

## 4. The Importance of a Public Health Strategy

The public health debate has focused on whether the health budget for public health is enough and whether an appropriation equal to 2 to 4% of this is sufficient to fund effective communication, health education and prevention services.

A public health population strategy aims to influence favourably the determinants of a disease in the population as a whole. Current strategies aim to reduce evidence-based health risks. If these strategies were funded to be effective, they could increase the chance of preventing high-risk individuals from developing Type 2 diabetes, and could also reduce the chance of individuals with low risk becoming high risk<sup>63</sup>.

The advantage of a nationally co-ordinated public health strategy is that any strategies aimed at increasing physical activity, reducing animal fat in the diet and reducing obesity are likely to have a positive effect on reducing cardiovascular disease and improving general health and other risk factors for people with established diabetes. The development of complications of Type 2 diabetes are theoretically preventable, but only through lifestyle modification involving improved nutrition, reduction in weight and increased physical activity levels when implemented early and continued for many years.

Public Health Initiatives are based on common sense principles, including for example:

1. People who are obese are more likely to develop disabilities and costly health outcomes
2. To stop people becoming more obese or overweight – initiatives focused on nutrition and exercise are required
3. Public Health diabetes strategies need to be implemented now – not after years of collecting data, analysing it, debating the merits and then implementing initiatives 10-20 years later – or meanwhile more of those at risk for diabetes will develop diabetes and then complications.

---

<sup>63</sup> Simmons D, Voyle J, O’Dea K, 1997; Australian Guidelines, 2000.

Public health initiatives are a key part of any diabetes debate. The Sport, Fitness and Leisure Ministerial Taskforce<sup>64</sup>, stated that a fundamental change in the way New Zealand tackles public health issues is required to keep the population from becoming more unwell from lack of fitness which leads to diabetes or even mortality<sup>65</sup>.

Public health initiatives have been limited because of failure to give strategies a chance of succeeding by adequately resourcing them. Often the recommended long-term strategies are set for 5 to 10 years whereas the budget processes are based on 1 to 3 year time horizons.

Table 9 below shows that public health spending increased from \$95.6 million in 1996/97 to \$108.0 million in 1998/99. Public Health's share of Vote Health, however, dropped from 1.8% to 1.7% (total health care expenditure was approximately \$8.4 billion<sup>66</sup> in nominal terms in 1998/99).

Table 9: Annual Public Health Expenditure and Health Education by the Ministry of Health 1996/97 to 1998/99

Public Health Expenditure for:	1996/97		1997/98		1998/99	
	\$ million	% of total	\$ million	% of total	\$ million	% of total
Science services to support field work	10.2	51.5	10.2	58.0	11.3	71.8
Surveillance and surveys of health status and outcomes	2.6	13.2	3.0	17.0	2.4	14.9
Health education and promotion	4.0	<b>20.2</b>	1.7	<b>9.4</b>	0.4	<b>2.6</b>
Other national programmes	3.0	15.1	2.8	15.6	1.7	10.7
<b>Sub Total</b>	<b>19.8</b>	<b>100.0</b>	<b>17.6</b>	<b>100.0</b>	<b>15.8</b>	<b>100</b>
HFA as purchaser	75.8	79.3	83.6	82.6	92.1	85.3
<b>Total</b>	<b>95.6</b>	<b>100.0</b>	<b>101.2</b>	<b>100.0</b>	<b>108.0</b>	<b>100</b>

Source: Ministry of Health

The drop in Public Health's share of the Vote Health Appropriation suggests two possible gaps:

- the public health debate has not been fully recognised by Ministry Health officials and previous Ministers of Health through a sufficient share of the health vote
- and/or the total health vote is focussed on current acute health requirements and is inadequate to invest in strategies which are longer-term in nature.

<sup>64</sup> Report of the Sport, Fitness & Leisure ministerial taskforce, 2001.

<sup>65</sup> Wei M, Gibbons LW, Kampert JB et alia, 2000.

<sup>66</sup> Ministry of Health, 2000.

Spending on health education and promotion has fallen from \$4.0 million in 1996/97 to \$0.4 million in 1998/99. The total spent for health education and promotion (1998/99) is \$400,000. In comparison, the amount of the advertising spend on food was from January to December 1999 was \$222 million<sup>67</sup>. Add to this advertising and marketing by confectionery companies and other high saturated fat producers, it is easy to see why consumption of these foods stays high even while New Zealanders are gaining weight<sup>68</sup> and need more obesity/diet related public policy, community and hospital services and other initiatives.

Table 10: Proportion of Vote Health for Public Health

In 2000/2001:		
Total cost to the taxpayer of health:\$8bn		
Personal health	\$7.9b	
Public health	<u>\$0.1b</u>	
	\$8.0b	
Prevention		2.6%
Health education		<u>1.2%</u>
Proportion of health vote on encouraging wellness		3.8%

Source: Ministry of Health

We recommend that the debate about the merits of public health expenditure needs to start from the perspective of health risk over time. Then these risks need to be taken into account when determining the total health vote. Additional funding allocated to the health vote for public health initiatives can be regarded as an investment in the health of an individual, the population and the economy. In addition, the model shows that there are significant benefits brought about by effective public health programmes aimed at educating those with diagnosed diabetes about lifestyle changes and promoting screening to those with the risk of undiagnosed diabetes and IGT<sup>69</sup>.

<sup>67</sup> AC Nielsen, 2000.

<sup>68</sup> Wilson BD, Wilson NC, Russell DG, 2001

<sup>69</sup> American Diabetes Assn, 2000; Bourn D, Mann J, 1992; Davies MJ, Ammari F, Sheriff C et alia, 1999; Engelau M et alia, 1998; Scherbaum WA, 2001; Shaw JE, Zimmet PZ, de Courteau M et alia, 1999.

