Achieving Efficiencies in the Provision of National Health Promotion Programmes

A Draft Discussion Document

Prepared for the Ministry of Health

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Executive Summary

In the current fiscal environment the government is seeking innovative ways of undertaking business and looking for efficiency and effectiveness gains in the public sector. A key focus is on delivering more and better services with existing resources.

The Ministry of Health provides national leadership for the health sector and is the principal funder of national health promotion programmes in New Zealand. The Ministry's core functions include strategic policy, legislation, regulation, and funding and monitoring of health services.

The HSC is a small Crown entity responsible for promoting health and healthy lifestyles to all New Zealanders. The HSC supports the Ministry of Health's work through national health promotion programmes by increasing access to health information that encourages, supports and enables New Zealanders to make better choices about their health. The HSC is currently funded to deliver four such national health promotion programmes. The Ministry of Health, along with a number of other government agencies, also provides a range of national health promotion programmes.

This paper proposes that efficiency and effectiveness gains in the health sector could be achieved by clustering national health promotion programmes under one entity. The benefits include:

- Greater cost effectiveness – This includes economies of scale (eg, gaining efficiencies through increasing the size of the organisation), economies of scope (eg, bulk buying of research, media and resources over multiple programmes), reduced duplication, reduced external consultancy costs (as most of the expertise will be in-house), and an ability to prioritise the allocation of funding across multiple health promotion areas.
- Improved service - An ability to create greater national consistency, operate outside of issue-based and funding silos, and to simplify matters for the sector, through allowing it to deal with a single agency.
- Clearer roles and responsibilities - Better alignment of functions to achieve the government's priorities, greater concentration on core business, and limited potential for duplication (or gaps).
- Estimated savings of at least $400,000 through clustering research, media, and resources activities from HSC and Ministry of Health national health promotion programmes alone.

While the HSC, the Ministry of Health, a DHB collective, or a completely new entity could fulfil this national role. This paper argues that the HSC is the best location for clustering national health promotion programmes, to support the work of the Ministry of Health and the broader health promotion sector. Clustering national health promotion services into the HSC offers the following benefits for the Ministry and government:

- A flexible structure that can quickly respond to changing government, Ministry, and Minister's requirements, including the flexibility to plan and allocate budgets over three year periods, and provision to simply vary its contract service schedule to add programmes and services.

- Proven capacity, capability and experience in delivering successful and embedded national health promotion programmes, while managing complex issues and relationships. HSC is a specialist agency with the necessary skill set and experience to deliver national health programmes most effectively.
- An excellent understanding of its customers (population groups that health promotion services are trying to reach and influence).
- The capacity and capability to engage with frontline workers (particularly in terms of supporting resources and information).
- An ability to work alongside the Ministry of Health at a strategic partnership level while having greater flexibility to deliver programmes and related activities.
- Well-established public sector relationships along with non-government organisations and private sector partnerships that leverage greater value for money for government. For example, the Cancer Society covers at least half the costs of the sun safety programme and supports the programme through its own regional delivery infrastructure. HSC's management of these relationships reduces potential for conflicts of interest in a non-funder and non-regulator role.

Recommendations:

It is recommended that the Ministry of Health:

a. Agree that there is an opportunity to increase efficiency and achieve effectiveness gains by clustering national health promotion programmes into a single entity.

b. Establish a joint project with the HSC and external experts to scope and quantify potential cost savings associated with HSC undertaking an increased number of national health promotion programmes.

c. With or without undertaking (b) above, direct HSC to deliver all national health promotion programmes currently delivered by the Ministry of Health.

d. Consider the opportunity and advantages of increasing HSC's role beyond those national health promotion programmes currently delivered by the Ministry of Health.

1 Background

This discussion paper provides a proposal to achieve greater efficiencies and economies of scale and scope by clustering national health promotion programmes[1] into the Health Sponsorship Council (HSC).

The Ministry of Health provides leadership for the health sector and is the principal government funder of national health promotion programmes in New Zealand. The Ministry's core functions include strategic policy, legislation, regulation, and funding and monitoring of health services.

The HSC is a Crown entity responsible for promoting health and healthy lifestyles to all New Zealanders. The HSC supports the Ministry of Health's work by increasing access to health information that encourages, supports and enables New Zealanders to make better choices about their health. The HSC is currently funded by the Ministry of Health to deliver four national health promotion programmes - tobacco control (Smokefree/Auahi Kore), sun safety (SunSmart), physical activity and nutrition, and problem gambling.

The government is seeking innovative ways of doing business and looking for further efficiency and effectiveness gains in the public sector. A key focus has been on delivering more and better services with existing resources.

The government's drive for improvements in public services included directing departments and Crown entities to identify actions to improve their performance, line-by-line reviews of departments, and consideration of in-depth, internally led reviews for issues that would benefit from a government-wide perspective. In addition, central agencies are piloting a performance improvement framework that systematically highlights areas of strengths, areas where performance can be improved, and how this could be done.

Given this context, the HSC believes there are opportunities to create further efficiencies in the broader health sector through clustering all national health promotion programmes under a single entity. Such arrangements would allow government to create critical mass and generate economies of scale and scope in the purchase and delivery of national health promotion programmes. This proposal contributes directly to the government's health priority of achieving greater efficiencies in Ministry departmental expenditure as well as Ministry-managed non-departmental expenditure. The following proposal sets out the scope, rationale and potential benefits for establishing this new arrangement.

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[1] For the purpose of this paper *national health promotion programmes* are defined as government funded programmes that increase access to health information nationally and support New Zealanders to take care of their own health. These programmes focus on promoting healthy ideas and concepts that motivate individuals, families, and communities to adopt and/or maintain healthy attitudes and behaviours.

2 The Current Situation in the Health Sector

2.1 Strategic Context

The New Zealand health sector has experienced significant change over the last 18-24 months. This change has been driven by the need to manage rising treatment costs, increased patient demand, an ageing population, and international workforce shortages. In 2009 the Ministerial Review Group made recommendations to enhance the performance and sustainability of the health and disability system, with government adopting the following:

- Stronger clinical leadership in decision-making.
- Accelerating improvements in quality and safety.
- Higher system performance and securing future sustainability.
- Improved national and regional service planning and decision-making.
- Minimising administrative costs and reducing bureaucracy and waste.

The government's expectations for the public health system is on delivering *better, sooner, more convenient* healthcare for all New Zealanders. The government wants shorter waiting times, less bureaucracy, and a trusted and motivated health workforce. The government is also building on the Primary Healthcare Strategy by ensuring services are located in the most appropriate place, including the potential shift of services previously provided in the secondary care sector to more convenient primary care settings through the establishment of multi-disciplinary Integrated Family Health Centres and more permissive funding within current primary care funding streams.

2.2 Health Sector Priorities

The Minister of Health has signalled three key health sector priorities[2] over the short to medium term:

- Financial management and sustainability – This includes improving DHB productivity, establishing affordable employment relations' settlements, achieving greater efficiencies in Ministry departmental expenditure as well as Ministry-managed non-departmental expenditure, and responding to the Ministerial Review Group's proposed reforms.
- Clinical workforce and leadership – This involves prioritising investment in workforce development opportunities, strengthening clinical leadership, increasing supply of medical practitioners, attracting practitioners to areas of need, and coordinating career planning and training.
- Ensuring quality – The government has established a Health Quality and Safety Commission to provide advice and information on, and drive improvements in, quality and safety in health and disability services.

In addition the District Health Boards are responsible for meeting six key health targets, including:

- Shorter stays in emergency departments.
- Improved access to elective services.
- Shorter waits for cancer treatment.
- Increased immunisation.

[2] Implementing the New Zealand Health Strategy 2010

- Better help for smokers to quit.
- Better diabetes and cardiovascular services.

The existing range of nationally funded health promotion programmes complements three health target areas (ie, immunisation, smoking, and diabetes and cardiovascular disease).

2.3 State Services Performance

In the context of the various interdepartmental mergers (ie, New Zealand Food Standards Authority with the Ministry of Agriculture, the National Library of New Zealand and Archives New Zealand into the Department of Internal Affairs, etc), Ministers have set out a number of objectives relating to any machinery of government change. In summarised form, the objectives agreed by Ministers are:

- Improved service, which includes improving the quality of service to citizens, improved responsiveness to ministers and better alignment of functions to government priorities.
- Reduced cost, which includes removing duplication, achieving economies of scale and scope.
- Future-proofing the long-term delivery of government services.

2.4 Current Roles and Responsibilities

In the New Zealand health and disability sector government-owned national health promotion programmes are prioritised, funded, implemented, supported, and monitored by a range of agencies. The Ministry of Health and the HSC provide the broad range of national health promotion programmes, based on identified health priorities. Other government-owned entities, such as Alcohol Advisory Council of New Zealand (ALAC), Sport and Recreation New Zealand (SPARC), Accident Compensation Corporation (ACC), Ministry of Social Development (MSD), and the Pharmaceutical Management Agency (PHARMAC), deliver issue-specific national health promotion activities.

The Ministry of Health is the government's major funder of national health promotion programmes in the health sector. The Ministry's focus is on providing health sector leadership and its core functions include policy, regulation, legislation, Ministerial support, and funding and monitoring of health services. Currently the Ministry operates at both the strategic and operational levels in relation to funding and providing national health promotion programmes. For example, the Ministry itself delivers national health promotion programmes such as breastfeeding, breast and cervical screening; *Like Minds, Like Mine* (mental illness), and immunisation. In addition, the Ministry contracts the HSC to undertake other national health promotion programmes (Smokefree/Auahi Kore, problem gambling, SunSmart, and nutrition and physical activity). Therefore, the Ministry has a dual role in monitoring the performance of its own services and that of other providers in the sector.

The HSC is the Crown's national health promotion delivery agency and has a purchase agreement administered by the Ministry of Health. Under the current arrangement the HSC is accountable to the Ministry of Health through two independent business units - Governance and Crown Entities (as part of its statutory function) and the National Health Board (as part of its provider/contractual function).

3 Issues Arising

The current arrangements for the prioritisation, funding and implementation of national health promotion programmes raise three issues:

- The fragmented nature of roles and responsibilities of the government organisations leads to:
    - duplication – two organisations doing the same or similar things
    - organisations working independently across different issues and, therefore, not learning from each other's successes, knowledge and experience
    - missed opportunities to leverage buying power, economies of scale and economies of scope
    - unnecessary costs – multiple transaction costs, inefficiencies in spending.

- The lack of a common approach leads to:
    - inconsistencies in messaging.
    - inconsistencies in the quality of services.

- Multiple linkages between customers and providers can lead to:
    - unnecessary transaction costs (ie, consumers and providers having to work with multiple agencies on multiple issues)
    - difficulty in establishing relationships with providers and hence lack of continuous improvement and consistency of standards.

4 The Case for Integration

The case for integration focuses on five areas:

1. Greater cost effectiveness.
2. Improved service.
3. More effective connection to the Ministry.
4. Greater flexibility and innovation.
5. Clearer roles and responsibilities.

4.1 Greater Cost Effectiveness

A single health promotion programme delivery entity would generate greater cost effectiveness outcomes, including the following:

- Economies of scale – creating critical mass will reduce the average cost of running the organisation with the same level of overheads .
- Economies of scope – creating critical mass will lower the average cost for producing two or more programmes. This will be achieved through including bulk buying of research and evaluation, mass media, resources, and merchandise across more than one programme.
- Reduced duplication of activities across and within programme areas.

- Reduced need for external consultancy costs as most of the expertise will be in-house.
- Enhanced ability to prioritise the allocation of funding across competing health promotion programmes.

4.2 Improved Service

Potential improved service outcomes could be achieved a number of ways:

- The benefits that come from vertical integration of functions (ie, strategy, research and evaluation, message design and delivery, procurement, community engagement, understanding the needs of frontline workers) and of horizontal integration across health promotion programmes (ie, those currently undertaken by the HSC as well as those undertaken by the Ministry – breast feeding, breast and cervical screening, mental health and immunisation).
- More effective interventions ensure greater ability to draw out, and draw on, best practice rather than having this isolated within silos.
- Consistency of messages.
- It is easier for the sector to engage with a single agency.

4.3 More Effective Interaction With the Ministry

- Supporting and interacting with the Ministry at a more strategic level.
- Maintaining the relationship with the Ministry at a whole-of-Ministry level.

4.4 Greater flexibility and innovation

- Ability to create more flexible and innovative solutions and approaches for issues. Enhanced critical mass allows the entity to encourage greater competition across semi-independent units, and research identifies the key role of competition and group size in innovation.
- Improved access to knowledge and research information across similar issues.
- Greater opportunities to share ideas and solutions across similar areas.

4.5 Clearer Roles and Responsibilities

A consolidated integrated single agency would ensure clearer roles and responsibilities that would:

- better align functions to achieve the government's priorities.
- enable agencies to concentrate on their core business (strategic policy development, funding and monitoring in the case of the Ministry and national health promotion for HSC).
- remove potential for duplication (or gaps).

5 Options for Achieving Better Integration

Within the context of seeking to achieve more effective integration (particularly of the horizontal variety), there are several options that need to be raised. These options include the following:

1. Clustering all national health promotion programmes within the HSC.
2. Establishing a new entity responsible for these national health promotion programmes.
3. Clustering all national health promotion programmes within the Ministry of Health.
4. Clustering all national health promotion programmes within a national DHB collective.
5. Requiring the Ministry and the HSC to enter into a Memorandum of Understanding (or similar document) setting out shared goals, roles and responsibilities etc and, importantly, setting out the basis upon which greater integration is to be achieved while still retaining health promotion responsibilities in both organisations.

The HSC recommends option 1 above be adopted based on the list of the advantages and disadvantages of each proposed option presented in Appendix One.

6 Why HSC?

Clustering national health promotion programmes under the HSC will benefit the Ministry and the government.

6.1 Advantages of HSC Form and Function

- The Ministry (as a department) is better suited to leading the sector, providing the strategic policy, and funding and monitoring functions. The HSC (as a Crown entity) is better suited to service delivery, particularly where close involvement of Ministers is not necessary and/or desired.
- The HSC has a flexible structure that can quickly respond to changing government requirements. The HSC can plan and allocate budgets over three year periods if work needs to be delayed or planned in future years. The HSC's contract service schedule can be simply varied to add or replace programmes and services.
- There is provision for HSC to respond efficiently and effectively to the Minister's direction, in accordance with the Crown Entities Act 2004. This gives the Minister of Health the power to add to the functions of a Crown entity such as the HSC and direct the entity to perform any additional function that is consistent with the HSC's objectives to promote and encourage healthy lifestyles.
- The HSC already has a form (and mandate) that allows it to undertake the extended range of services. All that is required is a simple change of contract specification.

6.2 Understanding of Customers

The HSC understands its customers. HSC has:

- an excellent understanding of its customers (population groups that health promotion services are trying to reach and influence)
- the capacity and capability to engage with frontline workers (particularly in terms of supporting resources and information).

The HSC achieves this knowledge through focus group research, behavioural surveys, and up-to-date evidence reviews. The HSC also proactively tests ideas and concepts with the sector, Ministry and Minister, as appropriate, to refine ideas and manage potential risks.

6.3 Capability and Capacity

The HSC has a proven capacity, capability and experience in delivering national health promotion programmes. HSC has:

- well established health promotion, commercial marketing and communications expertise that it can apply to the wider government health sector at low cost. This includes methods to achieve greater audience reach for the same money (ie, use of social media vs printing publications)
- an established and expert research and evaluation team for developing and disseminating health sector information and knowledge
- a demonstrated ability to undertake national monitoring and evaluation surveys
- well established relationships, collaborations and partnerships with New Zealand universities, other health sector organisations (such as the Cancer Society, Heart Foundation, ASH) and international research organisations
- the ability to provide sector capacity development opportunities such as skills training, and quality improvement.

6.4 Proven Success

The HSC has a 20-year history of success in delivering national health promotion programmes, including the following:

- There is plentiful evidence of impacts achieved with campaigns and other interventions undertaken by HSC (examples of successes are listed in Appendix Two).
- HSC's work and expertise is recognised and drawn on internationally (eg, Global Tobacco Research Network, National Social Marketing Centre).
- HSC delivers innovative approaches (eg, Smoking Not *Our* Future) and high quality health education resources.
- Frameworks and performance measures for assessing and reporting on impact are well established.

- HSC offers a low risk option for the government/Ministry.

6.5 Connectivity with Consumers and Providers

- The HSC has well established public sector relationships and partnerships with non-government and private sector organisations, which leverage greater value for money for government (eg, the Cancer Society covers at least half the costs of the sun safety programme and supports the programme through its own regional delivery infrastructure).
- These relationships help to build trust and confidence, reduce risk, and strengthen incentives.
- Contracting services within the HSC reduces the potential conflicts of interest that the Ministry, as a regulator, would experience in trying to work with private partners on some projects.

7 International Examples of National Health Promotion Entities

There are some examples of international models of national health promotion agencies, which could be applied to the New Zealand context. These examples are listed below.

7.1 Health Promotion Board (Singapore)

The Health Promotion Board (HPB) is a national agency responsible for national health promotion and disease prevention programmes in Singapore. The HPB is a statutory board supporting the Ministry of Health of Singapore. It was established in 2001 as the main driver for national health promotion and disease prevention programmes. HPB's goal is to increase the quality and years of healthy life and prevent illness, disability and premature death.

The HPB implements national programmes that aim to reach children, adults and the elderly. These programmes include health and dental services for school children, breast screening, AIDs education, cervical screening, childhood injury prevention, mental health education, national myopia prevention, physical activity, national smoking control, nutrition, osteoporosis education, workplace health promotion, HPB online, Healthline, Health information centre and HealthZone. HPB initiates new programmes over time to address health concerns among the community.

7.2 Australian National Preventive Health Agency

Established in January 2011, the Australian National Preventive Health Agency (ANPHA) is accountable to the Commonwealth Minister for Health and Ageing. The ANPHA is responsible for supporting efforts to combat preventable disease by:

- providing evidence-based advice to Health Ministers on key preventive health issues
- providing national leadership and stewardship of surveillance and data on preventable chronic diseases and their lifestyle-related risk factors

- collating evidence to assess and report biennially on the state of preventive health in Australia
- supporting behavioural change through educational, promotional and community awareness programs relating to preventive health, including:
    - the promotion of a healthy lifestyle and good nutrition
    - reducing tobacco use
    - minimising the harmful drinking of alcohol
    - discouraging substance abuse
    - reducing the incidence of obesity among Australians
- providing financial assistance to third parties to support the development and evolution of evidence around preventive health interventions and to achieve preventive health gains
- forming partnerships with relevant groups (industry, non-government and community sectors) to encourage cooperative action leading to preventive health gains
- promulgating national guidelines, standards, codes, charters and other frameworks to guide preventive health initiatives, interventions and activities
- managing schemes rewarding best practice in preventive health interventions and activities.

7.3 Health Protection Agency (United Kingdom)

Established in 2003 under the National Health System in the United Kingdom, the Health Protection Agency (HPA) is responsible for protecting the public from threats to their health from infectious diseases and environmental hazards. It does this by providing advice and information to the general public, to health professionals such as doctors and nurses, and to national and local government.

The HPA:

- provides advice to the public on how to stay healthy and avoid health hazards, and advises people working in healthcare
- provides data and information to government to help inform its decision making
- prepares the nation for future threats to health that could happen naturally, accidentally or deliberately
- supports and advises other organisations that play a part in protecting health
- uses its research to develop new vaccines and treatments to help patients.

The HPA carries out a number of functions on behalf of, or in collaboration with, the commercial sector and other external bodies. The purpose of these partnerships is to develop practical solutions to healthcare problems and to generate funds for further investment.

7.4 Compatability

Under its current legislative mandate the HSC could perform most of the types of functions described within these international models.

8 Estimated Savings

Significant savings could be made by clustering all national health promotion programmes into a single entity. A rough calculation of potential savings made as a result of clustering all Ministry-related programmes into the HSC would be at least $350,000 - $400,000 based on the following:

- Research and evaluation (clustering all programme-related surveys into one national healthy lifestyle survey): $200,000.
- Media - Savings with bulk media buying (ie, additional 2.5% media rebate): $150,000 - $200,00.
- Overheads – Overhead costs will be saved by placing programmes into one entity. HSC overheads are not likely to increase and would be spread over a larger number of programmes. Overall, a reduction of back-office support for a range of front line programmes would be achieved.
- There are potential savings from reduced external consultancy costs assuming that relevant expertise will be in-house.[3]

More accurate and detailed costings would need to be obtained as outlined in section 9 below.

9 Future Work

Based on the proposed benefits and rough cost saving estimates above, there is merit in pursuing a more rigorous evaluation of potential cost savings from clustering national health promotion programmes from the Ministry of Health into the HSC.

Potential exists to cluster national health promotion programmes and/or elements from other health sector contributors (such as SPARC, ACC, ALAC, and MSD), although this may require legislative changes. In addition, there are opportunities to cluster other national programmes from organisations delivering against the government's broader public sector objectives (eg, road safety, energy savings, environment, retirement savings, etc).

The HSC recommends that a joint Ministry/HSC project group be established to quantify the potential costs and savings associated with a clustering of national health promotion programmes, based on an agreed scope. It might also be appropriate to obtain independent advice and expertise for this exercise from external experts such as Martin Jenkins, Deliotte, or PricewaterhouseCoopers.

If the cost benefit/s from the proposed clustering is justifiable the next step would be to discuss and plan for the following:

- How a clustering of services would work in practice.
- The development of transitional arrangements, including milestones, time frames, etc.

10 Recommendations

It is recommended that the Ministry of Health:

a. Agree that there is an opportunity to increase efficiency and achieve effectiveness gains by clustering national health promotion programmes into a single entity.

b. Establish a joint project with the HSC and external experts to scope and quantify potential cost savings associated with HSC undertaking an increased number of national health promotion programmes.

c. With or without undertaking (b) above, direct HSC to deliver all national health promotion programmes currently delivered by the Ministry of Health.

d. Consider the opportunity and advantages of increasing HSC's role beyond those national health promotion programmes currently delivered by the Ministry of Health.

Appendix One – Advantages and Disadvantages of Options for Integration

Retain the Status Quo

Advantages

- Business continues as normal.
- No policy or legislative changes would be required.

Disadvantages

- Significant potential for efficiencies less likely to be realised.
- Lack of clarity of roles and responsibilities in the sector.
- Lack of coherent national health promotion leadership.
- Less effective services with potential for inconsistent messages, duplication and gaps.

Cluster all national health promotion programmes within the HSC

Advantages

- Greater ability to achieve cost efficiencies through economies of scale and scope.
- Greater clarity of roles and responsibilities in the sector.
- Coherent national health promotion leadership established.
- Improved services – consistent resources and messages, reduced duplication and/or gaps.
- Existing experience, expertise and facility used.
- A central hub for developing and disseminating research and evaluation knowledge.
- Existing health promotion relationships maintained.
- Enhanced support for frontline workers.
- Potential for improved interactions between the Ministry and HSC.
- Potential for greater flexibility and innovation outside of a government department.
- Potential to avoid conflicts of interest in managing some private partnerships as a non-funder and non-regulator.
- A familiar and well regarded health promotion entity for local and regional providers to work with.
- Easy to do – simple change of contract specification.

Disadvantages

- Relies on a delivery infrastructure that is not controlled by the HSC (ie, DHBs).
- Additional work required to develop new relationships in new programme areas.
- Capacity would need to be created for new programme areas.
- Limited overhead savings.

Establish new entity

Advantages

- Ability to establish a fresh approach to national health promotion.
- Greater clarity of roles and responsibilities in the sector.

Disadvantages

- Relies on local delivery infrastructure that is not controlled by the entity (ie, DHBs).
- New legislation required.
- Perceived as an increase in bureaucracy.
- Potential loss of institutional expertise and experience from people not wishing to transfer.

Cluster all national health promotion programmes within the Ministry of Health

Advantages

- Greater ability to achieve cost efficiencies through economies of scale and scope.
- Increased connection to strategic sector focus.
- No policy or legislative changes required.
- Savings made from HSC overhead costs (ie, Board and some management staff).
- Minimal compliance costs.

Disadvantages

- Relies on local delivery infrastructure that is not controlled by the entity (ie, DHBs).
- Inconsistent with Ministry strategic functions.
- Funding and monitoring role conflicts with provider role.
- Potential to lose specialist health promotion experience and expertise if HSC staff fail to transfer.
- Perception of increased growth in bureaucracy with FTE increase in Ministry.

- Potential for conflicts of interest in dealing with some partnerships as a funder and regulator.
- Programme flexibility and innovation likely to be constrained within a government department.
- Possible increased consultancy and related transaction costs.
- Overhead savings are limited.
- Additional work required to develop new relationships in new programme areas.
- Capacity would need to be created for new programme areas.

Cluster all national health promotion programmes into a DHB collective

Advantages

- Greater ability to link into national, regional and local DHB activities.
- Easier access to national and regional delivery infrastructure.

Disadvantages

- Not recognised for national health promotion programme experience and skills.
- Potential for greater transaction costs to get agreement of DHBs.
- Potential loss of institutional expertise and experience from people not wishing to transfer.
- DHBs not previously known to work in this way.

Establish Memorandum of understanding between Ministry and HSC

Advantages

- Simple to establish and administer.
- Clarity of roles and responsibilities between agencies.
- Greater interaction between Ministry and HSC.
- Simple efficiencies can be made (eg, Joint media purchasing)
- No policy or legislative changes required.

Disadvantages

- Significant potential for efficiencies less likely to be realised.
- Potential for lack of clarity of roles and responsibility externally.
- Increased transaction costs between organisations.

Appendix Two – Examples of HSC Successes

Smokefree

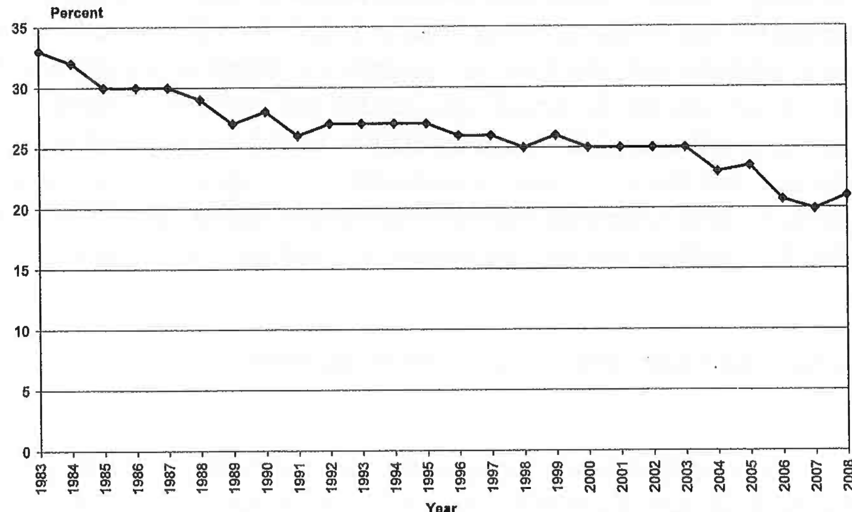
The 'Smokefree' brand was developed for the tobacco control sector in 1990. It was launched to motivate smokers to adopt a smokefree lifestyle and to encourage and promote consistent and effective messages among health workers (at the time many DHBs had their own smokefree logo and messaging). The brand was successful in unifying a diverse tobacco control sector (there is now only one smokefree logo and messaging, and campaigns are developed nationally and delivered in a consistent way across the country). As well as a communication device for the general public, this brand has been used by health providers to engage and associate with schools, sporting and cultural events, and community groups, and is pervasive throughout New Zealand.

New Zealand's Smokefree brand has been adopted internationally in countries such as the United States of America and Ghana.

Since the introduction of smokefree the number of adult smokers has continued to decline (see graph below).

Current smoking among those aged 15 years and over, 1983–2008

(unadjusted prevalence)



Sources: AC Nielsen NZ Ltd (1983–1995, 1997–2005); 1996 and 2006 Censuses of Population and Dwellings, Statistics New Zealand; 2006/07 New Zealand Health Survey; NZTUS 2008.

Sun Safety

The sun safety programme is a successful partnership between the HSC and the Cancer Society of New Zealand. This partnership allows the Crown to gain additional benefits out of an established and well-regarded non-government organisation. The Cancer Society covers at

least half the costs of the sun safety programme and supports the programme through its own regional delivery infrastructure.

While rates of skin cancer and melanoma continue to rise (reflecting the sun worshipping behaviour of the 1970s, 1980s, and 1990s), people are responding positively to behaviour change messages.

- One-quarter (25%) of research respondents report changes to their sun protection behaviour since seeing or hearing SunSmart messages, while the majority of the rest (60%) reported that the messages reinforced behaviours they do to protect themselves.
- Around 30% of parents and caregivers who had seen SunSmart messages said they made changes to the way they protect their children in the sun.

Smoking Not Our Future

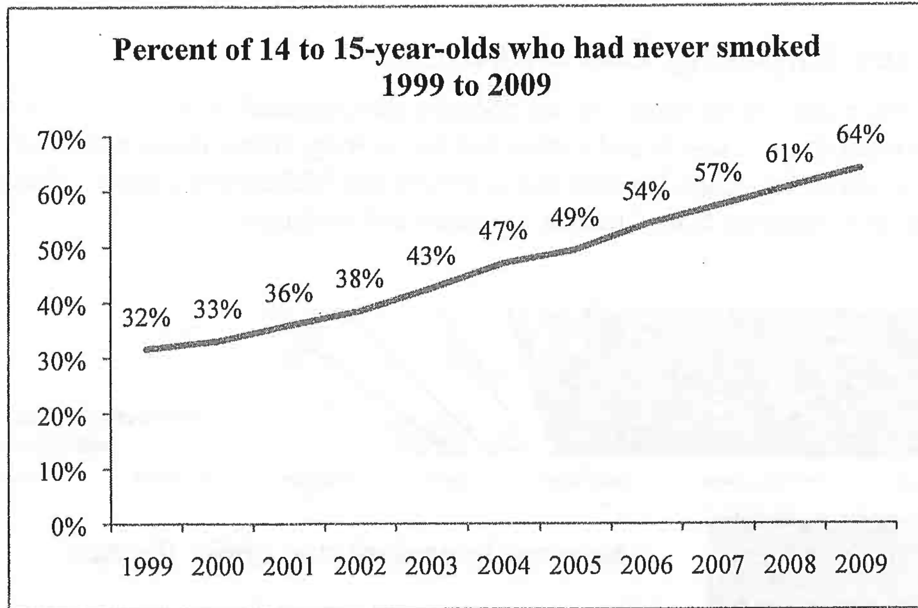
The Smoking Not *Our* Future campaign was launched by the HSC in 2007 to denormalise tobacco use by increasing negative perceptions of the social outcomes of smoking among young people. It features youth-oriented celebrities talking through a range of media channels about smoking, being smokefree, and quitting smoking.

Results of the Smoking Not *Our* Future campaign evaluation identify that there is high recall of the Smoking Not *Our* Future television commercials among young people, across age, gender, ethnicity, and smoking status. Young people overall showed high levels of agreement with a series of statements designed to measure the impact of the television commercials, and again this impact was similar across age, gender, and ethnicity. Young people who were current smokers had as high levels of agreement with most of the impact statements, and many indicated that the television commercials encouraged them to quit smoking. The success of this youth-focused campaign contrasts favourably against the 'Why Start' campaign, which was funded $1.0 million per year for three years and then terminated.

Smoking Not *Our* Future has had an effect on behaviours:

- One in three respondents to research had done something in response to Smoking Not *Our* Future (ie, talked about it, attempted to quit, haven't started, encouraged others not to start smoking etc).
- One in four know someone who had tried to quit as a result of Smoking Not *Our* Future.
- 59% agreed 'the ads have put me off smoking'.

The proportion of 14 and 15-year-olds that have never smoked (that is, never even had one puff of a cigarette) has increased from 33% in 2000 to 64% in 2009 (refer the graph below). This increase represents a huge amount of work undertaken by the tobacco control sector. HSC has significantly contributed to the increase through Smoking Not *Our* Future.



National Year 10 ASH Snapshot Survey.

National Monitoring

The HSC undertakes long-term research such as the biennial Health and Lifestyles Survey to track the impact of HSC's four programmes, the triennial Sun Exposure Survey (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). HSC also provides youth smoking data for the Ministry of Health, DHBs and (through our participation in the Global Youth Tobacco Survey) the World Health Organization. These activities inform the programmes of HSC and the wider health sector.

English

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Tobacco Free Initiative (TFI)

Tobacco Free Initiative
Research and policy
Surveillance
Capacity building
Communications
Global network
Publications

Global Youth Tobacco Survey (GYTS)

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Background

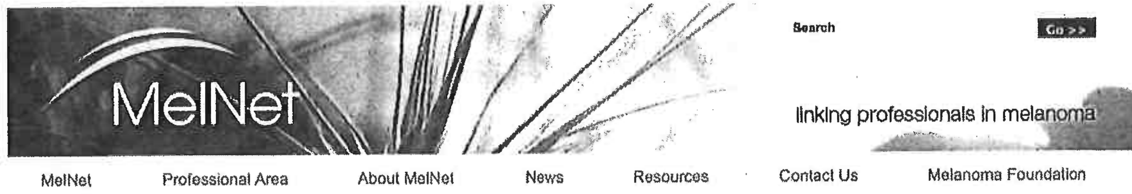
In December 1998, TFI convened a meeting in Geneva with the Centers for Disease Control and Prevention (CDC), the United Nations Children's Fund (UNICEF), the World Bank and representatives from countries in each of the six WHO regions to discuss the need for standardized mechanisms to collect youth tobacco use information on a global basis. The outcome of this meeting was the development by WHO and CDC of a Global Tobacco Surveillance System, which uses the Global Youth Tobacco Survey (GYTS) as its data collection mechanism.

Description

The GYTS is a school-based survey designed to enhance the capacity of countries to monitor tobacco use among youth and to guide the implementation and evaluation of tobacco prevention and control programmes. The GYTS uses a standard methodology for constructing the sampling frame, selecting schools and classes, preparing questionnaires, following consistent field procedures, and using consistent data management procedures for data processing and analysis. The information generated from the GYTS can be used to stimulate the development of tobacco control programmes and can serve as a means to assess progress in meeting programme goals. In addition, GYTS data can be used to monitor seven Articles in the WHO FCTC.

Sector Capacity Development

The HSC regularly facilitates sector capacity development opportunities in health promotion, social marketing, research and evaluation (knowledge dissemination through fact sheets and reports) and issue-related events and activities (eg, Melanoma Summit, annual tobacco control conference, requests from frontline agencies and workers).



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Professionals Register Here

The most important day under the sun

Melanoma Summit
New Zealand 2011

Nearly 200 professionals working in melanoma gathered at Te Papa in Wellington on 11 March 2011 for the second national Melanoma Summit. Participants included GPs, pathologists, dermatologists, surgeons, oncologists, nurses, health promoters, policy makers and researchers. A number of people affected by melanoma also attended as Melanoma Foundation participants.

Summit highlights

Among the issues highlighted at the Summit were:

- New Zealand's melanoma incidence and thickness are increasing in New Zealand, and our death rate is 40% higher than in Australia (Dr Mary Jane Sneyd, Hugh Adam Cancer Epidemiology Unit, University of Otago)
- Sun exposure will increase a person's risk of developing melanoma, whether they are young or old (Professor Bruce Armstrong, University of Sydney)
- Sunbed use before the age of 35 increases the risk of melanoma by 75 percent (Craig Sinclair, Head of WHO Collaborative Centre for UV Radiation and Director of Cancer Prevention Centre, Cancer Council Victoria)
- Voluntary standards in the sunbed industry are not working (Dr Ben Tallon, Tauranga Hospital)
- GPs need clarity around advice to give on sun protection, whilst balancing this against the need for adequate levels of vitamin D, according to preliminary findings of a University of Otago study (Dr Tony Reeder, Cancer Society Social and Behavioural Research Unit)
- Dermoscopy is more accurate than clinical examination based on four recent meta-analyses; it also "forces" physicians to dedicate more time and care for individuals with pigmented skin lesions (Professor Peter Soyer, University of Queensland)