robust assurance around HSC's programmes. The recommendations from the 2007/08 SunSmart process and the 2008/09 tobacco process are currently being implemented. This will continue into 2009/10.

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

HSC will refine and improve its procurement processes to meet best practice (in line with recommendations from a procurement audit undertaken in 2008/09).

Cooperation and coordination

The HSC brings together often disparate groups to ensure effective communication and working together to meet individual and shared goals. The HSC's programmes are designed to complement and add value to work that is undertaken by others eg, the Ministry of Health, DHBs, public health organisations, and non-government organisations. Additionally, the HSC looks for opportunities to work with the private sector eg, gaming venue operators.

Integrated action with communities and across government is a significant opportunity for health, social and economic gain.

Fiscal environment

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

No surprises

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

Outcomes

Health Outcomes

The Ministry of Health currently has seven high-level health outcomes for the New Zealand population. They are:

- Leadership and planning are clear, effective and coordinated.
- More services are delivered locally in the community and in primary care.
- Whānau Ora: Māori families are supported to achieve their maximum health and well-being.
- Every dollar is spent in the best way to improve health outcomes.
- Systems and services are more patient-centred.
- Workforce supply meets service demand.
- Faster access to high quality hospital services.

Through HSC's programme areas, we contribute to the first five:

- Leadership and planning are clear, effective and coordinated. One of the HSC's key roles is working closely with government and non-government organisations and the private sector, bringing together often disparate groups to ensure they communicate with each other and work together to meet individual and shared goals. HSC provides frameworks, leadership, resources and support for these activities.
- More services are delivered locally in the community and in primary care. Evidence shows that national initiatives are most effective when delivered in communities. HSC works with communities to help them decide the most appropriate ways to address health issues.
- Whānau Ora: Māori families are supported to achieve their maximum health and well-being. Māori are a key audience for the HSC. Knowledge gained through research helps HSC develop initiatives that will encourage them to choose healthier lifestyles.
- Every dollar is spent in the best way to improve health outcomes. HSC is committed to the need to deliver effective and efficient programmes.
- Systems and services are more patient-centred. Research undertaken by the HSC ensures we understand people's needs and are able to design initiatives accordingly.

Long-term Outcomes and Objectives

Long-term conditions such as heart disease, cancer, type 2 diabetes, obesity and tobacco-related conditions are the leading cause of ill health and early death in New Zealand. These conditions disproportionately affect low income earners, Māori and Pacific peoples, and account for 80% of early deaths. Continuing improvements in health promotion and disease prevention are key to avoiding these diseases developing, slowing the rate of disease progression, improving health, preventing the need for expensive health care, and increasing workplace productivity.

HSC's long-term outcomes focus on:

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

Objective – supporting the health sector

In addition to these outcomes, the HSC has an objective of supporting the health sector. This objective focuses on working with the wider health sector eg, other front-line workers, doctors and nurses, and health promoters, to develop their skills and knowledge so they are better able to achieve government health outcomes.

HSC supports the wider sector with the following activities:

- Organising professional development opportunities on health promotion, health issues, research and evaluation eg, the biennial national Smokefree and melanoma gatherings.
- Supporting training opportunities for community health workers eg, evaluation and planning seminars.
- Providing a mechanism for sharing best practice through websites and listserves eg, Melnet (melanoma network).

- Developing linkages with international experts and organisations such as the Cancer Council of Victoria (Australia), the Cancer Institute of New South Wales, the Centers for Disease Control and Prevention (CDC), WHO, and the Global Dialogue for Effective Stop Smoking Campaigns.
- Maintaining and developing relationships with:
    - other government agencies and national organisations such as SPARC and the Ministry of Education
    - DHBs eg, funding and planning units, HEHA Project Managers
    - members of relevant industry groups.

Intermediate Outcomes and Interventions

The following sections describe the context for HSC's programmes and the intermediate outcomes it is working towards. Intermediate outcomes are shorter-term and, when achieved, contribute to final outcomes.

In the first three sections, diagrams illustrate the cause-and-effect links between what the HSC does (the activities and outputs) and the health gains that it is ultimately trying to achieve for New Zealanders (the outcomes). For tobacco control and sun safety the long-term outcomes and links with the intermediate outcomes are based on international work. The long-term outcomes for problem gambling are based on the objectives in the government's strategic plan – *Preventing and Minimising Gambling Harm – Strategic Plan 2004-2010* (Ministry of Health 2005).

For obesity prevention, HSC's work contributes to a number of outcomes in the HEHA Strategy.

HSC monitors the contribution of the activities and outputs to its intermediate outcomes with annual performance measures. It also monitors progress towards long-term outcomes by measuring indicators that show the extent of health gains (including impacts on at-risk communities), increases in knowledge about healthy lifestyle choices, and the adoption of healthy lifestyle behaviours.

Tobacco control

Why is tobacco control important?

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

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

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

New Zealand smoking rates declined steadily from the 1970s to the 1990s, then fell substantially. Public education, health promotion, regulation, and help with quitting have all assisted in this reduction in smoking. Māori rates for smoking also have dropped significantly, especially for Māori women.

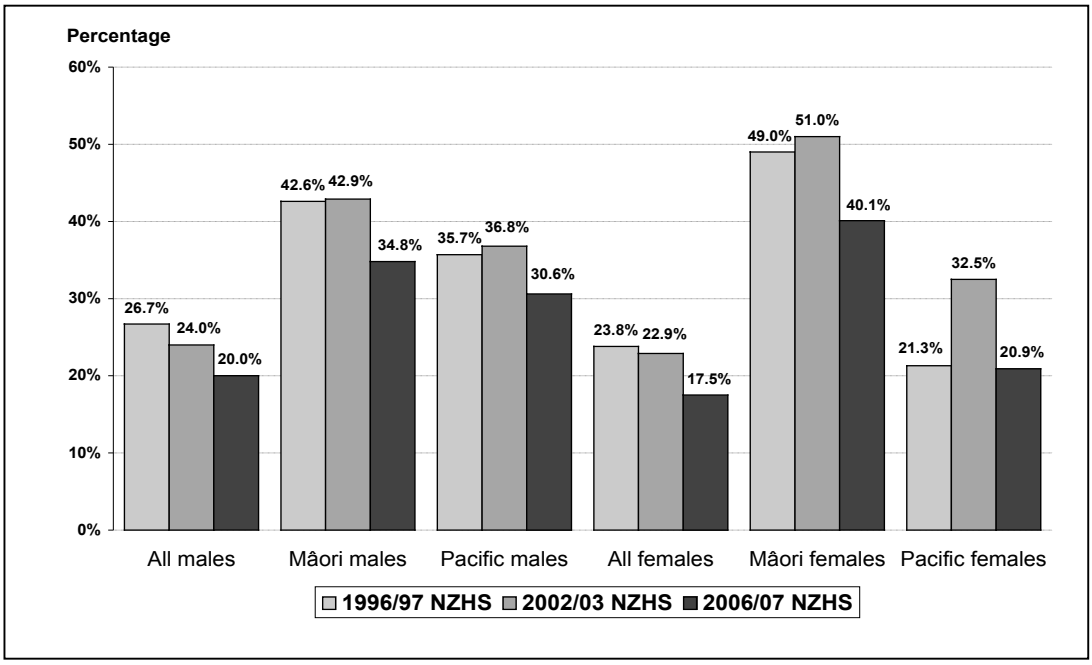
However, smoking remains the biggest preventable cause of ill health and early death in New Zealand. It is estimated that smoking is currently responsible for approximately 4,700 deaths per year in this country (Ministerial Committee on Drug Policy 2007, p25). In addition, second-hand smoke is a substantial health hazard (there is no level of exposure to second-hand smoke that is free of risk), being responsible for about 300 deaths per year in New Zealand.

The *2006/07 New Zealand Health Survey* shows that one in every five (19.9% - unadjusted prevalence) New Zealand adults (15 years and over) was a *current smoker*[2]. This equates to 619,000 adults (Ministry of Health, 2008a) and is the lowest rate since monitoring of tobacco

[2] Definition of current smoker: someone who has smoked more than 100 cigarettes in their lifetime and currently smokes at least once a month. The *2006/07 New Zealand Health Survey* defines adults as people aged 15 years and over.

use began more than 30 years ago. This New Zealand prevalence figure is very similar to that for Australia (19% in 2007 for adults 18 years and over) and the United Kingdom (currently 22% for people 16 years and over).

The *2006/07 New Zealand Health Survey* shows that the prevalence of smoking has decreased – from 25.2% in 1996/97 to 18.7% in 2006/07 (note: to allow comparisons these figures are for *daily smoking* and are age adjusted[3], as the 2002/03 survey did not measure *current smokers* using the international definition adopted for the 2006/07 survey). The decline over this period was evident for both men and women.



Daily smoking for adults by gender and ethnicity (age standardised prevalence), 1996/97, 2002/03 and 2006/07

(Ministry of Health, 2006/07 New Zealand Health Survey)

Despite this decline, the burden of tobacco use is still borne disproportionately by Māori and Pacific populations – the prevalence of current smoking in 2006/07 for Māori was 42.2% and for Pacific peoples 26.9%, compared with 18.6% for people of European/Other ethnicity (these figures are unadjusted and are for adults). The figures also show that, after adjusting for age, Māori women were more than twice as likely to be current smokers than women in the

[3] Definition of daily smoking: adults currently smoking one or more cigarettes per day. Figures are age standardised so populations with different age structures can be compared – for further details of this method, see Ministry of Health, 2008, page 16.

total population, and Māori men and Pacific men were 1.5 times more likely to be current smokers than men in the total population.

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

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

As well as Māori and Pacific peoples, the burden associated with smoking falls disproportionately on people of lower socio-economic status, with the highest prevalence among people living in the most deprived areas – the 2006/07 Health Survey showed that for both men and women the prevalence of current smoking was three times higher in the most deprived areas (NZDep 2006 quintile 5) than in the least deprived (quintile 1), when adjusted for age. For men, the figure for the most deprived areas was 34.2% while for the least deprived areas it was 12.2%. The corresponding figures for women were 32.2% and 11.4%.

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

What we are seeking to achieve

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

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

HSC's current focus is on the first and second of these objectives. Work over the past few years has contributed to substantial reductions in exposure to second-hand smoke,

particularly in people's homes, and the HSC will continue to monitor second-hand smoke exposure to make sure that the achievements of the last four years are sustained.

The HSC's tobacco control programme is guided by international and national evidence and best practice and we work closely with the Ministry of Health and the wider tobacco control sector to make sure that what we do is integrated with and supports the work of others. Our five-year programme plan was reviewed in 2008/09 to reflect current priorities and incorporate the recommendations from the external quality improvement review carried out in 2008.

The current programme aims to:

Encourage all New Zealanders to choose a smokefree lifestyle.

What we will do to achieve success

Over the next three to five years, HSC's tobacco control programme will have two main components: a youth-focused component and an adult-focused one.

The **youth-focused** component will provide information and promote messages to young people in order to:

- increase the skills of pre-adolescents and adolescents to refuse tobacco or to quit, if they already smoke
- denormalise and deglamourise tobacco use by reducing young people's exposure to smoking behaviour, and increase anti-tobacco and pro-smokefree attitudes among youth, and their parents and caregivers and role models
- strengthen young people's associations with key social and cultural organisations that contribute to self-identities that exclude tobacco use, for example by increasing young people's participation in school and community activities that reinforce Smokefree and Auahi Kore messages.[4]

To achieve these outcomes we will continue to promote Smokefree/Auahi Kore and quitting messages using celebrities (Smoking Not *Our* Future), working with the media and event

[4] These outcomes are based on the objectives in the *Framework for Reducing Smoking Initiation* (HSC, 2005).

organisers to promote Smokefree/Auahi Kore in a range of media and at major youth events (eg. Smokefreerockquest, Smokefree Pacifica Beats and the Big Day Out), and working with schools.

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

- provide accurate and credible information about the facts and risks surrounding tobacco use
- increase knowledge about the benefits of tobacco control and a smokefree lifestyle
- maintain public support for tobacco control measures, including support for those people who want to quit.

Effective tobacco control is not only about encouraging and supporting people to quit but gaining societal support for measures that help people to choose and maintain smokefree lifestyles. Recent United Kingdom research shows that lack of emotional support from partners and peers or emotional stress contributes to quitters relapsing (NHS, 2008). Increasing understanding about the challenges of quitting and the addictive nature of tobacco will create a social and cultural environment that supports quitting and smokefree lifestyles.

To increase pro-Smokefree/Auahi Kore and anti-tobacco attitudes among society at large and make Smokefree/Auahi Kore lifestyles and environments the 'norm', the HSC will continue to deliver its intervention (currently referred to as Smokefree People) that began in 2008/09 with Face the Facts. Information, resources and support will be provided to cessation providers (eg, primary healthcare providers and health promoters) to increase the number of quit attempts. Work also will continue to create more smokefree environments used by children (eg, parks and playgrounds).

New work will be undertaken to identify effective messages to motivate pregnant women to quit smoking.

Within Māori environments and settings (such as marae and kura kaupapa) the focus will be on increasing the acceptance of an Auahi Kore kaupapa.

The diagram on pages 25 and 26 shows how these objectives are translated into HSC's intermediate outcomes and how, in turn, these contribute to the long-term outcomes for the tobacco control sector in New Zealand. The first column in the diagram shows how the work in 2009/10 will contribute to these intermediate outcomes.

How we will demonstrate success

Indicators to measure progress towards achieving intermediate (3-5 year) and long-term outcomes include the following. Note, the bullet points in the Indicator column show whether the indicator is expected to increase, stay the same, or decrease:

Intermediate Indicators

Indicator	**Current**	**Trend**
Proportion of young people reporting anti-tobacco attitudes. • Maintained or increased.	66% of young people (14- and 15-year-olds) agree that non-smokers dislike being around people who are smoking (2008). 53.1% of young people agree that tobacco companies should not be allowed to sell their products in the dairy at the checkout (2008).	Increasing (New Zealand Youth Tobacco Monitor - NZYTM). Benchmarked in 2008/09 (NZYTM).
Proportion of adults reporting anti-tobacco attitudes. • Maintained or increased.	50% of adults (18+ years) agree that cigarettes and tobacco should not be sold in New Zealand in 10 years time (2008). 53.5% of adults (18+ years) agree that tobacco companies should not be allowed to promote tobacco by having different brand names and packaging (2008).	Benchmarked in 2008/09 (HSC's 2008 Health and Lifestyle Survey - HLS). Benchmarked in 2008/09 (2008 HLS).

Indicator	Current	Trend
Proportion of adults who report increased knowledge and awareness of tobacco-related harm (based on selected indicators). • Increased.	58.9% of adults (18-65 years) agree that "if cigarettes were not displayed in shops, children would be less likely to start smoking" (2009). 39.3% of adults (18-65 years) agree that "nicotine patches and gum double the chances of quitting smoking successfully" (2009).	Benchmarked in 2008/09 (HSC's 2009 Advertising Survey). Benchmarked in 2008/09 (HSC's 2009 Advertising Survey).
Proportion of adults responding to new knowledge (eg, for smokers the number of quit attempts, for smokers and non-smokers their support for tobacco control measures). • Maintained or increased.	50% of current smokers/recent quitters (18-65 years) had made a serious quit attempt in the last 12 months (2009). 63.4% of adults (18-65 years) agree that the government should do more to reduce the harm done by smoking (2009).	Benchmarked in 2008/09 (HSC's 2009 Advertising Survey). Benchmarked in 2008/09 (HSC's 2009 Advertising Survey).
To make sure that exposure to second-hand smoke remains at current low levels or decreases, the HSC will continue to monitor the:		
Proportion of the population reporting exposure to second-hand smoke in homes.* • Maintained or decreased.	12.5% of people (15-64 years) said that other people smoked inside their home (2006).	Benchmarked in 2006 (New Zealand Tobacco Use Survey - TUS).
Proportion of the population reporting exposure to second-hand smoke in cars.* • Maintained or decreased.	14.9% of people (15-64 years) said that other people smoked inside their car (2006).	Benchmarked in 2006 (TUS).

* 2008 figures for these two measures will be available shortly.

Long-term Indicators

Indicator	Current	Trend
Prevalence of tobacco use among young people. • Maintained or decreased.	7.3% of young people (14- and 15-year-olds) are daily smokers (2008).	Decreasing (NZYTM).
Prevalence of tobacco use among adults (current smokers). • Maintained or decreased.	20.2% of adults (18+ years) smoke (2007 figure, 2008 figure will be available shortly).	Decreasing (2006/07 New Zealand Health Survey).
Proportion of young people who are *never smokers*. • Maintained or increased.	57.3% of young people (14- and 15-year-olds) said – they never smoked (2008).	Increasing (NZYTM).
Proportion of young smokers who have made a quit attempt. • Maintained or increased.	61.9% of smokers in Year 10 (14- and 15-year-olds) said they had tried to stop smoking in the last year (2008).	Maintained (NZYTM).
Proportion of adult smokers who have made a quit attempt. • Maintained or increased.	33.5% of current adult smokers/recent quitters (18-64 years) who had deliberately quit for at least a week in the last 12 months. (2006 – 2008 figures will be available shortly).	Benchmarked in 2006 (TUS).

These indicators are measured using data from monitors conducted by HSC and other organisations. Monitoring tobacco-related inequalities is a key part of this work, with all indicators monitored by people's ethnicity and the deprivation index of the area they live in.

Progress to date

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

The adult survey followed ‘impressive reductions’ in smoking among secondary school students (see page 18 for the figures).

As reported in our 2008/09 Statement of Intent, HSC's work over the last five years has contributed to a decline in exposure to second-hand smoke in homes and cars and an increase in the number of smokefree public and recreational areas outdoors.

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

Managing to encourage all New Zealanders to choose a smokefree lifestyle.

HSC's Key Activities/Outputs	HSC's Contributing Outcomes	Tobacco Control - Long-Term Outcomes
1.1.1 Smoking Not *Our* Future messages: – to promote positive views about Smokefree/Auahi Kore and negative views about tobacco use – to motivate young people to choose Smokefree/Auahi Kore lifestyles and quit smoking. 1.1.3 Ten or more events staged – to promote Smokefree/Auahi Kore messages (eg, Smokefreerockquest, Smokefree Pacifica Beats, Big Day Out.) 1.2.3 Smokefree/Auahi Kore Schools messages promoted: – to increase awareness and understanding among school stakeholders (internal and external) that smoking is a significant health issue – to support schools to address smoking (initiation and cessation) effectively – to review, update and develop Smokefree/Auahi Kore resources for schools. 1.2.4 Kura pages for the Smokefree/Auahi Kore Schools Website developed in te reo Māori. 1.3.1 Information, advice and resources provided to communities: – to increase the number of smokefree outdoor public places (eg, parks and playgrounds) and reduce the number of places where children are exposed to smoking behaviour.	**Youth-focused:** Increasing the skills of pre-adolescents and adolescents to refuse tobacco or to quit, if they already smoke. Denormalising and deglamourising tobacco use by reducing young people's exposure to smoking behaviour, and increasing anti-tobacco and pro-Smokefree attitudes among youth. Strengthening young people's associations with key social and cultural organisations that contribute to self-identities that exclude tobacco use eg, by increasing young people's participation in school and community activities that reinforce Smokefree and Auahi Kore messages.	Reduced smoking initiation. Reduced exposure to second-hand smoke. Pro-Smokefree/Auahi Kore attitudes and lifestyles are the norm. Increased quitting among adults and young people. Decreased tobacco-related inequalities. Reduced tobacco-use prevalence and consumption among adults and young people. Reduced tobacco-related morbidity and mortality.

Note: in this and the other diagrams in this section the activities and outputs may contribute to one or more intermediate outcomes and the intermediate outcomes may contribute to one or more long-term outcomes. Numbers in column one refer to the key activities and outputs in Part Two.

HSC's Key Activities/Outputs	HSC's Contributing Outcomes	Tobacco Control - Long-Term Outcomes
1.1.2 Face the Facts messages: – to inform adults about the facts and risks surrounding tobacco use, increase knowledge about the benefits of tobacco control and maintain public support for tobacco control measures, including support for those people who want to quit.	**Adult-focused:** Increasing knowledge and awareness of the facts and risks surrounding tobacco use and the benefits of Smokefree lifestyles. Maintaining public support for tobacco control measures. Increasing pro-Smokefree/Auahi Kore attitudes.	
1.2.1 Information and resources provided to cessation providers (eg, primary healthcare providers and health promoters) to increase the number of quit attempts. 1.2.2 Support to the Quit Group in the promotion of front-line services to increase quit attempts. 1.2.5 Research completed to identify effective messages to motivate pregnant women to quit smoking.	Increasing quit attempts by young people and adults.	
1.3.2 Auahi Kore kaupapa promoted to motivate Māori to create smokefree settings and quit smoking.	Reduced inequality from tobacco-related harm.	
1.4.1 Facilitate the work of the national Smokefree/Auahi Kore Working Group.		
1.5.1 National monitors continued to survey smoking patterns, pro-Smokefree/Auahi Kore attitudes and disseminate results.		

Note: Long-term outcomes and links to intermediate outcomes are based on work by the US Centers for Disease Control and Prevention. Reduced tobacco use, consumption and tobacco-related morbidity and mortality results from achieving the other long-term outcomes. Long-term outcomes relate to both youth- and adult-focused intermediate outcomes.

Sun safety

Why is sun safety important?

In the area of sun safety, New Zealand is following international trends – showing an increase in the incidence of skin cancer. More than 300 New Zealanders die every year from skin cancer, with melanoma being responsible for most of these deaths - 269 in 2005 (New Zealand Health Information Service). New Zealand now has the highest incidence rate for melanoma in the world.

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

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

Skin cancer has been estimated to cost the New Zealand health system in excess of NZ$33 million per annum.

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

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

What we are seeking to achieve

The New Zealand Skin Cancer Control Strategic Framework has the goal of *reducing the proportion of New Zealanders who develop and die from skin cancer.* The framework has three strands – prevention, early detection and treatment. HSC's sun safety activities contribute primarily to prevention and the overall goal for the sun-safety prevention programme for the next two years is to *reduce the incidence of sunburn in 8 to 12-year-olds* by increasing effective use of sun protection strategies and reducing the time children are exposed to harmful UVR.

What we will do to achieve this

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

Reduce the incidence of sunburn in 8 to 12-year olds.

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

- Increase the percentage of parents and caregivers taking steps to protect their 8 to 12-year-olds from getting sunburnt (ie, focusing on the home environment).
- Increase the percentage of organisations and agencies with influence over recreational settings (eg, health promoters, sports organisations, local councils, and event organisers) taking steps to protect 8 to 12-year-olds from getting sunburnt in these settings.
- Increase the percentage of organisations and agencies with influence over the media (eg, health promoters, the MetService, and television and print media) that are taking steps to increase messages that encourage, and decrease messages that discourage, sun protection behaviours.
- Increase the percentage of primary and intermediate schools taking steps to protect 8 to 12-year-olds from getting sunburnt. Note, this objective is the primary responsibility of the Cancer Society.

The focus for the programme, therefore, is to develop and implement initiatives for each of these settings, beginning with a focus on the home environment.

Exposure to UVR before the age of 20 is a particularly strong risk factor for melanoma incidence, so the Skin Cancer Control Steering Committee's Strategic Framework for 2005-2008 identifies children under 13 years old and their caregivers as the target audience. The

current sun safety programme focuses on the parents and caregivers of 8 to 12-year-olds, as this is the age at which children become more independent of their parents, therefore needing parents to reinforce sun safe behaviours.

HSC is also continuing to develop working relationships with national and international organisations to contribute to the prevention, early detection and treatment of skin cancer.

The diagram on pages 32 and 33 shows how these objectives are translated into HSC's intermediate outcomes and how, in turn, these contribute to the long-term outcomes for skin cancer control in New Zealand. The first column in the diagram shows how the work for 2009/10 will contribute to these intermediate outcomes.

How we will demonstrate success

Indicators to measure progress towards achieving intermediate (3-5 year) and long-term outcomes include the following. Note, the bullet points in the Indicator column show whether the indicator is expected to increase, stay the same, or decrease:

Intermediate indicators

Indicator	**Current**	**Trend**
Percentage of parents/caregivers reporting their 8-12-year-old was sunburnt (reddening or soreness of the skin). • Maintained or decreased.	40.1% of parents and caregivers said that their child experienced some sunburn in the last summer.	Benchmarked in 2008 (Health Lifestyle Survey - HLS).
Percentage of parents/caregivers reporting that the following were done to protect their 8-12-year-old from getting sunburnt: • Maintained or increased.	Covered up with clothing – 47.2%. Wore a hat – 77.4%. Wore sunglasses 20.3%. Wore sunscreen – 84.8%.	Benchmarked in 2008 (HLS).
The following indicators also will be used to monitor sun safe behaviours among the wider population (the figures in the middle column below are from the HSC's 2006 Sun Protection Survey):		
Proportion of people (15 to 69 years) adopting sun safe behaviours. • Maintained or increased.	33% of people said they wore a hat.	Increasing.

Indicator	Current	Trend
	39% of people said they wore sun glasses.	Maintained.
	36% of people said they wore sunscreen.	Increasing.
Proportion of people (15 to 69 years) reporting severe sunburn. • Maintained or decreased.	39% of people said they had been severely sunburnt before.	Decreasing.

Long-term indicators

Indicator	Current	Trend*
Incidence of melanoma. • Maintained or decreased.	1,896 registrations in 2004.	Increasing.
Number of deaths from melanoma. • Maintained or decreased.	269 in 2005.	Increasing.

*Note: these indicators are currently increasing due to behaviour of the 1970s, 1980s and 1990s (and possibly due to better detection and registration) and will only decrease when the impact of current programmes becomes evident in future.

These indicators will be measured using data from monitors conducted by HSC and other organisations.

Progress to date

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

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

Initial evaluation of parents and caregivers' response to the new communications showed that 52.1% had seen the new message and 70.7% of these people said they were a “lot more concerned” about this health issue as a result.

The messages will continue to be promoted in 2009/10. Further monitoring of responses to the messages is underway.

Exposure to UVR is the main cause of sunburn and a UV Index (UVI) is in use to make people aware of the level of UVR each day (the UVI is shown in newspapers and some television networks alongside the weather forecast, and broadcast nationally through radio networks and on-line). Research undertaken in 2008/09 showed that New Zealanders have a poor awareness and understanding of the current UVI (47% of people surveyed were aware of the index and 77% of these people said they understood it). Work will continue through 2009/10 to identify a better way to communicate this important information to people.

Managing to reduce the incidence of sunburn in 8 to 12-year-olds.

HSC's Key Activities/Outputs	HSC's Contributing Outcomes	Sun Safety - Long-Term Outcomes
2.1.1 SunSmart messages promoted: – to increase awareness and understanding of the risks posed by ultraviolet radiation (UVR) – to motivate parents and caregivers to take steps to protect their children from getting sunburnt. 2.1.2 Improved UVI developed and promoted: – to increase awareness and understanding of the risks posed by UVR – increased understanding and use of the UV Index (UVI) to assist with the public's planning around sun safety. 2.2.1 Information provided to health sector (GPs/nurses/pharmacies): – to facilitate discussions about skin cancer and sun safe behaviours.	Increasing the percentage of parents and caregivers taking steps to protect their 8 to 12-year-olds from getting sunburnt (ie, focusing on the home environment).	Decreased incidence of sunburn. Reduced exposure to UVR. Increase (effective) use of sun protection strategies. Increased prevention, early detection and effective treatment of skin cancers.
2.3.1 Resources developed and distributed: – to support the work of national, regional and local organisations and reinforce SunSmart messages. 2.3.2 Formal working relationships with national bodies (eg, Tennis NZ and Surf Lifesaving NZ): – to improve the reach of SunSmart messages, and support the development and implementation of sun safe policies and practices. 2.3.3 Information provided to local authorities.	Increasing the percentage of organisations and agencies with influence over recreational settings (eg, health promoters, sports organisations and local councils) taking steps to protect 8 to 12-year-olds from getting sunburnt in these settings.	

HSC's Key Activities/Outputs	HSC's Contributing Outcomes	Sun Safety - Long-Term Outcomes
2.4.1 Relationships with key agencies involved in the provision and dissemination of UV information maintained – to ensure New Zealanders receive consistent, frequent messages in weather forecasts and media coverage about risks surrounding UVR and how to avoid sunburn.	Increasing the percentage of organisations and agencies with influence in the media (eg, health promoters, the MetService, television, radio and print media) that are taking steps to increase messages that encourage, and decrease messages that discourage, sun protection behaviours. Increasing the percentage of primary and intermediate schools taking steps to protect 8 to 12-year-olds from getting sunburnt. Note, this is the primary responsibility of the Cancer Society. Increasing collaboration and partnerships between agencies and organisations for improved prevention, early detection and effective treatment of skin cancers.	
2.4.2 Working relationships with national and international agencies on national skin cancer control initiatives: – to ensure consistency of messages and policy and provide an integrated approach.		
2.5.1 Triennial Sun Exposure Survey implemented: – to track people's sun safe attitudes and behaviours.		

Note: Long-term outcomes and links to intermediate outcomes are based on work by the US Centers for Disease Control and Prevention.

Problem gambling

Why is preventing and minimising gambling harm important?

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

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

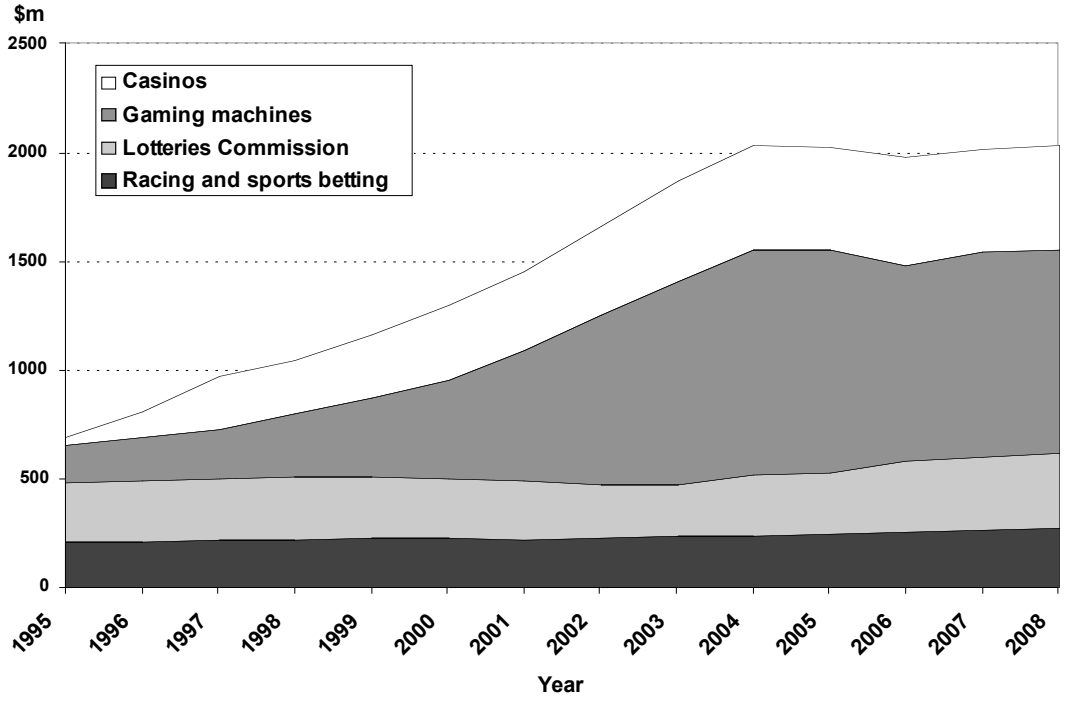
The *2006/07 New Zealand Health Survey* (Ministry of Health, 2008a) found that two out of three adults had gambled in the previous 12 months (65.3% of people aged 15 years and over). The Survey also estimated that just over 5% (5.4%) of gamblers were at low risk of their gambling being a problem and 2% were at moderate risk. A further 0.6% of gamblers, 13,000 adults, met the criteria for problem gambling. Almost 3% (2.8%) of adults, 87,000, had experienced problems due to someone's gambling in the previous 12 months. This is consistent with overseas studies that estimate that between five to 10 other people are affected by the behaviour of a serious problem gambler (Productivity Commission, 1999).

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

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

Statistics released in 2009 by the DIA show a further, albeit small, increase in the amount New Zealanders' spent on gambling in 2007/08. Spending on the main forms of gambling

increased to $2.034 billion in 2007/08 ($2.02 billion in 2006/07). This is due largely to players spending more on Lotteries Commission products, racing and sports betting, and casino gambling.



Expenditure ('Losses') 1994/95-2007/08
(Source: DIA)

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

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

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

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

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

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

The Ministry of Health is responsible, under the Act, for the prevention and treatment of problem gambling. The Ministry's approach is outlined in a six-year strategic plan – *Preventing and Minimising Gambling Harm: Strategic plan 2004-2010* (Ministry of Health, 2005).

The Ministry's strategy includes provision for a social marketing programme to:

- encourage New Zealanders to make healthy lifestyle choices about gambling
- promote discussion about the effects of gambling in the community
- reduce the incidence of problem gambling among the general population, with a specific emphasis on at-risk populations.

The Ministry has contracted HSC to develop and deliver this social marketing programme.

What we are seeking to achieve

HSC's work focuses on changes both upstream and downstream. Upstream changes include denormalising harmful gambling, by getting society to understand and question the issues around gambling harm, and building public support for measures that prevent and minimise gambling harms and create safer families, safer communities, and safer venues and gambling products. Downstream changes include providing support for frontline workers and

community-led responses that range from increasing individuals' help-seeking behaviour to community initiatives to identify and address gambling harms at the local level.

The programme's messages are targeted at all New Zealand adults. At the same time, approaches are being developed with those groups in the population that are disproportionately affected by gambling harms to reduce inequalities experienced by these groups.

What we will do to achieve success

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

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

This goal will be realised by:

- denormalising harmful gambling.
- increasing people's skills and resilience to prevent and minimise harmful gambling.
- increasing protection for individuals, families/whānau, and communities.
- reducing the harms of gambling for individuals, families/whānau and communities.

The diagram on page 42 shows how these objectives are translated into HSC's intermediate outcomes and how, in turn, these contribute to longer-term outcomes to prevent and minimise gambling harm. The first column in the diagram shows how the work in 2009/10 will contribute to these intermediate outcomes.

How we will demonstrate success

The *GBAS* provides a baseline for monitoring the problem gambling programme. The survey is scheduled to be repeated in 2010 to monitor initial responses to the programme and the activities of service providers. Intermediate (3-5 year) and long-term indicators include the following. Note, the bullet points in the Indicator column show whether the indicator is expected to increase, stay the same, or decrease:

Intermediate indicators

Indicator	Current	Trend
Proportion of people who say they can describe the signs that a person is gambling at a harmful level. • Maintained or increased.	67% of people (15+ years) said they could describe the signs that a person is gambling at a harmful level.	Benchmarked in 2006/07. (Note all indicators shown in this table were benchmarked in the 2006/07 GBAS).
Proportion of people who say they can describe the consequences for the wider community when people gamble too much. • Maintained or increased.	61% of people (15+ years) said they could think of consequences for the wider community.	Benchmarked in 2006/07.
Proportion of people who say they are aware of ways to avoid problem gambling. • Maintained or increased.	73% of people (15+ years) said they could think of things people can do to avoid spending more time and money on gambling than they meant to.	Benchmarked in 2006/07.
Note: although the responses for the three measures are quite high, follow up questions show that in 2006/07 people's knowledge and awareness was not necessarily comprehensive or accurate. Monitoring will chart whether or not people's knowledge and awareness becomes more comprehensive and accurate.		
Proportion of people who report arguments about the time or money spent on gambling in their family or wider household. • Maintained or decreased.	16% of people (15+ years) said there had been arguments about gambling.	Benchmarked in 2006/07.
Proportion of people who report someone going without something or bills not being paid because too much was spent on gambling by someone in their family or wider household. • Maintained or decreased.	16% of people (15+ years) said someone had gone without something or bills were not being paid because too much was spent on gambling.	Benchmarked in 2006/07.
Proportion of people who are aware of services available for people experiencing gambling harm. • Maintained or increased.	64% of people (15+ years) said they could name a service or organisation that they could direct a person to for help.	Benchmarked in 2006/07.

Long-term indicators

Indicator	Current	Trend
Proportion of people who use strategies to avoid gambling too much. • Maintained or increased.	26% of people said they or their household had used one or more of a range of strategies they were aware of to avoid gambling too much.	Benchmarked in 2006/07. (Note all indicators shown in this table were benchmarked in the 2006/07 GBAS).
Proportion of people who think gambling does more harm than good. • Maintained or increased.	51% of people (15+ years) said that raising money through gambling does more harm than good.	Benchmarked in 2006/07.
Proportion of people who participate in debate and discussion about the place of gambling in their community and community responses to gambling harms. • Maintained or increased.	19% of people (15+ years) said their family or household had talked about the dangers of gambling or the harm it can cause in the last 12 months.	Benchmarked in 2006/07.
Proportion of people who say they talk about good ways to avoid gambling too much. • Maintained or increased.	12% of people (15+ years) said their family or household had talked about good ways to avoid gambling too much in the last 12 months.	Benchmarked in 2006/07.
Proportion of people who report taking part in discussion or meetings in their community. • Maintained or increased.	4% of people (15+ years) said they had taken part in a discussion or meeting in their community in the last five years.	Benchmarked in 2006/07.
Proportion of people and adults who are aware of things that communities can do. • Maintained or increased.	The GBAS provides measure of awareness and involvement in a number of potential community initiatives.	Benchmarked in 2006/07.

Progress to date

The HSC's problem gambling programme was launched in April 2007 with 'Kiwi Lives', which communicates information and messages about the damaging effects of problem gambling in homes and communities and aims to increase awareness and understanding of problem

gambling and its impacts. Kiwi Lives also aims to create a supportive environment for front-line health workers and communities.

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

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

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

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

Initial figures from the Gambling Helpline showed a positive response when Kiwi Lives testimonials were being shown on television. The number of calls from first-time callers in December 2008 and May 2009 was around one-third higher for each of these months than for the previous two months (ie, comparing the December and May figures with the average

figure for the respective two previous months). Anecdotal feedback from the public indicates a good understanding of the key messages. A formal evaluation will be completed in 2009/10.

The *GBAS* provides a snapshot of New Zealanders' views about gambling and gambling-related harm and these indicate that the majority of people will be responsive to, and supportive of, initiatives that seek to prevent and minimise gambling harm. There is wide support also for a comprehensive response to this issue that involves Government, as well as individuals, families/whānau, communities, and the gambling industry.

In 2009/10 the second stage of Kiwi Lives will be extended to provide resources to meet the cultural needs of Māori and Pacific peoples and to begin working with the gambling industries to support their work to prevent and minimise gambling harm.

Managing to reduce the incidence of problem gambling and the impact of gambling harms in Aotearoa/New Zealand

HSC's Key Activities/Outputs	HSC's Contributing Outcomes	Problem Gambling – Long-term Outcomes
3.1.1 Kiwi Lives (stage 2) messages promoted: – to increase New Zealanders' knowledge about the harms of problem gambling and how to avoid and respond to these harms.	Denormalising harmful gambling (by getting society to understand and question the issues around gambling harm, and building public support for measures that prevent and minimise gambling harms).	Increased and sustained knowledge about gambling harm and support for measures to prevent and minimise gambling harm.
3.2.1 Kiwi Lives messages and resources disseminated to problem-gambling sector providers: – to provide them with ready access to information, advice and initiatives to support their work in preventing and minimising gambling harm. 3.3.1 Kiwi Lives resources developed in association with Māori and Pacific communities – to meet the social and cultural needs of these communities	Increasing people's skills and resilience to prevent and minimise harmful gambling. Increasing protection for individuals, families/whānau, and communities. Reducing the harms of gambling for individuals, families/whānau, and communities.	Increased family/whānau and community capacity to take action to prevent and minimise gambling harm. Increased access to physical and social environments that prevent and minimise gambling harm. Reduced incidence of problem gambling and gambling-related harm among target populations.
3.4.1 Relationships with national and regional organisations developed and maintained: – to encourage consistent messages and approaches to increase effectiveness of work to prevent and minimise gambling harm.		Decreased health inequalities associated with harmful gambling.
3.5.1 Results analysed and disseminated from tracking attitude and behaviour change in response to Kiwi Lives: – to support development of the programme and inform the problem gambling sector.		

Note: Long-term outcomes are based on relevant objectives in the Ministry of Health's Strategic Plan for Preventing and Minimising Gambling Harm.

Obesity prevention through better nutrition and increased physical activity

Why is better nutrition and increased physical activity important?

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

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

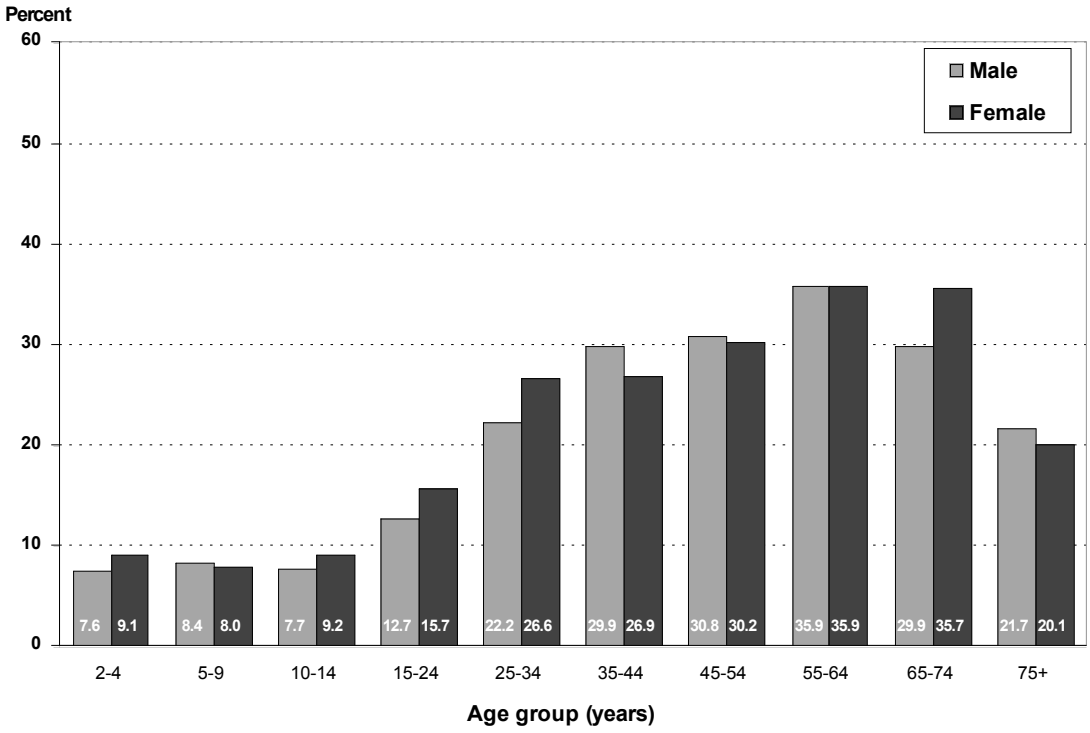
Some health consequences of obesity, such as diabetes, cancer and cardiovascular disease, cause major disability and illness, and require costly, long-term treatment and support. Projections suggest we are facing a steep increase in obesity in the future.

For example, new cases of type 2 diabetes are predicted to increase by 45% by 2011 and overall prevalence by 60% for European New Zealanders, 132% for Māori, and 146% for Pacific people (Ministry of Health, 2002).

The Ministry of Health's updated estimates of the direct health-care costs of obesity suggest costs in the order of NZ$460 million for the year 2004 (ranging from approximately $400 to $500 million) (Ministry of Health, 2008b). Delay in addressing obesity-related issues at a primary prevention level will lead to further demand for health services in the future. It is forecast that health costs for type 2 diabetes will reach $1.77 billion by 2021/22 unless urgent action is taken.

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

In New Zealand in 2006/07, one in five children was overweight (20.9% of 2 to 14-year-olds) and a further one in twelve (8.3%) was obese (Ministry of Health, 2008a). Among adults, one in three (36.1%) were overweight and a further one in four (26.5%) were obese.[5] There was an increase in the prevalence of obesity for adults from 1997 to 2006/07, but the rate of increase appears to be slowing, with no statistically significant increase from 2002/03 to 2006/07 for both men and women. There was no change in the proportion of school-aged children who were obese over this period, although in less than one generation childhood rates of obesity in New Zealand have tripled (Ministry of Health 2004).



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

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

[5] People aged 18 years and over were classified as overweight and obese using the World Health Organization's Body Mass Index (BMI) cut-off points. For people 2 to 17 years old the BMI cut-off points developed by the

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

Healthy Eating – Healthy Action, Oranga Kai – Oranga Pumau (HEHA) is the strategic approach to preventing obesity through improving nutrition and increasing physical activity for all New Zealanders (Ministry of Health, 2003). The HEHA Strategy was originally launched in 2003 with its implementation plan in 2004. The Ministry of Health is the lead agency in the implementation of the Strategy. Significant progress has been made to date in its implementation (Ministry of Health, 2008c).

The vision for HEHA is "an environment and society where individuals, families and whānau, and communities are supported to eat well, live physically active lives, and attain and maintain a healthy body weight". The work to prevent obesity, improve nutrition and increase physical activity is wide-ranging and requires multiple actions by multiple players to make it happen.

To provide greater national coordination of obesity prevention, physical activity and nutrition-related activities in New Zealand, the HSC has been contracted to develop and deliver a service to support the DHBs' HEHA Project Managers. This service will:

- facilitate more efficient and consistent communication of messages to the community, resulting in many players in the community working on the same themes concurrently, increasing coherency and effectiveness in message delivery
- harness experience and expertise of the Ministry of Health, HEHA Project Managers and non-government organisations to identify themes, materials and community engagement tools that will best support the activities of agencies and communities involved in delivering nutrition, physical activity and obesity prevention messages.

International Obesity Taskforce were used (for details see Ministry of Health, 2008, pages 104 and 105).

What we are seeking to achieve

The overall health goal for the HEHA Strategy is:

> *To improve health and well-being and to reduce obesity and the burden of disease through better nutrition and increased physical activity.*

The objectives of the HSC's support service are as follows:

- To support DHBs and frontline workers by developing and promoting consistent nutrition and physical activity messages to target populations most at risk of obesity.
- To increase public awareness and understanding of the risks of obesity and the benefits of better nutrition and increased physical activity.

The development and implementation of the support service will draw on a successful community model that has been implemented in more than 200 cities in Europe – EPODE (Ensemble, prévenons l'obésité des enfants/Together let's prevent childhood obesity). An EPODE-like programme is also currently being initiated in South Australia.

EPODE has central coordination and local implementation. Local project managers in each EPODE community have similar roles to the DHB HEHA Project Managers, who are placed in each of the 21 DHBs and are tasked to lead, coordinate, facilitate and support agencies and communities involved in implementing nutrition, physical activity and obesity prevention-related activities.

Among the functions of the EPODE central coordinating agencies are developing:

- common themes for community education and information initiatives
- support materials for communication for the target messages
- 'roadmaps' that provide local project managers with guidance on community engagement, use of the materials, and possible associated activities and promotions.

What we will do to achieve success

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

HSC's specific activities for 2009/10 will include:

- Working with the Ministry of Health to develop a coherent and coordinated approach to developing and distributing nationally consistent messages for obesity prevention, physical activity and nutrition via the DHBs' HEHA Project Managers.
- Developing and implementing a communications plan that will include developing themes and associated activities, creating public understanding of the themes, developing roadmaps and a resources plan. This work will be informed by an environmental scan and best practice.
- Developing and implementing monitoring and evaluation plans for the support service.

How we will demonstrate success

A set of indicators to measure progress towards achieving the service's objectives will be developed as part of the monitoring and evaluation plans.

Progress to date

Progress made by the HEHA strategy since its launch in 2003 has been documented by the Ministry (Ministry of Health, 2008c). The support service that HSC has been contracted to deliver in 2009/10 is a new service and progress with its implementation will be reported in HSC's 2009/10 annual report and the 2010/11 Statement of Intent.

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PART 2: Statement of Prospective Service Performance

Output Class One – Marketing Healthy Lifestyles

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

Total Cost for Output Class One 2009/10: $13,032,000 (ex GST).

To increase the number of people choosing healthy lifestyles, for the tobacco control, sun safety and problem gambling programmes, HSC groups its work into four key activities that include:

- Communicating information directly to adults and young people to:
  - inspire them to choose healthy lifestyle options
  - make sure they know what being and staying healthy means and the benefits for them and their families/whānau
  - inform them about the help and support available, if they need to change current behaviours.
- Supporting the work of other front-line service providers - doctors, nurses, health promoters, educators and counsellors – by:
  - providing evidence, materials (resources), advice and training to make their work more effective and efficient
  - providing a platform for nationwide 'conversations'. For example, the HSC leads the promotion of sun safety messages through the SunSmart programme (run in conjunction with the Cancer Society of New Zealand). This wider promotion of sun safety messages raises New Zealanders' awareness of the impact of skin cancer and melanoma and the harms of sunburn. This supports front-line services by enabling doctors, nurses and other health workers to talk about the issues and undertake early detection work safe in the knowledge that many people will be aware of the implication of their behaviours on their health.
- Working with communities to help them determine (and implement) the most appropriate ways to address local health issues.
- Working with national and regional agencies to integrate approaches and services in order to increase effectiveness and value for money.
- Research, monitoring and evaluation.

To support the work to reduce obesity, HSC groups its work into two key activities that include:

- Delivering a support service for DHBs' HEHA Project Managers and local communities to:
  - facilitate more efficient and consistent communication of messages to the community
  - support the HEHA Project Managers in communicating nationally consistent messages when engaging with their local communities.
- Research, monitoring and evaluation.

The outputs for each of the four programmes for 2009/10 are described in more detail in the sections that follow.

Tobacco Control

HSC's tobacco control work aims to *encourage all New Zealanders to choose a smokefree lifestyle* (see pages 25 and 26 for the intermediate outcomes that contribute to this aim). Key activities for 2009/10 include:

Key Activities/Outputs	Performance Measure
1.1 Communicating information directly to young people and adults	
1.1.1 Smoking Not *Our* Future messages: – to promote positive views about Smokefree/Auahi Kore and negative views about tobacco use – to motivate young people to choose Smokefree/Auahi Kore lifestyles and quit smoking.	○ Smoking Not *Our* Future messages reach intended audience, particularly Māori and Pacific young people: – TARP (Target Audience Rating Point) levels met or exceeded. (Note: the next survey to track young people's responses to the messages will be in 2010/11).
1.1.2 Face the Facts messages: – to inform adults about the facts and risks surrounding tobacco use, increase knowledge about the benefits of tobacco control and maintain public support for tobacco control measures, including support for those people who want to quit.	○ Face the Facts messages reach intended audience: – TARP (Target Audience Rating Point) levels met or exceeded – quit attempts prompted when Face the Facts promoted – measured by calls to the Quit Line and self-reported behaviours – evaluation shows that 50% or more of New Zealanders have seen one or more of the 'Facts'. – evaluation shows increased knowledge about the facts and risks surrounding tobacco use – evaluation shows increased knowledge about the benefits of tobacco control – evaluation shows maintained public support for tobacco control measures.
1.1.3 Ten or more events staged: – to promote Smokefree/Auahi Kore messages (eg. Smokefreerockquest, Smokefree Pacifica Beats, Big Day Out).	○ Smokefree/Auahi Kore awareness and intentions increased by supporting popular youth events: – event organisers report all events are well attended – event organisers report HSC messages/smokefree policies (where applicable) are displayed and implemented.
1.2.5 Research completed to identify effective messages to motivate pregnant women to quit smoking.	○ Results show effective messages identified following research and testing with pregnant women.
1.2 Supporting other front-line service providers	
1.2.1 Information and resources provided to cessation providers (eg, primary healthcare providers and health promoters) – to increase the number of quit attempts.	○ Messages and resources support work of cessation providers – measured by: – resources distributed and used.
1.2.2 Support to the Quit Group in the promotion of front-line services – to increase quit attempts.	○ Smoking Not *Our* Future and Face the Facts promote Quit Line. – Statistics from the Quit Line show increased levels of help seeking when the messages are promoted.

Key Activities/Outputs	Performance Measure
1.2.3 Smokefree/Auahi Kore Schools messages promoted: – to increase awareness and understanding among school stakeholders (internal and external) that smoking is a significant health issue, – to support to schools to address smoking (initiation and cessation) effectively and – to review, update and develop Smokefree/ Auahi Kore resources for schools.	○ An increased number of schools report using best practice and Smokefree/Auahi Kore policy template. ○ Boards of Trustees and Principals report a greater understanding of the importance of smokefree/auahi kore environments. ○ Smokefree/Auahi Kore Schools presence at six events and conferences including NZ School Trustees Association, National Primary Principals, and Te Akatea. ○ Website activity levels reported six-monthly (December and June) based on the number of hits on the Smokefree/Auahi Kore Schools website and the number of resources downloaded from the website.
1.2.4 Kura pages for the Smokefree/Auahi Kore Schools website developed in te reo Māori.	○ Kura website pages developed and launched using a Māori-centred approach to hauora and the underlying Kura Kaupapa Māori curriculum of Te Aho Matua.
1.3 Working with communities	
1.3.1 Information, advice and resources provided to communities: – to increase the number of smokefree outdoor public places (eg, parks and playgrounds) and reduce the number of places where children are exposed to smoking behaviour.	○ Support provided to at least three regions.
1.3.2 Auahi Kore kaupapa promoted: – to motivate Māori to create smokefree settings and quit smoking.	○ Community events and activities that promote the Auahi Kore kaupapa are supported by partnerships with at least 20 community-based Māori groups to strengthen community action in promoting the Auahi Kore kaupapa.
1.4 Working with other regional, national and international agencies	
1.4.1 Facilitate the work of the national Smokefree/Auahi Kore Working Group.	○ Facilitate six meetings.
1.5 Research, monitoring and evaluation	
1.5.1 National monitors continued: – to survey smoking patterns, pro-Smokefree/Auahi Kore attitudes and disseminate results.	○ 2009/10 NZ Youth Tobacco Survey completed successfully (on time and to budget) and results distributed to the sector. ○ Dissemination of results from 2008/09 adult monitors.

Sun Safety

HSC's sun safety work contributes towards *reducing the incidence of sunburn in 8 to 12-year-olds* (see pages 32 and 33 for the intermediate outcomes that contribute to this aim).

Key Activities/Outputs	Performance Measure
2.1 Communicating information directly to young people and adults	
2.1.1 SunSmart messages promoted – to increase awareness and understanding of the risks posed by ultraviolet radiation (UVR), including increased understanding of the UV Index (UVI) – to motivate parents and caregivers to take steps to protect their children from getting sunburnt.	○ SunSmart messages reach intended audiences, particularly parents and caregivers – TARP (Target Audience Rating Point) levels met or exceeded.
2.1.2 Improved UVI developed and promoted – to increase awareness and understanding of the risks posed by UVR.	○ Improved index developed and made available to the public in the media.
2.2 Supporting other front-line service providers	
2.2.1 Information provided to health sector (GPs/nurses/pharmacies): – to facilitate discussions about skin cancer and sun safe behaviours.	○ Information available in GPs' surgeries. ○ Fact Cards distributed to pharmacies.
2.3 Working with communities	
2.3.1 Resources developed and distributed: – to support the work of national, regional and local organisations and reinforce SunSmart messages.	○ SunSmart resources developed and delivered to other organisations – measured by uptake of resources. ○ Partners report increased effectiveness in promoting the SunSmart objectives – measured by HSC's stakeholder survey.
2.3.2 Formal working relationships with national bodies (eg, with Tennis NZ and Surf Lifesaving NZ): – to improve the reach of SunSmart messages, and support the development and implementation of sun safe policies and practices.	○ Contracts with at least two national bodies are established and supported.
2.3.3 Information provided to local authorities.	○ Resources distributed to local authorities. ○ Local authorities report increased effectiveness in developing and implementing policies and practices – measured by HSC's stakeholder survey.

Key Activities/Outputs	Performance Measure
2.4 Working with other regional, national and international agencies	
2.4.1 Relationships with key agencies involved in the provision and dissemination of UV information maintained: – to ensure New Zealanders receive consistent, frequent messages in weather forecasts and media coverage about risks surrounding UVR and how to avoid sunburn.	○ National media continue to promote supplied UVI information. ○ At least two media releases issued in partnership with NIWA and/or MetService. ○ At least three meetings held with NIWA and/or MetService to align UV work.
2.4.2 Working relationships with national and international agencies on national skin cancer control initiatives: – to ensure consistency of messages and policy and provide an integrated approach.	○ HSC represented on New Zealand Guidelines Group, Cancer Council Australia and National Skin Cancer Committee. ○ Meet at least four times a year with Cancer Society New Zealand national office.
2.5 Research, monitoring and evaluation	
2.5.1 Triennial Sun Exposure Survey implemented: – to track people's sun safe attitudes and behaviours.	○ Survey designed and implemented on time and to budget.

Problem Gambling

HSC's problem gambling work contributes towards *reducing the incidence of problem gambling and the impact of gambling harms in Aotearoa/New Zealand* (see page 42 for the intermediate outcomes that contribute to this aim).

Key Activities/Outputs	Performance Measure
3.1 Communicating information directly to young people and adults	
3.1.1 Kiwi Lives (stage 2) messages promoted: – to increase New Zealanders' knowledge about the harms of problem gambling and how to avoid and respond to these harms.	○ Kiwi Lives messages reach intended audiences, particularly people disproportionately affected by problem gambling, and increase knowledge and understanding of harms/responses – TARP (Target Audience Rating Point) levels met or exceeded – evaluation shows that 50% or more of New Zealanders have seen one or more of the testimonials shown on TV – evaluation shows an increase in knowledge about the harms of gambling – evaluation shows an increased understanding of how people should prevent and minimise gambling harm – statistics from the Gambling Helpline show increased levels of help seeking when the messages are promoted – website activity levels reported six-monthly (December and June) based on the number of hits on the Problem Gambling website and the number of resources downloaded/ordered from the website.
3.2 Supporting other front-line service providers	
3.2.1 Kiwi Lives messages and resources disseminated to problem-gambling sector providers: – to provide them with ready access to information, advice and initiatives to support their work in preventing and minimising gambling harm.	○ Kiwi Lives messages and resources support work of problem-gambling sector providers – measured by: – resources distributed and used – reports from HSC stakeholder survey confirm that providers' work is more effective as a result of Kiwi Lives messages and resources – stocktake of resources used by the problem-gambling sector shows duplication is minimised.
3.3 Working with communities	
3.3.1 Kiwi Lives resources developed in association with Māori and Pacific communities: – to meet the social and cultural needs of these communities.	○ Kiwi Lives messages and resources support work of Māori and Pacific communities – measured by: – resources distributed and used – reports from HSC stakeholder survey confirm that Māori and Pacific communities' work is more effective as a result of tailored Kiwi Lives messages and resources.

Key Activities/Outputs	Performance Measure
3.4 Working with other regional, national and international agencies	
3.4.1 Relationships with national and regional organisations developed and maintained: – to encourage consistent messages and approaches to increase effectiveness of work to prevent and minimise gambling harm.	○ Organisations report increased integration and effectiveness of work – measured by: – HSC's stakeholder survey.
3.5 Research, monitoring and evaluation	
3.5.1 Results analysed and disseminated from tracking attitude and behaviour change in response to Kiwi Lives: – to support development of the programme and inform the problem gambling sector.	○ Results from tracking analysed to inform programme development and made widely available on Kiwi Lives website – measured by: – website activity levels reported six-monthly based on the number of hits on the relevant Problem Gambling website pages and the number of documents downloaded from the website – measured at 31 December 2009 and 30 June 2010 – repeat of the benchmark survey (Gaming and Betting Activities Survey) underway.

Obesity prevention through better nutrition and increased physical activity

HSC's work in obesity prevention contributes to the HEHA Strategy's goal to *improve health and well-being and to reduce obesity and the burden of disease through better nutrition and increased physical activity* (see page 46 for the objectives of HSC's services that contribute to this goal).

Key Activities/Outputs	Performance Measure
4.1 Delivering a support service for DHB HEHA Project Managers and local communities to:	
Facilitate more efficient and consistent communication of messages to the community.	
4.1.1 Coherent and coordinated approach developed with the Ministry of Health for developing and distributing nationally consistent messages via DHB HEHA Project Managers, including: – developing and disseminating roadmaps to assist HEHA Project Managers implement the themes and activities – provide a scientific rationale for messages.	○ Regular progress meetings with, and reports to, the Ministry of Health. ○ Roadmaps developed for HEHA Project Managers. ○ Scientific rationale for messages documented and disseminated.
4.1.2 Annual communications plan developed with the Ministry of Health and HEHA Project Managers to: – identify target audiences for themes and activities – establish two themes and a suite of activities relating to these themes to support DHBs' community engagement – raise public awareness of the HEHA themes and regional activities – identify the need for resources to support regional and local activities (including use of existing resources) – inform other organisations and individuals working in the HEHA sector about the themes and activities.	○ 2009/10 communication plan developed, approved by the Ministry of Health and disseminated to HEHA Project Managers. ○ Two themes and associated suite of activities developed and one theme implemented by 30 June 2009/10.

Key Activities/Outputs	Performance Measure
Support the DHBs in communicating nationally consistent messages when engaging with their local communities.	
4.1.3 Support HEHA Project Managers in implementing annual communications plan to: – support healthy eating health action behaviours among vulnerable population groups, including Māori, Pacific peoples, and low income families – encourage an integrated approach to obesity prevention programmes at grass roots level and assist frontline delivery and community action – provide centrally developed and produced resources to ensure national message consistency.	○ Roadmaps disseminated to HEHA Project Managers to support regional activities/promotions and provide scientific rationale for messages. ○ Resources to inform and educate identified target markets developed and made available to HEHA Project Managers.
4.2 Research, monitoring and evaluation	
4.2.1 Monitoring and evaluation plan developed and implemented for the support service, including: – resource/product testing – monitoring HEHA Project Managers to obtain their views on the resources and services delivered.	○ Monitoring and evaluation plan developed and implemented for the support service. ○ Resource and product testing completed as required. ○ Feedback from HEHA Project Managers on resources and services obtained and results reported.

Reporting

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

Quarterly Reports

The HSC will by the agreed date following the close of the quarter (ie. 9 November 2009, 9 February 2010, 9 May 2010, 9 August 2010) provide a report detailing financial and non-financial performance against performance measures in this Statement of Intent and the Contract. The reports will include comments on progress against the performance indicators and targets due for completion later the year.

Informal Reports

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

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

Reports to Parliament

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

- Statement of Intent 2010/11.
- Annual Report 2009/10.

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

Part 2a: Financial Statements

Statement of Responsibility

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

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

Hayden Wano
Chairman
30 June 2009

Tracey Bridges
Board Member
30 June 2009

Prospective Statement of Output Costs

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

The programmes are described for the 2009/10 financial year and details of activities are outlined on pages 51 to 58.

Annual expenditure on programmes by year (ex GST)

	Projected 2009 ($000)	**2010 ($000)**	**2011 ($000)**	**2012 ($000)**
Tobacco Control	9,511	8,395	8,088	7,988
SunSmart	1,155	977	950	950
Obesity Prevention	3,160	1,328	1,325	1,325
Problem Gambling	1,772	2,332	1,635	1.635
TOTAL	**15,598**	**13,032**	**11,998**	**11,898**

Prospective Statement of Comprehensive Income

	Projected 2009 ($000)	2010 ($000)	2011 ($000)	2012 ($000)
Revenue				
Ministry of Health	14,966	11,796	11,271	11,271
Other	448	277	277	277
Total revenue	**15,414**	**12,073**	**11,548**	**11,548**
Expenditure				
Community partnerships and sponsorships	1,612	1,501	1,350	1,364
Health promotion resources	611	790	711	717
Media and communications	7,977	4,992	4,590	4,531
Research	1,316	1,265	988	848
Programme employee benefits	893	1,021	1,041	1,062
Projects	783	787	708	714
Other programme expenditure	243	250	225	227
Direct programme expenditure	**13,435**	**10,606**	**9,613**	**9,463**
Programme support	1,040	1,187	1,210	1,250
Total programme expenditure	**14,475**	**11,793**	**10,823**	**10,713**
Corporate services	1,077	1,194	1,125	1,135
Depreciation and amortisation	46	45	50	50
Total expenditure	**15,598**	**13,032**	**11,998**	**11,898**
Net Deficit	**(184)**	**(959)**	**(450)**	**(350)**
Other comprehensive income	0	0	0	0
Total comprehensive income	**(184)**	**(959)**	**(450)**	**(350)**
Note:				
Total employee benefits	2,263	2,367	2,409	2,457

Prospective Statement of Movements in Equity

	Projected 2009 ($000)	2010 ($000)	2011 ($000)	2012 ($000)
Opening equity	3,582	3,398	2,439	1,989
Total comprehensive income:				
Net Deficit	(184)	(959)	(450)	(350)
Closing equity	**3,398**	**2,439**	**1,989**	**1,639**

Prospective Statement of Financial Position

	Projected 2009 ($000)	2010 ($000)	2011 ($000)	2012 ($000)
Equity	**3,398**	**2,439**	**1,989**	**1,639**
Current assets				
Cash and cash equivalents	4,418	3,364	2,894	2,554
Trade and other receivables	200	200	200	200
Inventory	190	170	150	150
Total current assets	**4,808**	**3,734**	**3,244**	**2,904**
Non-current assets				
Property, plant and equipment	130	145	135	125
Intangible assets	10	10	10	10
Total non-current assets	**140**	**155**	**145**	**135**
Total assets	**4,948**	**3,889**	**3,389**	**3,039**
Current liabilities				
Accounts payable	75	70	70	70
Employee benefit liabilities	140	150	165	180
GST payable	100	100	100	100
Other payables	1,235	1,130	1,065	1,050
Total current liabilities	**1,550**	**1,450**	**1,400**	**1,400**
Total liabilities	**1,550**	**1,450**	**1,400**	**1,400**
Net assets	**3,398**	**2,439**	**1,989**	**1,639**

Prospective Statement of Cashflows

	Projected 2009 ($000)	2010 ($000)	2011 ($000)	2012 ($000)
Cashflows used in operating activities				
Cash from:				
Ministry of Health	15,737	11,796	11,271	11,271
Interest received	140	90	90	90
Other	321	187	187	187
	16,198	12,073	11,548	11,548
Cash disbursed to:				
Payments to suppliers and employees	16,737	13,067	11,978	11,848
Net goods and services tax	(171)	0	0	0
	16,566	13,067	11,978	11,848
Net cashflows used in operating activities	**(368)**	**(994)**	**(430)**	**(300)**
Cashflows used in investing activities				
Cash disbursed to:				
Purchase of fixed assets	30	60	40	40
Net cashflows used in investing activities	**(30)**	**(60)**	**(40)**	**(40)**
Net (decrease) in cash and cash equivalents	(398)	(1,054)	(470)	(340)
Plus projected opening cash and cash equivalents	4,816	4,418	3,364	2,894
Closing cash and cash equivalents	**4,418**	**3,364**	**2,894**	**2,554**

Statement of Accounting Policies

Reporting Entity

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

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

Basis of Preparation

Statement of Compliance

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

The financial statements comply with NZIFRS, and other applicable Financial Reporting Standards, as appropriate for public benefit entities. This includes New Zealand Financial Reporting Standard No.42: *Prospective Financial Statements* (FRS-42). Consistent with all Crown Entities the HSC first adopted NZIFRS on 1 July 2007.

The prospective financial statements have been prepared for the special purpose of the 2009/10 Statement of Intent (SOI) of the HSC to the Minister of Health. They are not prepared for any other purpose and should not be relied upon for any other purpose.

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

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

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

Measurement system

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

Functional and presentation currency

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

Significant Accounting Policies

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

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

Budget figures

These prospective financial statements were authorised for issue by the HSC on 30 June 2009.

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

Revenue

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

Revenue from the Crown

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

Interest

Interest income is recognised using the effective interest method.

Rental income

Lease receipts under an operating sub-lease are recognised as revenue on a straight-line basis over the term of the lease in the Prospective Statement of Financial Performance.

Operating leases

Leases that do not transfer substantially all the risks and reward incidental to ownership of an asset to the HSC are classified as operating leases. Lease payments under an operating lease are recognised as an expense on a straight-line basis over the term of the lease in the Prospective Statement of Financial Performance.

Cash and cash equivalents

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

Debtors and other receivables

Debtors and other receivables are measured at fair value, less any provision for impairment.

Investments

Bank deposits

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

Inventories

Inventories are measured at cost adjusted when applicable for any loss of service potential.

Property, plant and equipment

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

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

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

Gains and losses on disposals are determined by comparing the proceeds with the carrying amount of the asset. Gains and losses on disposals are included in the Prospective Statement of Financial Performance.

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

The costs of day-to-day servicing of property, plant and equipment are recognised in the Prospective Statement of Financial Performance as they are incurred.

The carrying values of revalued items are reviewed at each balance date to ensure that those values are not materially different to fair value. Additions between revaluations are recorded at cost.

Depreciation

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

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

Intangibles

Software acquisition

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

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

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

Amortisation

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

The amortisation charge for each period is recognised in the Prospective Statement of Financial Performance.

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

Acquired computer software	3 years	33% SL

In prior years, the diminishing value method was adopted. The change to the straight line method better reflects the economic lives of the HSC's intangible assets. This change in method had no material effect on the prior year financial statements. Therefore no prior year adjustment was made.

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

Short-term employee entitlements

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

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

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

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

Superannuation schemes

Defined contribution schemes

Obligations for contributions to KiwiSaver and the State Sector Retirement Savings Scheme are accounted for as defined contribution superannuation schemes and are recognised as an expense in the Prospective Statement of Financial Performance as incurred.

Goods and Services Tax (GST)

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

The net amount of GST recoverable from, or payable to, the Inland Revenue Department (IRD) is included as part of receivables or payables in the Prospective Statement of Financial Position.

The net GST paid to, or received from the IRD, including the GST relating to investing and financing activities, is classified as an operating cash flow in the Prospective Statement of Cashflows.

Income Tax

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

Output costs

The Prospective Statement of Output Costs reports the cost of delivering each HSC programme.

Cost allocation

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

Cost allocation policy

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

Criteria for direct and indirect costs

'Direct costs' are those costs directly attributable to a specific programme.

'Indirect costs' are those costs that cannot be identified in an economically feasible manner with a specific programme. Programme support, corporate services and depreciation expenditure are indirect costs.

Programme support comprises activities that are provided to support programmes such as research, policy development, programme planning and support, project management, quality improvement and pilot projects (eg, Māori leadership initiative).

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

Cost drivers for allocation of indirect cost

Indirect costs are allocated based on the pro-rata costs of the programmes.

Sponsorship liabilities

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

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

Significant accounting estimates and assumptions

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

Ministry of Health Funding Agreement

The income and expenditure figures contained in this SOI are based on the assumption that a three-year contract commencing 1 July 2009 will be satisfactorily concluded with the Ministry of Health. At the time of preparation the income figures were agreed but a contract had not been executed.

Problem Gambling

The Problem Gambling income figures for the 2011 and 2012 financial years assume that funding will continue at the same levels. This income is, however, subject to a new levy being agreed during the 2010 financial year.

General assumption – cost levels

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

Property, plant and equipment useful lives and residual value

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

An incorrect estimate of the useful life or residual value will impact the depreciation expense recognised in the Prospective Statement of Financial Performance, and carrying amount of the asset in the Prospective Statement of Financial Position.

The HSC minimises the risk of this estimation uncertainty by:

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

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

Financial instruments

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

Revenues and expenses in relation to all financial instruments are recognised in the Prospective Statement of Financial Performance.

Statement of cash flows

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

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

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

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

Changes in accounting policies

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