Evidence-based purchasing of health promotion: methodology for reviewing evidence

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SUMMARY

In recent years, greater emphasis has been placed on evidence-based practice by health care purchasers, managers and practitioners around the world. This is seen as a means of delivering greater benefits to patients and populations within existing resources. Evidence-based practice requires accessible information in a form that is relevant to the problems decision-makers face. The process of evidence-based practice needs to be informed by the best available research evidence of the effectiveness of health-promoting interventions combined with good judgement as to the applicability of that evidence and the feasibility of implementation in the local context. The nature of evidence which can be brought to bear on the decision-making process may vary in both quality and reliability. In the field of health promotion, the nature of problems requiring solutions is complex. Commonly there are multiple variables affecting multiple health outcomes. In addition, there is limited available evidence for the effectiveness of interventions and it is of variable quality. These factors pose problems for ensuring evidence-based health promotion. This article describes New Zealand research commissioned by one of four regional purchasers of health services. The purchaser required the development of a framework to prioritize interventions in 22 health promotion areas identified as priorities by the Minister of Health. Our framework was used to consider a broad range of different kinds of evidence, including scientific research, organizational capacity, socio-cultural factors and local community-based knowledge related to the determinants of health. Making explicit the nature of our framework and the evidence we considered, enabled our recommendations about the most appropriate interventions to be as valid and reliable as possible. Our judgement is that as for evidence-based medicine, evidence-based health promotion must employ both quantitative and qualitative evidence, and that the final judgement about purchasing of health promotion initiatives is essentially subjective and political.

Key words: evidence-based health promotion; health promotion purchasing; models; theory

INTRODUCTION

The concept of evidence-based health practice, whose philosophical origins extend back to mid-nineteenth century Europe, is highly topical for public health practitioners, clinicians, managers, purchasers and the public alike. While centres of evidence-based medicine (EBM) have been established worldwide, new EBM practice journals have appeared and EBM has become a common topic in the laymedia, the implications for health promotion have yet to be addressed (Chalmers, 1993). A recent article in the British Medical Journal cautioned that considering health promotion with the tools used in EBM carried the risk that health promotion may be designated ‘not effective’ because it is being assessed with inappropriate tools (Speller et al., 1997), and
pointed out that the ‘selection of studies is done on the basis of the quality of research only, not on the quality of the health promotion interventions’. On the other hand, to not even try to explicitly base health promotion on the best evidence for effective practice carries the risk that when resources are scarce, unsubstantiated health promotion practices become a low priority. In this paper, we review the EBM approach before presenting a modified evidence-based health promotion framework and illustrating its application using public health examples.

Evidence-based medicine (EBM)

Evidence-based purchasing of any services or interventions requires a decision-making process that makes the scientific evidence accessible to decision-makers, makes the research relevant to ‘real-world’ problems, and makes decision-makers aware of the evidence and how to interpret it in the context of their own ‘problems’. EBM is a framework for asking questions, tracking down new types of strong and useful evidence, distinguishing it from weak, irrelevant or useless evidence, and putting it into practice. According to the Evidence-Based Medicine Working Group, EBM ‘de-emphasises intuition, unsystematic clinical experience, and pathophysiologic rationale as sufficient grounds for clinical decision-making, and stresses the examination of evidence from clinical research’. EBM ‘requires new skills of the physician, including efficient literature searching and the application of formal rules of evidence evaluating the clinical literature’ (Evidence-Based Medicine Working Group, 1992). Sackett et al.’s (1996) definition of EBM:

evidence-based health promotion is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individuals, communities, and populations. The practice of EBHP means integrating local expertise with the best available external evidence yielded by systematic research.

The process and practise of EBHP requires skills that are not traditionally part of health promotion/health education training. It includes more than defining individual, group or community problems, and appropriate programmes to resolve those problems. EBHP requires conducting extensive cross-disciplinary literature searches, selecting the most effective of the relevant programmes, and applying rules of evidence and appraisal of study quality to determine the validity of the findings. It also requires attention to recognized health promotion concepts, socio-cultural factors and organizational factors (Long and Sheldon, 1992).

In addition, EBHP asks the practitioner to present to the purchaser a reliable summary of the area, including its strengths and weaknesses, and the ability to extract the specific recommendations and apply them accordingly. EBHP also involves applying traditional skills of health promotion and health education, for example sensitivity to the cultural and emotional needs of individuals and particular populations, e.g. the elderly, and indigenous populations, e.g. New Zealand Maori.

PARADIGM UNDERLYING THE APPROACH TO EVIDENCE COLLECTION

The questions of what constitutes knowledge and how we assess knowledge are fundamental
ontological and epistemological questions. The philosophy behind our approach is that all knowledge and thus all evidence is socially constructed (Guba and Lincoln, 1994). Our integrated model acknowledges that scientific evidence, while crucial, is only one type of evidence. Scientific, professional and community groups make legitimate claims to expertise, and often these claims compete. Similarly, Labonte and Robertson (1996: 431) have concluded that the constructivist paradigm is ‘more suited to the goals of current health promotion’ than the conventional positivist paradigm, which is the basis of EBM.

Our methodology is pluralistic. We accept that a wide range of types of evidence is admissible. In some cases, the relationship between the informant and the evidence will correspond to scientific protocol. In other cases, community informants will have developed popular epidemiological theories, which operate under a different system. Within the context of the Treaty of Waitangi (discussed later), Maori historical experience provides another strand of evidence. Various kinds of evidence are important and our model makes the weighting we give to these different types explicit.

**Methodological issues**

Evidence-based health promotion emphasizes the need to move from sound theoretical principles to rigorous evaluations of health promotion interventions. Knowing how to use the available research literature and community expertise is imperative for ensuring the provision of optimal delivery.

Intervention information comes from two principal sources: the actual target population and research based on other populations. To provide effective programme delivery, both types of information are required. EBHP requires a bottom-up approach that integrates the best external evidence with sound internal evidence derived from local expertise and population choice. Information about the target population is elicited through procedures/sources, e.g. quality-of-life analysis, focus groups, local and regional morbidity and mortality tables, etc. Information from scientific research requires obtaining the best available evidence by: (i) framing questions that are pertinent and answerable; (ii) tracking down articles and sources; and (iii) exercising discrimination when selecting.

The importance of the local context in health promotion means that obtaining New Zealand-based evidence for health promotion is particularly important, though difficult.

The strong emphasis on RCTs and meta-analyses in EBM has to be suitably modified in the practice of EBHP. Most studies and programmes in health promotion do not, as EBM does, use random assignment or control groups; these may be impractical and very expensive and ignore some of the unique features of health promotions interventions (McPherson, 1995). However, in common with EBM, EBHP’s problems cannot be solved solely by Medline and Internet searches, as there is a lack of systematic information in printable or searchable form. The currently available information systems are poorly designed for use by practising health promoters, and are very time consuming. In addition, as Britton et al. (1998) point out, it is important to distinguish between being ‘not effective’ and being ‘not evaluable’.

There have been significant attempts to address scientific evidence for health promotion. The Canadian Community Health Practice Guidelines Working Group developed systematic methods to assemble and review scientific evidence, assess current practices, develop an approach to the formulation of guidelines for community health practice and identify research needs (Gyorkos et al., 1994). However, there remains a broad question about the effectiveness of guidelines ‘when the rationale behind guidelines is not communicated convincingly, fundamental questions remain about their value and relevance’ (Rafuse, 1994). The NHS Centre for Review and Dissemination (1995) at the University of York also developed a comprehensive framework for undertaking systematic reviews of effectiveness of health services. However, neither of these working groups considered EBHP from a purchasing perspective.

Recent health reforms in New Zealand have separated the purchase of all health services, including health promotion, from the provision of services, and there is a growing emphasis on efficiency and flexibility of services (Howden-Chapman and Ashton, 1994). Funding continues to be predominantly public, although private providers have been encouraged by a variety of economic incentives. It appears from our review of the literature that New Zealand health purchasers are at the forefront of EBHP purchasing.
Elements for the practice of EBHP in New Zealand

Our framework is based on the methodology developed by the Canadian Task Force on the Periodic Health Examination (1979, 1994), which was adopted by the US Preventive Services Task Force (1989). However, our framework is broader, to accommodate the philosophy and practice of health promotion and take into account the Government's obligations to Maori under the Treaty of Waitangi, and to incorporate already developed principles for services for Maori.

The Treaty of Waitangi was an agreement between Maori and the British Crown signed in 1840. The Treaty, which consists of a preamble, three articles and a postscript, lays down the ground rules by which Maori and settlers would coexist in New Zealand. One Treaty provision is derived from each of the three articles. The first article, *Kawanatanga*, provides for the right of the Government and its agencies to govern. The second, *Tino Rangatiratanga*, provides for tribes to exercise authority over their own affairs. The third, *Orietanga*, provides a guarantee of equity between Maori individuals and other New Zealanders (Durie, 1994a).

Consistent with Maori views, the 1988 Royal Commission on Social Policy stated that the Treaty was as relevant to the future as to the past. The Royal Commission identified three Treaty principles relevant to social policy: partnership, participation and protection. Partnership refers to the nature of the ongoing relationship between Maori tribes and the Crown or its agents. Participation refers to positive Maori involvement in all aspects of New Zealand society. Protection, at least in health terms, refers to the Crown's obligation to be proactive in seeking opportunities to enhance Maori health (Durie, 1994a).

Therefore, Maori have a Treaty-based right to equity in health status with other New Zealanders. Maori presently suffer disproportionately from ill health compared to other New Zealanders (Pomare et al., 1995; Howden-Chapman and Cram, 1998). Maori themselves have always recognized the implications of the Treaty in health terms, but it was only in 1992 that the Treaty was recognized by the Minister of Health as the founding document of New Zealand. However, while there has been reference to the Treaty in some public health policy, the Treaty is only enforceable when incorporated into legislation (Durie, 1994a). There are no references to the Treaty in health legislation and therefore no enforceable requirement that public health purchasing take account of the Treaty. Nevertheless, the Crown has Treaty-based obligations and therefore consideration of the Treaty must be explicit in any New Zealand EBHP framework.

Our approach expands the criteria of acceptability of evidence to allow for the consideration of already developed principles for the purchasing, delivery, monitoring and assessment of acceptable services for Maori (Durie, 1994b; Durie et al., 1995; Ratima et al., 1995). The principles were identified in three models, the first of which provided a framework for auditing public health programmes with respect to cultural appropriateness and health gains for Maori (Durie, 1994b). For example, programme providers are expected to be 'culturally safe', i.e. sensitive to Maori culture, values and beliefs, in order to avoid inappropriate practices which may marginalize Maori participation. Also, programmes should be consistent with Maori priorities and ensure active Maori involvement at all levels (Durie, 1994b). Two additional models are *He Anga Whakamana*, a model for the delivery of disability support services for Maori (Ratima et al., 1995) and the culturally effective purchasing framework (Durie et al., 1995). The principles emphasized in all three models include: enablement; active participation; cultural safety; effectiveness; accessibility; and consistency with Maori priorities.

The economic evaluation was based on the work of Drummond et al. (1987) which has already been incorporated into the evidence-based work of the Canadians and Americans. The assessment of validity of research has been modified from Schechter's (1994) work on critical appraisal of published research.

We were aware that the health promotion measures we were concerned with were those that health purchasers can influence. Changes in national laws or taxes are therefore outside of the scope of this framework. Any effective and efficient preventive health care has to consider (and combine) the best health promotion interventions and the best clinical preventive strategies. In addition, the purchaser must not only help the individuals or group increase their knowledge about the options, but also help them understand the strength of the available evidence.
A FRAMEWORK FOR EVIDENCE-BASED PURCHASING OF HEALTH PROMOTION PROGRAMMES

Our framework is based upon the core purchasing principle of effectiveness. Effectiveness is the capacity of a health promotion programme to meet the health needs of the target population and lead to improved health outcomes. A health promotion programme, which is effective within the New Zealand context, must meet effectiveness criteria in four inter-related dimensions. Specifically, it must:

1. provide scientific evidence of need and effectiveness (scientific dimension);
2. fit policy frameworks and be consistent with Treaty-based obligations (organizational dimension); (3) be sensitive to social and cultural needs (socio-cultural dimension);
4. adopt recognized health promotion principles (health promotion dimension).

Our framework acknowledges the importance of evidence outside the narrow scientific paradigm, and that successful health promotion programmes require an integrated approach. That is, consideration must be given to a number of dimensions, and one cannot be viewed in isolation from the others.

At the core of our framework are four dimensions of effectiveness: rules of evidence; adherence to Government objectives and the Government’s Treaty of Waitangi-based obligations; sensitivity to the socio-cultural context and equity of opportunity; and an emphasis on an approach consistent with the Ottawa Charter. At
the second level, each of these dimensions of effectiveness was expanded iteratively into five key themes, in consultation with our Advisory Group. Each key theme was operationalized into a number of measurable indicators, which then provide guidance as to the types of evidence which are required to assess programme effectiveness. While the framework offers examples of measurable indicators, the list is not exhaustive, as the most appropriate indicators are best negotiated between the purchasers and providers and may vary according to the target population and local situation. Further, in some cases, a suggested indicator may relate to more than one key theme, and therefore indicators are not specifically linked to a particular key theme.

The scientific dimension

The central effectiveness criteria for the scientific dimension are based on the ranking of research methods and rules of evidence. These rules are intended to grade the quality of scientific evidence provided in support of each intervention and are ranked according to the following methods.

1. Well-designed randomized controlled trials.
2. Well-designed controlled trials without randomization.
3. Well-designed cohort studies.
4. Well-designed case-control studies.
5. Recommendations from respected authorities based on health promotion and clinical experience, descriptive studies, or reports of expert committees.
6. Endorsement of interventions by specific target populations.

At the second level, the key themes identified relate both to the design and cost effectiveness of the studies being used as evidence. The initial question is how rigorous is the study design? The question of clinical effectiveness follows, does the intervention lead to improved health outcomes? Internal and external validity are important considerations, they show to what degree the evidence reflects the effect of the intervention and to what degree the evidence is generalizable to the target community. After considering the effectiveness of the design, cost efficiency is reviewed. A comparison of the relative costs and benefits of different interventions is necessary to determine whether the programme is efficient (Ashton, 1992). With cost efficiency data it is then possible to look at the question of allocative efficiency, is the mix of programmes the most appropriate way to improve health?

Each of the key themes has third level indicators. Was the study sample representative of the target population? Were the study findings confounded by biases, distorting factors, or errors in the data or experimental design? Was there cross-contamination, i.e. did the controls and subjects interact in such a way that observed effects were contaminated? Or was there co-intervention? Was there another intervention acting at the same time, making it difficult to untangle the effects of one intervention from another? Most importantly, did the measurable health gains for the target group occur as a result of the intervention?

The organizational dimension

The central effectiveness criteria for the organizational dimension are meeting the Government Objectives for Health and Disability Support Services, as specified in policy guidelines to the regional purchasing authorities; and the Government’s Treaty of Waitangi-based obligations.

Interventions need to be assessed for their relevance to Government health gain priority areas and for their accordance with the Government’s six over-arching purchasing principles, which are as follows (Shipley, 1995).

1. Equity—services should be accessible and meet the needs of the people.
2. Effectiveness—services should provide beneficial outcomes for consumers.
3. Efficiency—the greatest health gain for the money spent.
4. Safety—regional purchasers should protect the public from avoidable harm.
5. Acceptability—services should be responsive to social and cultural diversity.
6. Risk Management—regional purchasing authorities should develop strategies to minimize risk to providers and consumers.

Similarly, programmes should be consistent with Government Treaty-based obligations. Reviewing programmes in terms of their consistency with Treaty provisions (governance, tribal authority and equity) and principles (partnership, participation and active protection)
provides a mechanism to assess health promotion programmes in terms of meeting Crown Treaty-based obligations.

Clearly, some of the purchasing principles and Treaty provisions and principles overlap with other key effectiveness areas, but as most health promotion efforts in New Zealand are publicly funded, consideration of government objectives and Treaty-based obligations is essential.

At the second level, the key themes are as follows. Proposed programmes must also take into account the health service context. For example, when a purchaser is considering a well-child programme for Maori caregivers and their children, e.g. the programme Tipu Ora (Te Puni Kokiri, 1994), it is important to know whether such a programme complements, rather than duplicates, existing services, e.g. the mainstream Plunket well-child programme. Tipu Ora, was innovative, it employed Maori community workers with extensive local knowledge and networks, and was based on Maori philosophies and processes. It therefore differed from the pre-existing approach and built on the organizational structure of the Women’s Health League (a voluntary Maori community organization).

Purchasers must also take into account the legislative and regulatory requirements. Proposed interventions or programmes must be able to be accommodated within current public health laws and occupational health and safety regulations. In the current climate of fixed budgets, the implications of the Government’s resource allocation need to be considered. Has there been explicit prioritizing of the area, and does the programme fit within identified resource priority areas? For example, Maori health and child health are presently Government priority areas, so targeted initiatives in these areas are more likely to be funded. A well-organized intersectoral approach can enhance the potential for programme effectiveness. To take the example of the Maori well-child programme, such a programme can fruitfully involve educational pre-school services, Maori community groups and local councils. Furthermore, consideration needs to be given to political durability; is the intervention sustainable in a political environment where coalitions of interest change?

At the third level, the indicators provide guidelines as to the type of evidence that is required within each dimension when considering a programme’s effectiveness. For example, in terms of priorities, does the programme address one or more Government priority areas? And at the level of intersectoral cooperation, how many sectors are involved and to what extent does the programme incorporate institutional mechanisms to facilitate cooperation across sectors? In assessing a programme’s political durability, a third level indicator would be evidence in political manifestos or coalition agreements of multi-party support for a particular type of intervention.

The health promotion dimension

The central effectiveness criteria for the health promotion dimension are contained in the Ottawa Charter, which provides the standards for health promotion. The second level themes that derive from the Ottawa Charter are as follows. Purchasers should take into account ownership issues, e.g. whether there are opportunities for community ownership of the programme. An example of a programme that is founded on community ownership is Health Through the Marae, which has been developed and managed by the Ngati te Ata tribe. The marae-based (traditional Maori community centre) programme promotes healthy lifestyles among Maori, e.g. increased participation in exercise and reduced smoking.

Health promotion programmes should have a workforce which is representative, and therefore reflects the community that the programme serves. For example, Plunket is the largest provider of well-child services in New Zealand and has in recent years sought to address poor Maori representation within their workforce by establishing the Plunket Kaiawhina Service (Maori community health workers) to better ensure that Maori workers are available to Maori clients. Workforce development requirements should also be considered. Civil readiness relates to the readiness of a community to take on an intervention. Some communities will be less ready than others to take on an intervention, and will therefore require additional resourcing in order to prepare the community and thereby maximize the potential of the intervention. An example is the Maori Women’s Welfare League’s immunization promotion programmes. The programmes work with a marginalized group, generally young Maori mothers of low socio-economic status, and therefore the interventions are likely to require additional funding to account for the state of readiness of their target
community to take up the intervention. Other issues that should be considered are whether comprehensive strategies are being employed by the intervention, and the environmental impact of the programme, i.e. how a programme, e.g. a school-based injury prevention intervention, impacts upon the school’s physical and social environment.

At the third level, there are measurable indicators for the Health Promotion Dimension. Clear community leadership will be important in the community taking ownership of an intervention, therefore is there readily identifiable health leadership within the community? In terms of workforce, is the workforce representative of the community it serves and are there opportunities for community participation at all levels of the programme workforce? In gauging the degree of civil readiness, an indicator is the extent of community organization which may be reflected in the numbers of established community organizations, e.g. the Maori Women’s Welfare League, which have a tradition of fostering community initiatives, e.g. Smokefree Netball. In assessing whether comprehensive strategies have been employed, purchasers would ask providers to identify how many strategies the programme employs. Finally, an assessment of the environmental impact of the programme might require measurement of the impact of the programme on the physical environment.

The socio-cultural dimension

It is essential that equity is a primary consideration in the purchasing of health promotion programmes. Equity emphasises fair access to health promotion interventions based upon the needs of the target community and their capacity to benefit from the intervention. Equitable health services decrease disparities in health status between population groups. The socio-cultural dimension takes into account the principles for Maori health services, which include: enablement, active participation, cultural safety, effectiveness, accessibility and consistency with Maori priorities.

At the second level, five key themes have been identified. The first theme relates to the accessibility of the intervention. For example, the 1990 Maori asthma review concluded that a key reason behind the greater Maori morbidity and mortality from asthma, relative to the general population, was the lack of appropriate health care and asthma education. Partly in response to this programme, the Wairarapa Maori Asthma Management Programme was established as a partnership between a Te Hauora Runanga o Wairarapa (a tribal Maori health group) and the Wellington Asthma Research Group, School of Medicine (D’Souza et al., 1994). The intervention provided free clinics on marae and other local Maori community centres. Feedback from participants indicated that clinics held at Maori community centres were more accessible than doctors’ surgeries, not only for geographical reasons but because people felt more comfortable in familiar settings. Further, affordability was also identified as important. The second theme is acceptability. To use the same example, the Wairarapa Maori Asthma Management Programme followed Maori processes throughout the programme, and Maori community health workers provided follow-up support for participants. Subsequent programme evaluations have shown the programme to be effective in reducing asthma problems and leading to other broader benefits, and to have been acceptable to the target population.

The second theme, safety, refers to safety in both physical and non-physical terms. Using the example of the Asthma Programme, doctors from the Wellington School of Medicine ensured that the programme was safe in technical terms, while the Maori community health workers ensured that the programme was culturally safe.

The third theme of cultural effectiveness can be used to describe a programme which is not only culturally safe but goes one step further to affirm cultural identity. An example of such a programme is Te Papa Takaro o Te Arawa, which is a tribal intervention promoting healthy lifestyles through sporting events, some of which are based on marae. The programme has the additional benefit of affirming cultural identity through encouraging the involvement of people of the Te Arawa tribe in tribal affairs, and providing an opportunity for those who have become disconnected from the tribe to establish or re-establish tribal links. Importantly, programmes should also be assessed for their public health impact. That is, the public health implications of the intervention.

One third-level indicator has been identified for each of the themes described above. An indicator of accessibility is the location of the intervention, is it geographically accessible to the target community. One measure of the acceptability
of the programme is whether it is likely to be affordable to the target population. An indicator of safety is the professional competence of programme workers, do they have the relevant professional or technical qualifications? In assessing the cultural effectiveness of an intervention, it will be important to establish whether there has been cultural input into the development of the programme, e.g. has cultural expertise (i.e. recognized cultural experts within an ethnic group) been drawn on in the development of the intervention? Finally, a measure of the likely public health impact of a programme is the degree of public health requirement in the target area.

The developmental phase

Ideally, when making purchasing decisions, the inter-relatedness of the four dimensions is acknowledged and the evidence from the dimensions is balanced, but it is necessary to recognize the limited availability of scientific evidence relevant to health promotion. In contrast to EBM, there are few rigorous published studies investigating the effectiveness of health promotion programmes, and in particular, programmes which specifically target minority ethnic groups, e.g. Maori and Pacific Island people.

Yet, it is important that an EBHP framework retains the flexibility to accommodate rapid societal changes and innovative interventions. Where there is a lack of scientific evidence but strong support in the remaining dimensions, a developmental phase is recommended. The developmental phase allows for purchasing of innovative interventions, which are required to have sound evaluation processes in place. Developmental phases are essential in meeting the needs of Maori, Pacific Island people, and other indigenous populations and immigrant populations. Resourcing of developmental programmes requires funding levels that recognize that not all communities are equally prepared to take on an intervention. Additional funding may be required, e.g. to allow for workforce development or more extensive community consultation.

Nonetheless, developmental programmes should be contractually required to be carefully evaluated. Through such an iterative process, we see the rigour and effectiveness of health promotion programmes being gradually improved. The longer-term view being that evaluation of developmental programmes will in time contribute sound scientific evidence to inform future purchasing decisions.

CONCLUSION

This paper has proposed a framework for evidence-based purchasing of health promotion programmes which, while based on EBM principles, extends the definition of evidence. A broader definition of evidence is necessary not only because of the relative dearth of published studies in the health promotion field, but also because the effectiveness of health promotion programmes relies heavily upon how well the programmes fit within the local contexts. An important strength of the framework is that it pays particular attention to ensuring that cultural factors are considered in health promotion purchasing.

The proposed framework identifies four dimensions in which evidence should be considered in making health promotion programme purchasing decisions. The first dimension draws on the EBM approach to consider scientific evidence, however, the definition of evidence is extended to include community knowledge and experience. The organizational dimension assesses how the programme fits into existing institutional structures and identifies whether new programmes need new structures, and the health promotion dimension considers the consistency of the programme with the principles of the Ottawa Charter. Finally, the socio-cultural dimension considers the programme’s contribution to achieving equity.

Importantly, the framework maintains the flexibility to allow for purchasing of innovative programmes by incorporating a developmental approach. The developmental approach recognizes that in some areas, e.g. indigenous health, there is limited scientific evidence available to inform purchasing decisions, and in these situations greater weight should be accorded to the strength of evidence in the remaining three dimensions.

The proposed framework has been operationalized successfully within New Zealand by one of the regional purchasing authorities. Many of the issues raised in our framework apply not only to New Zealand, and in this respect the framework may have wider applications and be useful in evidence-based health promotion purchasing internationally.
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