Strategy to Prevent and Minimise Gambling Harm

2016/17 to 2018/19

Consultation document

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# Foreword

The Gambling Act 2003 sets out requirements for an ‘integrated problem gambling strategy focused on public health’. Four components that the strategy must include are: measures to promote public health, services to treat and assist problem gamblers and their families/whānau, independent scientific research and evaluation.

The Ministry of Health is responsible for developing the strategy at three-yearly intervals, and for implementing it. The Crown recovers the cost of developing and implementing the strategy, by way of a ‘problem gambling levy’ set by regulation at a different rate for each of the main gambling sectors. The Act specifies consultation requirements for the development of the strategy and the levy rates.

Consistent with these requirements, the Ministry is now seeking comment, through a consultation process, on its draft Strategy to Prevent and Minimise Gambling Harm for 2016/17 to 2018/19 and draft levy rates. The consultation document also includes the Needs Assessment required by the Act, which looks at facts and figures relating to gambling harm in New Zealand, and has informed development of this document. Some people might wish to comment on this as part of the consultation process.

At the time this document was being prepared, the Ministry was also leading an update of the New Zealand Health Strategy. The objectives of the update were to provide a unifying statement of the Government’s direction for the health sector, clear priority areas for the sector to focus on, commitment to the public about what they can expect from their health services, and a foundation for a safer and more clinically and financially sustainable sector. The Strategy to Prevent and Minimise Gambling Harm for 2016/17 to 2018/19 will need to align with the updated Health Strategy.

After considering feedback and making any necessary revisions, the Ministry will submit its proposed Strategy and levy rates to the Gambling Commission. The Gambling Commission will undertake an analysis, convene a consultation meeting and provide its own advice to the Associate Minister of Health with responsibility for Problem Gambling and the Minister of Internal Affairs.

Cabinet will subsequently make decisions on the shape of the Strategy and the levy.

The Ministry encourages you to have your say, to ensure an inclusive and comprehensive approach to preventing and minimising gambling harm for the three-year period from 1 July 2016 to 30 June 2019 and beyond.

Chai Chuah

**Director-General of Health**

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# Introduction

## Structure of this document

This consultation document is divided into four parts, as follows. The first two parts, the draft Strategic Plan and draft Service Plan, together comprise the draft Strategy to Prevent and Minimise Gambling Harm for 2016/17 to 2018/19.

### Draft nine-year Strategic Plan for 2016/17 to 2024/25

The draft Strategic Plan sets out the Ministry of Health’s approach to the prevention and minimisation of gambling harm, high-level objectives and priorities for action. It forms the strategic context for the draft three-year Service Plan.

### Draft three-year Service Plan for 2016/17 to 2018/19

The draft Service Plan sets out the Ministry of Health’s service priorities to prevent and minimise gambling harm in the three-year period from 1 July 2016 to 30 June 2019.

### Draft levy rates for 2016/17 to 2018/19

This section sets out draft levy rates for the three-year period corresponding to the draft Service Plan, and describes the process by which they were calculated.

### Gambling Harm Needs Assessment 2015

The Needs Assessment brings together a range of research and other information to describe the impact of gambling harm in terms of population need. It is complete in itself. However, those wishing for a more comprehensive understanding of the issues might wish to read the Needs Assessment in conjunction with *Informing the 2015 Gambling Harm Needs Assessment: Report for the Ministry of Health*, which is available with the consultation document on the Ministry’s website (www.health.govt.nz).

## How to have your say

Please take the time to make a submission. The final pages of this consultation document explain how to make a submission and how to make sure that it reaches the Ministry in time. There are also questions that might help you write your submission.

Your feedback is important: it will help shape the proposed Strategy to Prevent and Minimise Gambling Harm for 2016/17 to 2018/19 and the proposed levy rates that the Ministry submits to Ministers and the Gambling Commission for their consideration.

All submissions are due with the Ministry by **5 pm on Friday 11 September 2015**.

# 1 Draft nine-year Strategic Plan 2016/17 to 2024/25

## 1.1 Background

### 1.1.1 Functions of the Strategic Plan and Service Plan

The draft Strategic Plan outlines the statutory requirements for an integrated problem gambling strategy. It refers to the Ministry of Health’s responsibility for the strategy and to a complementary responsibility of the Department of Internal Affairs. It lists other strategic documents to which it will align and which it will complement. The draft Strategic Plan also suggests an overall goal for the strategy, principles and approaches to underpin the strategy, and high-level objectives and priorities for action. It forms the strategic context for the draft three‑year Service Plan.

The Ministry developed six-year strategic plans in both 2004 and 2010. Each set out the strategic context for two three-year service plans. The four service plans set out information on the Ministry’s service priorities for the relevant three-year periods.

From 1 July 2016, the pattern will change. Each three-yearly strategy will consist of a rolling nine-year strategic plan and a three-year service plan.

### 1.1.2 The strategy and the role of the Ministry of Health

Since 1 July 2004, the Ministry of Health has been responsible for developing and implementing the ‘integrated problem gambling strategy focused on public health’ that is described in section 317 of the Gambling Act 2003.

The Act says that the strategy must include:

* measures to promote public health by preventing and minimising the harm from gambling
* services to treat and assist problem gamblers and their families/whānau
* independent scientific research associated with gambling, including (for example) longitudinal research on the social and economic impacts of gambling, particularly the impacts of gambling on different cultural groups
* evaluation.

The Act defines a problem gambler as a person whose gambling causes harm or may cause harm, and ‘harm’ is defined as:

(a) harm or distress of any kind arising from, or caused or exacerbated by, a person’s gambling; and

(b) including personal, social, or economic harm suffered –

(i) by the person; or

(ii) by the person’s spouse, civil union partner, de facto partner, family, whānau, or wider community; or

(iii) in the workplace; or

(iv) by society at large.

The Ministry receives funding through Vote Health to develop and implement the strategy. The Crown then recovers the cost of this appropriation through a ‘problem gambling levy’ paid by the main gambling operators.

### 1.1.3 Role of the Department of Internal Affairs

The Department of Internal Affairs (DIA) is the main gambling regulator and the main policy advisor to the Government on gambling regulatory issues. DIA administers the Act and its regulations, issues licences for gambling activities, ensures compliance with the legislation and publishes statistical and other information concerning gambling. DIA’s role includes key regulatory aspects of gambling harm prevention and minimisation.

### 1.1.4 Alignment with other strategic documents

The current Strategic Plan will align with and complement a range of other strategic documents, including:

* *The New Zealand Health Strategy* (which is being refreshed in 2015)
* [*He Korowai Oranga*](http://www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga)*: Māori Health Strategy* (refreshed in 2014)
* [*’Ala Mo’ui: Pathways to Pacific Health and Wellbeing 2014–2018*](http://www.health.govt.nz/publication/ala-moui-pathways-pacific-health-and-wellbeing-2014-2018)
* [*Rising to the Challenge: The Mental Health and Addiction Service Development Plan  
  2012–2017*](http://www.health.govt.nz/publication/rising-challenge-mental-health-and-addiction-service-development-plan-2012-2017)
* *Te Puāwaiwhero: The Second Māori Mental Health and Addiction National Strategic Framework 2008–2015*.

## 1.2 Overall goal of the strategy

The Ministry is committed to a long-term approach that has not significantly changed from the approach outlined in its first six-year strategic plan. The overall goal is:

Government, the gambling sector, communities and families/whānau working together to prevent and minimise gambling harm, and to reduce related health inequities.

## 1.3 Key principles underpinning the strategy

A number of key principles have guided the development of both this nine-year Strategic Plan and the corresponding three-year Service Plan:

* to achieve health equity
* to maintain a comprehensive range of public health services based on the World Health Organization (WHO)’s Ottawa Charter for Health Promotion and New Zealand models of health (particularly Māori models, such as Te Pae Mahutonga and Te Whare Tapa Whā)
* to fund services that prevent and minimise gambling harm for priority populations
* to ensure culturally accessible and responsive services
* to ensure links between public health and intervention services
* to maintain a focus on healthy futures for Māori
* to maintain a focus on improving health outcomes for Pacific peoples
* to ensure services are evidence-based, effective and sustainable
* to develop the workforce
* to apply an intersectoral approach
* to strengthen communities.

## 1.4 A public health approach

The Act recognises the importance of prevention, and requires the Ministry to adopt a public health focus in addressing gambling harm.

Accordingly, the Ministry uses a continuum-of-harm approach based on the Korn and Shaffer model, as Figure 1 shows.

This approach recognises that people experience varying levels of harm from gambling. The triangle represents the general population as a whole. The left-most side of the triangle, the widest, represents that section of the population experiencing no gambling harm, and the point to the right represents those experiencing the most severe harm. People do not simply move along the continuum, but may enter and exit at various points. Some no longer require assistance, while others relapse and re-enter the continuum of harm, at the same point or at a different point.

While it is necessary to address the needs of those who have already developed a serious problem and who need specialist help, taking an early preventive approach can avoid a great deal of harm.

Figure 1: Gambling-related harm: the continuum of need and intervention

Figure 1: Gambling-related harm: the continuum of need and intervention

Source: Adapted from Korn and Shaffer 1999

## 1.5 A population health framework

As a complement to its public health approach, the Ministry uses a population health framework to address gambling harm across different groups within the population. Such a framework addresses differences in health status among and within populations. Its goal is to maintain or improve the health status of everyone living in New Zealand, and to achieve health equity.

Improved health and equity for all populations is one of the Health Quality and Safety Commission’s Triple Aim objectives.[[1]](#footnote-1) As noted in the Ministry’s *Statement of Intent 2015 to 2019*, the Ministry has a programme of work aimed at further strengthening quality and safety in the health and disability system.[[2]](#footnote-2) One of the Ministry’s initiatives in this area is working more closely with the Health Quality and Safety Commission.

## 1.6 Equity

The World Health Organization says that equity ‘refers to fair opportunity for everyone to attain their full health potential regardless of demographic, social, economic or geographic strata’. This definition relates both to health status and to the social determinants of health. Inequities are inequalities that are judged to be unfair, that is, both unacceptable and avoidable.[[3]](#footnote-3)

Inequities are not random. However, their causes are often complex and multifaceted. Therefore, achieving equity requires a strong evidence base and a strategic, integrated approach from the health sector and other sectors.

Inequities between Māori and non-Māori and between Pacific peoples and non-Pacific peoples are a particular challenge for New Zealand. The Ministry is working to enhance its long-standing focus on equity, through strategies and frameworks like *He Korowai Oranga: Māori Health Strategy*; *Equity of Health Care for Māori: A framework*; *’Ala Mo’ui: Pathways to Pacific Health and Wellbeing 2014–2018* and [*Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017*](http://www.health.govt.nz/publication/rising-challenge-mental-health-and-addiction-service-development-plan-2012-2017).

This focus on equity is relevant to the prevention and minimisation of gambling harm because there is clear evidence that some population groups (Māori and Pacific peoples in particular) are significantly more likely to experience gambling harm. For example, New Zealand’s 2012 National Gambling Study (NGS)[[4]](#footnote-4) found that Māori and Pacific peoples were more likely to experience gambling harm even after controlling for other key demographic and socioeconomic variables (Abbott et al 2014b, pp 126 and 127), and concluded that such inequities ‘have persisted since the time the first gambling survey was conducted in 1991’ (ibid, p 18).

## 1.7 Health literacy

Health literacy can contribute to the achievement of health equity. In the past, the Ministry defined health literacy as the capacity to obtain, process and understand basic health information and services in order to make informed and appropriate health decisions. This definition focused on consumer capability. However, internationally support is growing for a new definition of health literacy, focusing more strongly on how health systems, health care providers and practitioners can support consumers to access and understand health services.

This year the Ministry developed *A framework for health literacy* and *Health Literacy Review: A guide* to support the health system, health organisations and the health workforce to become health literate. The framework and guide are intended to improve the quality of services delivered to individuals, families/whānau and communities and ultimately to improve health outcomes.

## 1.8 The outcomes framework for the strategy

In the course of developing its first two six-year strategic plans to prevent and minimise gambling harm, the Ministry constructed an outcomes framework consisting of a set of 11 measurable objectives, a series of short-term to medium-term and long-term priorities for action and 65 outcome indicators. The outcome indicators were designed to measure progress towards the objectives and towards the overall goal of the strategy. The 11 objectives remain substantially unchanged and are presented below, along with revised priorities for action.

In July 2013 the Ministry published the [*Outcomes Framework for Preventing and Minimising Gambling Harm – Baseline Report*](http://www.health.govt.nz/publication/outcomes-framework-preventing-and-minimising-gambling-harm-baseline-report), developed by a broad sector advisory group, the Ministry itself and KPMG. This reported on achievement of all 11 objectives, and measured 56 of the 65 outcome indicators.

The Ministry intends to continue working with the Advisory Group to complete update reports for the period to 30 June 2016.

The experience of producing the *Baseline Report* suggests that, for reports relating to the period from 1 July 2016 onwards, it might be helpful to focus on a smaller set of critical outcome indicators when preparing updates. To this end, the Ministry will work with the Advisory Group and with other key stakeholders that have whole-of-government advisory roles, such as Te Puni Kōkiri and the Ministry of Pacific Island Affairs.

The 11 objectives are as follows.

**Objective 1:** There is a reduction in gambling-harm-related inequities (particularly in the gambling-harm-related inequities experienced by Māori and Pacific peoples, as the populations that are most vulnerable to gambling harm).

**Objective 2:** Māori have healthier futures, through the prevention and minimisation of gambling harm.

**Objective 3:** People participate in decision-making about local activities that prevent and minimise gambling harm in their communities.

**Objective 4:** Healthy policy at the national, regional and local level prevents and minimises gambling harm.

**Objective 5:** Government, the gambling sector, communities, families/whānau and individuals understand and acknowledge the range of gambling harms that affect individuals, families/whānau and communities.

**Objective 6:** A skilled workforce is developed to deliver effective services to prevent and minimise gambling harm.

**Objective 7:** People have the life skills and the resilience to make healthy choices that prevent and minimise gambling harm.

**Objective 8**: Gambling environments are designed to prevent and minimise gambling harm.

**Objective 9:** Services to prevent and minimise gambling harm effectively raise awareness about the range of gambling harms that affect individuals, families/whānau and communities.

**Objective 10:** Accessible, responsive and effective interventions are developed and maintained.

**Objective 11:** A programme of research and evaluation establishes an evidence base that underpins all activities to prevent and minimise gambling harm.

The Strategy is intended to prevent and minimise gambling harm. The Gambling Act 2003 defines ‘harm’ and sets out four components that the Strategy must include. Neither these legislative provisions nor the content of the other strategic documents and frameworks with which the Strategy is expected to align are under consideration in this consultation.

However, you might wish to comment on the draft Strategic Plan as a whole, the wording of the overall goal (section 1.2), or the objectives and the priority actions associated with each of the objectives as discussed below.

Does the draft Strategic Plan adequately address the strategic context for the draft Service Plan? If not, what issues or areas are not adequately covered?

Are there any objectives or priority actions that you particularly agree with or disagree with, and if so why? Are there other objectives that you think would be preferable or other priority actions that you think would more effectively or more efficiently prevent and minimise gambling harm, and if so why?

A more detailed description of the objectives and the priority actions follows.

### Objective 1: There is a reduction in gambling-harm-related inequities

The Ministry will maintain and enhance its focus on reducing avoidable differences in levels of gambling harm, and in the determinants of gambling harm, among different population groups. Its population health approach will continue to target at-risk populations, including Māori, Pacific peoples, some segments of the Asian population and those living in higher deprivation areas. The Ministry will also continue to monitor and address gambling-harm-related issues among other key groups, such as youth.

The Ministry will continue to ensure that dedicated Māori, Pacific and Asian services are available where appropriate, and that all services are culturally competent, health literate, high quality and effective. It also intends to identify factors that contribute to gambling-harm-related inequities, and to develop, pilot, evaluate and implement one or more initiatives specifically focused on reducing these inequities.

Table 1: Priorities for action – Objective 1

|  |  |  |
| --- | --- | --- |
| **Objective 1: There is a reduction in gambling-harm-related inequities** | | |
| **Priorities for action** | | |
| **Short- to medium-term priorities** | | **Long-term priorities** |
| Continue providing dedicated services for Māori, and for Pacific and Asian peoples, where appropriate, including services both for gamblers and for their families/whānau, continue to ensure that the provision of all services to prevent and minimise gambling harm is culturally appropriate, and ensure that all services are health literate, high quality and effective | | |
| Continue monitoring gambling-harm-related inequities (eg, the disproportionate prevalence of harm within some populations) and identify factors that contribute to them (eg, differences in the gambling environment by geographical area) | | |
|  | Develop, pilot, evaluate and implement one or more initiatives specifically focused on reducing gambling-harm-related inequities, particularly among Māori and Pacific peoples | |

#### Underlying principles: Diversity

High-level analyses may mask inequities within populations or among populations. For example, analyses relating to ‘Pacific peoples’ or ‘the Asian population’ may mask differences in the prevalence of gambling harm within one Asian or Pacific population (for example, within the Samoan population) or between different Pacific or Asian populations (for example, between Chinese and Indian populations). Similarly, there may be inequities within groups such as recent migrants, students (particularly international students) or people employed in particular industries.

The Ministry will continue to consider appropriate research and monitoring methods in the light of this diversity.

### Objective 2: Māori have healthier futures, through the prevention and minimisation of gambling harm

Objective 2 reflects the relationship between the Crown and Māori under the Treaty of Waitangi. It aligns with objective 1, and is supported by all the other objectives.

The Ministry recognises gambling-harm-related inequities both for Māori as a population group and within the Māori population group. For example, it acknowledges that while the prevalence of moderate risk/problem gambling is relatively high for both Māori men and Māori women, Māori women are more likely to experience harm from someone else’s gambling than Māori men. The Ministry recognises the role Māori women have as the cornerstone of Whānau Ora, and the likely implications of this difference on the wellbeing of rangatahi and tamariki, in particular in the context of issues such as child poverty and access to sufficient safe, nutritious food. The Ministry also notes that the Youth’12 survey found that Māori students were among the groups that were more likely to report indicators of ‘unhealthy gambling’ and were more likely to be worried about the gambling of others they live with.

The Ministry will maintain and enhance its focus on reducing avoidable differences in levels of gambling harm, and in the determinants of gambling harm, for Māori. It will continue to ensure that dedicated services are available where appropriate, and that all services are culturally competent, health literate, high quality and effective. The Ministry also intends to identify factors that contribute to gambling-harm-related inequities for Māori, and to develop, pilot, evaluate and implement one or more initiatives specifically focused on reducing these inequities.

Table 2: Priorities for action – Objective 2

|  |  |  |
| --- | --- | --- |
| **Objective 2: Māori have healthier futures, through the prevention and minimisation of gambling harm** | | |
| **Priorities for action** | | |
| **Short- to medium-term priorities** | | **Long-term priorities** |
| Continue providing dedicated services for Māori, where appropriate, including services both for gamblers and for their families/whānau, continue to ensure that the provision of all services to prevent and minimise gambling harm is culturally appropriate, and ensure that all services are health-literate, high quality and effective | | |
| Continue monitoring gambling-harm-related inequities for Māori (eg, disproportionate prevalence of harm among Māori) and identify factors that contribute to them (eg, differences in the gambling environment by geographical area) | | |
| Encourage services to prevent and minimise gambling harm (both public health and intervention) to align with *He Korowai Oranga*, and monitor the extent of that alignment | | |
| Maintain mechanisms to support a Māori voice to provide advice to the Ministry and DIA on the prevention and minimisation of gambling harm | | |
|  | Develop, pilot, evaluate and implement one or more initiatives specifically focused on reducing gambling-harm-related inequities for Māori | |

### Objective 3: People participate in decision-making about local activities that prevent and minimise gambling harm in their communities

Increased community awareness of gambling harm, grant distribution and related issues through public discussion and debate will continue to be a focus for this nine-year Strategic Plan. The Ministry expects a high level of interaction among services to prevent and minimise gambling harm, their client populations (particularly Māori and Pacific peoples, as the populations that are most vulnerable to gambling harm), other public and mental health services, and community groups.

The local government gambling venue review process (set out in sections 98 to 103 of the Gambling Act 2003) allows communities to address their councils and discuss the effectiveness of councils’ policies. This includes the availability and accessibility of certain types of gambling in the community. Community ownership and empowerment are important aspects of healthy and responsive communities, and are key aspects of a public health approach.

Table 3: Priorities for action – Objective 3

|  |  |
| --- | --- |
| **Objective 3: People participate in decision-making about local activities that prevent and minimise gambling harm in their communities** | |
| **Priorities for action** | |
| **Short- to medium-term priorities** | **Long-term priorities** |
| Enhance the capacity and capability of communities (particularly those communities that are most vulnerable to gambling harm) to participate in decision-making about the availability and accessibility of gambling, and the allocation of gambling profits, in their areas | |
| Enhance the capacity and capability of communities (particularly those communities that are most vulnerable to gambling harm) to develop and implement policies that prevent and minimise gambling harm to individuals, families/whānau and communities, and to take action on gambling-harm-related issues, in their areas | |

#### Underlying principles: Participation

Language barriers, lack of knowledge and lack of understanding all affect people’s opportunities to meaningfully participate in New Zealand’s range of formal decision-making processes. There is a need to address these and other barriers.

### Objective 4: Healthy policy at the national, regional and local level prevents and minimises gambling harm

Successfully preventing and minimising gambling harm relies on a foundation of relevant and effective public policy.

The Ministry will continue to comment on gambling issues in the light of the objectives in the Strategic Plan and the available research, and where appropriate will work collaboratively with DIA on policy development. It will also continue to provide information to assist territorial authorities when they are reviewing their gambling venue policies.

The Ministry will continue to approach the prevention and minimisation of gambling harm through health promotion, supply control and treatment avenues. A public health approach will continue to be a central pillar of the Ministry’s work.

Table 4: Priorities for action – Objective 4

|  |  |  |
| --- | --- | --- |
| **Objective 4: Healthy policy at the national, regional and local level prevents and minimises gambling harm** | | |
| **Priorities for action** | | |
| **Short- to medium-term priorities** | | **Long-term priorities** |
| Continue to contribute where appropriate to DIA’s development of gambling policy | | |
| Continue to provide information to other government sectors and agencies (eg, Local Government New Zealand, Te Puni Kōkiri, Department of Corrections, and the Ministries of Business Innovation and Employment, Consumer Affairs, Education, Justice, Social Development and Youth Development) to increase understanding and acknowledgement of the need to link policies to prevent and minimise gambling harm with policies in related areas, and work with those sectors and agencies to develop a whole-of-government approach to preventing and minimising gambling harm | | |
|  | Develop effective policy frameworks to guide the development and implementation of policies at the national, regional and local level that prevent and minimise gambling harm | |

### Objective 5: Government, the gambling sector, communities, families/ whānau and individuals understand and acknowledge the range of gambling harms that affect individuals, families/whānau and communities

A key aspect of the Ministry’s public health activity has been raising awareness of the harms arising from gambling. The Ministry will continue to fund a multi-media drive to raise awareness, de-stigmatise the issue and encourage people to seek help. Highlighting the actions expected and required of gambling venues in their host responsibility roles will also be a key focus.

The Ministry will again focus on increased buy-in from the wider government sector at a central level, to better address the wider issues associated with gambling harm. The Ministry will continue to work closely with other government agencies, as promoted in approaches such as Better Public Services.[[5]](#footnote-5) There is still considerable scope for wider screening of individuals and populations at risk of gambling harm, through work with other agencies.

Table 5: Priorities for action – Objective 5

|  |  |
| --- | --- |
| **Objective 5: Government, the gambling sector, communities, families/whānau and individuals understand and acknowledge the range of gambling harms that affect individuals, families/whānau and communities** | |
| **Priorities for action** | |
| **Short- to medium-term priorities** | **Long-term priorities** |
| Continue to identify, monitor and provide information and education on the impacts of gambling, including the range of gambling harms that affect individuals, families/whānau and communities | |
| Continue to support communities to incorporate a robust understanding of gambling harm into community social initiatives and public service delivery | |
| Continue to support gambling operators and gambling venue operators to incorporate a robust understanding of gambling harm into their operations and activities | |

### Objective 6: A skilled workforce is developed to deliver effective services to prevent and minimise gambling harm

The Ministry expects its gambling harm workforce to have a robust health equity, cultural competency and health literacy focus. Alignment with other relevant services, particularly those in the wider public health, mental health and addiction fields, is essential in order to deliver cost-effective, responsive and holistic services.

*Te Uru Kahikatea: The Public Health Workforce Development Plan 2007–2016* (Ministry of Health 2007) provides a national strategic approach to public health workforce development, including in the context of gambling harm. (A review of *Te Uru Kahikatea* is scheduled to begin in July 2015.) During the term of the second six-year Strategic Plan, the Ministry commissioned its gambling harm public health workforce development provider to identify the core competencies (including cultural competencies) and qualifications required for this workforce. The focus for the current nine-year Strategic Plan will be the implementation of an ongoing training programme to ensure that members of the workforce demonstrate those core competencies, and have the qualifications identified.

During the term of the second six-year Strategic Plan, the Ministry’s psychosocial intervention workforce development provider worked with the Addiction Practitioners’ Association Aotearoa-New Zealand (DAPAANZ) on the *Addiction Intervention Competency Framework* (DAPAANZ 2011). That Framework now includes problem gambling practitioner competencies. During the term of this nine-year Strategic Plan the Ministry intends to implement ongoing training to ensure that all practitioners demonstrate these competencies. The Ministry’s expectation is that all such practitioners will be registered as health practitioners permitted to practise within a relevant scope of practice under the Health Practitioners Competence Assurance Act 2003, or will be registered or endorsed by DAPAANZ as having demonstrated the relevant specific competencies, or will be equivalently registered with another relevant professional organisation.

Table 6: Priorities for action – Objective 6

|  |  |  |
| --- | --- | --- |
| **Objective 6: A skilled workforce is developed to deliver effective services to prevent and minimise gambling harm** | | |
| **Priorities for action** | | |
| **Short- to medium-term priorities** | | **Long-term priorities** |
| Finalise competencies for staff working within services to prevent and minimise gambling harm | Identify and implement workforce development training, career pathways and training opportunities for staff working within services to prevent and minimise gambling harm, so that they all demonstrate the required competencies and have relevant qualifications, registration or endorsement | |

### Objective 7: People have the life skills and the resilience to make healthy choices that prevent and minimise gambling harm

The Ministry recognises that for most people gambling is a recreational activity that is enjoyed safely and in moderation. However, a significant minority of people struggle with gambling. For some ethnic groups large-scale, commercial gambling is not something they have been exposed to before. Certain groups, including Māori, Pacific peoples, youth, migrants, older people and others, are particularly vulnerable to gambling harm, for a variety of reasons.

The Ministry will continue to design public health programmes and resources for vulnerable groups in the population, including resources to develop life skills, and will continue to provide information to assist in supporting healthy choices at an individual and community level.

Table 7: Priorities for action – Objective 7

|  |  |  |
| --- | --- | --- |
| **Objective 7: People have the life skills and the resilience to make healthy choices that prevent and minimise gambling harm** | | |
| **Priorities for action** | | |
| **Short- to medium-term priorities** | | **Long-term priorities** |
| Increase participation in the development of, and exposure to, culturally and linguistically appropriate campaigns and communications that provide information to people on the health and social risks of gambling | | |
| Identify ways to provide effective support to people who are seeking to independently moderate or manage their gambling behaviour (or the behaviour of their family/whānau) in some way, and provide that support | | |
| Continue to enhance the links between problem gambling services and other social and health services, to ensure that services work together to support problem gamblers and their family/whānau | | |
| Enhance communication and referral processes to ensure that other services that offer support to people experiencing harm from gambling address the needs of a referred client (and their family/whānau) |  | |
| Continue to identify and monitor protective and resiliency factors for gambling harm | Develop initiatives that build protective factors, life skills and resilience for people who gamble | |
| Increase the links between services to prevent and minimise gambling harm and broader mental health promotion life skills and resiliency programmes | Support community-based life skills and resiliency programmes that help people to make healthy choices that prevent and minimise gambling harm | |

### Objective 8: Gambling environments are designed to prevent and minimise gambling harm

There is compelling evidence that certain types of gambling are more likely to be associated with harm than others.

The Ministry will continue to focus on gambling technology and gambling environments over the course of this nine-year Strategic Plan. It will continue to advocate for technological and/or environmental changes to gambling environments that are likely to have a positive effect on gambling behaviour and be cost-effective.

Gambling venues are one of the best environments in which to observe, identify and intervene in potentially harmful gambling. However, the Ministry recognises that the indicators of potentially harmful gambling may not always be obvious. It is committed to working with operators to maximise the potential that venues offer for early detection of problem gambling. The Ministry will also support DIA in the judicious and effective use of its regulatory tools in situations in which operators or venues do not meet legal requirements.

Table 8: Priorities for action – Objective 8

|  |  |  |
| --- | --- | --- |
| **Objective 8: Gambling environments are designed to prevent and minimise gambling harm** | | |
| **Priorities for action** | | |
| **Short- to medium-term priorities** | | **Long-term priorities** |
| Continue to build strong relationships with DIA, gambling operators and gambling venue operators | | |
| Encourage and support DIA in the judicious and effective use of its regulatory tools to prevent and minimise gambling harm | | |
| Encourage the involvement of the public and services to prevent and minimise gambling harm in monitoring gambling operators’ and gambling venue operators’ compliance with their harm prevention and minimisation responsibilities | | |
| Continue to support the Health Promotion Agency (HPA) to develop and distribute materials to help non-casino gaming machine (NCGM) operators and NCGM venue operators identify potentially harmful gambling behaviour and take effective action to prevent and minimise harm | Develop and refine guidelines on host responsibility in other gambling environments (including telephone and online environments) | |

### Objective 9: Services to prevent and minimise gambling harm effectively raise awareness about the range of gambling harms that affect individuals, families/whānau and communities

Families /whānau of problem gamblers are often the worst affected by problem gambling. The Ministry therefore places great importance on helping families to recognise the problem, address the issues and seek help if necessary, and funds the HPA to undertake certain activities to this end.

The Ministry expects the services it funds to have a robust health equity, cultural competency and health literacy focus. As a result, it expects services to build relationships with other relevant organisations. This is one way of sharing relevant information and increasing the overall awareness of gambling harm and indicators of potentially harmful gambling.

Table 9: Priorities for action – Objective 9

|  |  |
| --- | --- |
| **Objective 9: Services to prevent and minimise gambling harm effectively raise awareness about the range of gambling harms that affect individuals, families/whānau and communities** | |
| **Priorities for action** | |
| **Short- to medium-term priorities** | **Long-term priorities** |
| Continue to support health promotion programmes that promote and increase awareness of the range of gambling harms | |
| Develop systems and processes that increase problem gamblers’ access to services and access to services by their families/whānau | |
| Develop tools and protocols to support the primary health care sector and other community services to include screening, brief assessment and brief and early intervention for problem gambling, as part of general health screening and day-to-day delivery, where appropriate | |

#### Underlying principles: Accessibility

When services are promoting messages aimed at preventing or minimising gambling harm, the media, language, metaphors, images and events they use, and the public figures they engage to champion the promotion, should all be relevant to the target groups.

Harm from gambling can be associated with mental illness, other addictions and substance abuse, family violence and a range of other social issues. Enhancing awareness of gambling harm among services that address these other health and social issues helps enhance the accessibility of services to prevent and minimise gambling harm.

### Objective 10: Accessible, responsive and effective interventions are developed and maintained

One of the Ministry’s obligations under the Act is the provision of high-quality, effective and accessible services to prevent and minimise gambling harm. Within these services, staff should be appropriately qualified and services should be culturally relevant to the communities they serve. All areas with access to gambling venues should have access to intervention services.

The continued provision of dedicated Māori, Pacific and Asian services is crucial.

While gambling occurs throughout New Zealand, it is not financially feasible to provide face-to-face services in all locations. Accordingly, the Ministry will continue to fund a toll-free helpline offering referrals to face-to-face services and intervention services for those without access to face-to-face services or those who prefer a helpline service.

The Ministry is committed to ongoing enhancement of services to prevent and minimise gambling harm and alignment with other services, strategies, obligations and best practice guidelines in the broader health sector.

Table 10: Priorities for action – Objective 10

|  |  |
| --- | --- |
| **Objective 10: Accessible, responsive and effective interventions are developed and maintained** | |
| **Priorities for action** | |
| **Short- to medium-term priorities** | **Long-term priorities** |
| Continue to ensure that problem gamblers and their family/whānau have access to a range of client-centred culturally responsive services | |
| Continue to support intervention providers to use standardised gambling screens, and continue to identify and validate best-practice interventions and alignments that address the range of gambling harms that affect individuals, families/whānau and communities | |
| Continue to develop and refine audit and evaluation criteria and standards to assess intervention service delivery of outcomes | |
| Develop and enhance accessible and culturally responsive online tools, including self-help tools, to help prevent and minimise gambling harm | |

#### Underlying principles: Accessibility

People who experience gambling harm are likely to display signs of distress in non-specialist settings, and not formally seek specialist support until a crisis occurs. Services to prevent and minimise gambling harm should engage with people who are likely to be experiencing harm from gambling, in a variety of relevant non-specialist settings.

### Objective 11: A programme of research and evaluation establishes an evidence base that underpins all activities to prevent and minimise gambling harm

A research programme will run in parallel to this Strategic Plan. It aims to fulfil both short-term and long-term research priorities, and includes longitudinal studies. The programme addresses the Act’s requirements for ‘independent scientific research associated with gambling’ and for ‘evaluation’.

A key component of the Ministry’s evaluation programme is its Outcomes Framework for Preventing and Minimising Gambling Harm. In July 2013 the Ministry published the [*Baseline Report*](http://www.health.govt.nz/publication/outcomes-framework-preventing-and-minimising-gambling-harm-baseline-report) for this Framework (Ministry of Health 2013a). The Ministry intends to review the current outcome indicators and produce update reports over the nine-year term of this Strategic Plan.

Table 11: Priorities for action – Objective 11

|  |  |  |
| --- | --- | --- |
| **Objective 11: A programme of research and evaluation establishes an evidence base that underpins all activities to prevent and minimise gambling harm** | | |
| **Priorities for action** | | |
| **Short- to medium-term priorities** | | **Long-term priorities** |
| Continue to ensure that research on gambling participation, gambling behaviours, attitudes to gambling, the prevalence and incidence of gambling harm, risk and resiliency factors for gambling harm, and co‑morbidities is available, to inform policy and service development | | |
| Continue to ensure that research and evaluation projects funded by the Ministry contribute to strategic outcomes, including supporting opportunities for innovation (eg, through use of smart technology) and enhancing the quality, effectiveness and value for money of services to prevent and minimise gambling harm | | |
| Increase the evidence on why Māori and Pacific peoples continue to experience gambling-harm-related inequities, and effective ways to reduce those inequities | Develop and pilot initiatives specifically focused on reducing gambling-harm-related inequities among Māori and Pacific peoples | |

#### Underlying principles: Diversity

Different linguistic and cultural contexts provide different ways of understanding gambling and its effects. Research should reflect this.

## 1.9 Alignment of the Strategy with *He Korowai Oranga: Māori Health Strategy*

This is a hyperlink link to [*He Korowai Oranga*](http://www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga)*: Māori Health Strategy*. Figure 2 below summarises the 2014 (most recent) version of this ‘living document’.

Pae Ora (healthy futures) is the Government’s vision and overarching aim for Māori health. Pae Ora is a holistic concept that includes three interconnected and mutually reinforcing elements – Mauri Ora (healthy individuals), Whānau Ora (healthy families) and Wai Ora (healthy environments).

The Ministry has aligned the current nine-year Strategic Plan with [*He Korowai Oranga*](http://www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga), in acknowledgement of the fact that the Strategy to Prevent and Minimise Gambling Harm contributes to Pae Ora.

Figure 2: *He Korowai Oranga*: ‘the cloak of wellness’



Table 12: Alignment of the Strategy with *He Korowai Oranga*

| **He Korowai Oranga** | **Examples of the Strategy’s alignment** |
| --- | --- |
| **Overall aim** |  |
| Pae Ora | * Principles underpinning the strategy – a focus on improving Māori health gain * Objective 2 – a specific Pae Ora objective |
| **Elements** |  |
| Mauri Ora | * Public health service specification purchase unit 5 (effective screening environments) * Free intervention services for individuals harmed by their own gambling or by someone else’s gambling * Intervention service specification purchase units: 1 – help line and information service 2 – help line and information service – brief interventions 3 – full interventions 4 – facilitation of access to other relevant services 5 – follow-up |
| Whānau Ora | * Objectives 5 and 7, and public health service specification purchase unit 4 (aware communities) * Public health service specification purchase unit 3 (supportive communities) * Free intervention services for whānau, including dedicated Māori services |
| Wai Ora | * Principles underpinning the strategy –public health services based on the Ottawa Charter and New Zealand models (healthy environments is a traditional element of a public health approach, and a component of Te Pae Mahutonga) * Objective 8, which has a particular focus on NCGMs; Māori women are particularly vulnerable to harm from NCGMs * Public health service specification purchase unit 2 (safe gambling environments) |
| **Directions** |  |
| Māori aspirations and contributions | * Objective 2 – a specific Pae Ora objective |
| Crown aspirations and contributions | * The strategy is a Crown strategy * Overall goal of the strategy – the Crown working with others, including families/whānau, to prevent and minimise gambling harm and to reduce related health inequities |
| **Key threads** |  |
| Rangatiratanga | * Dedicated Māori services using Māori-derived beliefs, values and practices |
| Building on the gains | * Principles underpinning the strategy – a focus on improving Māori health gain * Objective 2 –‑ a specific Pae Ora objective |
| Equity | * Overall goal of the strategy – a reduction in health inequities related to gambling harm – and a principle underpinning the strategy – health equity * Reference in health equity discussion to *Equity of Health Care for Māori: A framework* (Ministry of Health 2014) * Objective 1 – a specific health equity objective * Objective 2 – a specific Pae Ora objective – priority actions related to health equity for Māori * Objectives 6 and 9, which require a health equity focus * Planning and prioritisation processes – mapping need based on population-specific prevalence and access rates |
| **Pathways for action** |  |
| Whānau, hāpu, iwi, community development | * Principles underpinning the strategy – strengthen communities; and public health service specification purchase units 3 and 4 (aware and supportive communities) * Requirements for services to be free of charge |
| Māori participation | * Māori representation on key forums and bodies and dedicated Māori services * Infrastructure intervention and public health service specification purchase unit 2 (workforce development) |
| Effective service delivery | * Dedicated Māori services * Requirements for general services – Māori responsiveness, support for access to dedicated Māori services where available, and a focus on health literacy * Infrastructure intervention and public health service specification purchase unit 1 (kaumātua consultation and liaison) |
| Working across sectors | * Principles underpinning the strategy – intersectoral approach * Objectives 4 and 5 * Public health service specification purchase units 1 (policy development and implementation), 2 (safe gambling environments) and 5 (effective screening environments) * Intervention service specification purchase unit 4 (facilitation services) |
| **Core components** |  |
| Treaty of Waitangi principles | * Partnership – Māori representation on key forums and bodies * Participation – dedicated Māori services using Māori-derived beliefs, values and practices * Protection – objective 2: priority actions related to health equity for Māori |
| Quality improvement | * Infrastructure intervention and public health service specification purchase unit 2 (workforce development) * Overall goal of the strategy, principles underpinning the strategy and objective 1 * Gambling Act 2003 requirements for a specified consultation process to develop the strategy and the problem gambling levy rates are intended to ensure best value for resources |
| Knowledge | * Gambling Act 2003 requirement for independent, scientific research * Objective 11 * A national coordination service and service provider hui to share best-practice examples and stories of innovation * The Ministry’s Client Information Collection (CLIC) database – includes accurate ethnicity information * Funding for provider-initiated research projects that address issues of equity for Māori * Funding for research scholarships for Māori researchers |
| Leadership | * Māori representation on key forums and bodies * Health system leadership – an expectation that all New Zealanders will have health equity * Infrastructure intervention and public health service specification purchase unit 2 (workforce development) |
| Planning resourcing and evaluation | * Gambling Act 2003 requirements for the process to develop the strategy – a consultative process for planning and resourcing * Gambling Act 2003 requirement for evaluation * Research and audit projects evaluating intervention and public health services assess effectiveness and responsiveness for Māori |
| Outcome/performance measures and monitoring | * Outcomes framework baseline and update reports, which specifically address outcomes for Māori |

## 1.10 Alignment of the strategy with *’Ala Mo’ui: Pathways to Pacific Health and Wellbeing*

This is a hyperlink to[*’Ala Mo’ui: Pathways to Pacific Health and Wellbeing 2014–2018*](http://www.health.govt.nz/publication/ala-moui-pathways-pacific-health-and-wellbeing-2014-2018)*.* It is the Government’s plan for improving health outcomes for Pacific peoples. The long-term vision of *’Ala Mo’ui* is that Pacific ’āiga, kāiga, magafaoa, kōpū tangata, vuvale and fāmili experience equitable health outcomes and lead independent lives. Figure 3 summarises the 2014 (most recent) version of *’Ala Mo’ui*.

The Ministry has aligned the current nine-year Strategic plan with *’Ala Mo’ui*, in acknowledgement of the fact that the strategy to prevent and minimise gambling harm contributes to the achievement of health equity for all Pacific peoples in New Zealand.

Figure 3: The components of *’Ala Mo’ui*

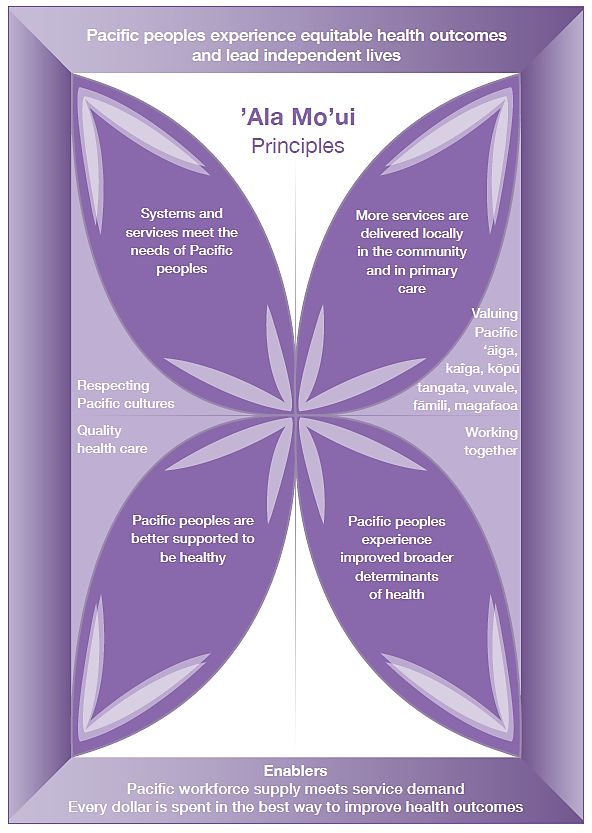


Table 13: Alignment of the strategy with *’Ala Mo’ui*

| **’Ala Mo’ui** | **Examples of the strategy’s alignment** |
| --- | --- |
| **Overall aim** |  |
| Health equity for all Pacific peoples | * Overall goal of the strategy – entails a reduction in health inequities related to gambling harm * Principles underpinning the strategy – reduce health inequities * Objective 1 – a specific health equity objective * Planning and prioritisation processes – mapping need based on population-specific prevalence and access rates |
| **Pacific principles** |  |
| Respecting Pacific culture | * Objectives 5 and 7, and public health service specification purchase unit 4 (aware communities) * Public health service specification purchase unit 3 (supportive communities) * Requirements for general services –meeting cultural needs of service users, and supporting them to access dedicated Pacific services where available |
| Family and communities | * Objectives 5 and 7, and public health service specification purchase unit 4 (aware communities) * Public health service specification purchase unit 3 (supportive communities) * Free intervention services for families |
| Quality health care | * Free intervention services for individuals and families * Overall goal of the strategy, principles underpinning the strategy, and objective 1 * Dedicated Pacific services, and requirements for general services – meeting cultural needs of service users, and supporting them to access dedicated Pacific services where available * Infrastructure intervention and public health service specification purchase unit 2 (workforce development) * Gambling Act 2003 requirements for research and evaluation – research and audit projects evaluating intervention and public health services |
| Working together – integration | * Principles underpinning the strategy – intersectoral approach * Objectives 4 and 5 and associated priority actions * Public health service specification purchase units 1 (policy development and implementation), 2 (safe gambling environments) and 5 (effective screening environments) * Intervention service specification purchase unit 4 (facilitation services) |
| **Enablers of outcomes** |  |
| Pacific workforce supply meets demand | * Dedicated Pacific services based in a Pacific cultural paradigm and using Pacific-derived beliefs, values and practices * Planning and prioritisation processes – mapping need based on population-specific prevalence and access rates * Infrastructure intervention and public health service specification purchase unit 2 (workforce development) |
| Every dollar is spent in the best way to improve health outcomes | * Gambling Act 2003 requirements for a specified consultation process to develop the strategy and the problem gambling levy rates are intended to ensure best value for resources Gambling Act 2003 requirements for research and evaluation – research and audit projects evaluating intervention and public health services |
| **Priority outcomes** |  |
| Systems and services meet the needs of Pacific peoples | * Dedicated Pacific services based in a Pacific cultural paradigm and using Pacific-derived beliefs, values and practices * Requirements for general services –meeting cultural needs of service users, and supporting them to access dedicated Pacific services where available |
| More services delivered locally in the community and in primary care | * Planning and prioritisation processes – mapping need based on population-specific prevalence and access rates |
| Pacific peoples are better supported to be healthy | * Overall goal of the strategy, principles underpinning the strategy, and objective 1 |
| Pacific peoples experience improved broader determinants of health | * Overall goal of the strategy, principles underpinning the strategy, and objective 1 |

# 2 Draft three-year Service Plan 2016/17 to 2018/19

## 2.1 Background

This section provides some background context to the draft Service Plan: a summary of developments in the service environment in the previous Service Plan period (2.1.1); a brief discussion of service delivery in that period (2.1.2); and factors considered by the Ministry for the new Service Plan period (2.1.3). Section 2.2 presents the draft Service Plan itself.

### 2.1.1 Developments in the service environment 2013/14 to 2015/16

There were a number of significant developments in the service environment over the 2013/14 to 2015/16 period, including:

* a gradual increase in the total amount gamblers spent on the main forms of gambling
* an apparent levelling-off in the first two years of the three-year period in annual non-casino gaming machine (NCGM) expenditure, at just over $800 million (this figure had been declining for around a decade)
* changes to the gambling legislative environment, most notably through the Gambling (Gambling Harm Reduction) Amendment Act 2013, the New Zealand International Convention Centre Act 2013 and the Gambling Amendment Act 2015
* changes to the wider legislative environment, for example through the Vulnerable Children Act 2014, which requires services to prevent and minimise gambling harm to adopt a child protection policy
* development of guidelines for the health sector in relation to working with the children of parents with mental illness or addiction[[6]](#footnote-6)
* the publication of a refreshed *New Zealand Suicide Prevention Action Plan* (Ministry of Health 2013b)
* the development of an outcomes-focused commissioning framework for mental health and addiction
* the Ministry’s request for proposals (RFP) for public health primary prevention and psychosocial intervention and support services, as specified in the Service Plan for 2013/14 to 2015/16
* a subsequent judicial review of the Ministry’s RFP process, delaying the Ministry’s implementation of its preferred service mix
* ongoing development of an integrated national telehealth service, which will incorporate the current Gambling Helpline
* a continuing increase in the number of Pacific people accessing intervention services for gambling problems
* finalisation of a set of public health core competencies to guide the public health workforce development provider
* roll-out of a multi-venue exclusion system, which at the time of writing was available in most New Zealand locations
* several developments in the context of research and evaluation, notably:
* publication of the first report on a world-leading randomised controlled trial on brief telephone interventions for gambling harm, and completion of a three-year follow-up
* completion of most aspects of the 2012 National Gambling Study (NGS), which includes several longitudinal follow-up components, and publication of several reports on the Study (Abbott et al 2014a, 2014b, 2014c and 2015)
* an evaluation of public health primary prevention and psychosocial intervention service delivery in the area of gambling harm
* a feasibility study on a smartphone application for preventing and minimising gambling harm
* a pilot of a financial literacy education programme for Māori and Pacific clients
* publication of the *Baseline Report* (Ministry of Health 2013a)
* the Health Promotion Agency (HPA) broadening its core programme of activity to include a component focusing on gambling venues, as specified in the service plan for 2013/14 to 2015/16.

### 2.1.2 Service delivery in 2013/14 to 2015/16

This section discusses service delivery during the 2013/14 to 2015/16 period in terms of public health activity, intervention activity, accessibility for and responsiveness to the needs of Māori and Pacific peoples, and research and evaluation.

#### Public health

The HPA’s health promotion programme is central to the Ministry’s national public health activity. Phase four of the HPA’s programme was launched in May 2014. It used a ‘game show’ concept to target people at higher risk of developing gambling problems, as well as concerned others. It actively promoted both the Gambling Helpline and a dedicated website run by the HPA: choicenotchance.org.nz.

An increase in funding in the 2013/14 to 2015/16 period enabled the HPA to broaden its core programme of activity to include a component focused on gambling venues. It consulted with NCGM operators, undertook qualitative research with venue staff and gamblers, and developed and disseminated materials to NCGM venues.

Throughout the period, a range of community-level activities including work with government agencies, church groups, educational institutions, marae and gambling venue operators continued to operate around the country.

Service providers continued to participate in territorial authorities’ reviews of their gambling venue policies, providing a community perspective to the three-yearly consultation process. Most territorial authorities now have either some form of cap on the number of gaming machines in their districts or a sinking-lid policy (meaning that when one or more machines are removed from a venue, the number of machines that may be operated in the district reduces accordingly).

#### Intervention

The 2013/14 year saw a slight increase in the number of brief interventions, and a larger increase in the number of fuller interventions.

#### Accessibility for and responsiveness to Māori and Pacific peoples

Throughout the period, the number of Māori accessing intervention services remained relatively high (in line with the relatively high vulnerability of Māori to gambling harm), as it has been since 2008. The number of Pacific people accessing intervention services increased substantially from 2012, so that that by the end of the period the figure more closely reflected the relatively high vulnerability of Pacific peoples to gambling harm.

#### Research and evaluation

In the 2013/14 to 2015/16 period, work in research and evaluation included:

* projects **completed** or **due for completion** by 1 July 2016:
* publication of the *Baseline Report* (Ministry of Health 2013a)
* most components of the 2012 National Gambling Study
* an analysis of the gambling modules in the 2011/12 New Zealand Health Survey and the 2014 Health and Lifestyles Survey
* an analysis of the gambling module in the Youth’12 survey
* an analysis of the gambling module in the Growing up in New Zealand longitudinal study
* a three-year follow-up component for the randomised controlled trial on brief telephone interventions
* a national study of the burden and harms associated with gambling, using WHO burden of disease methodology
* a kaupapa Māori study on the impacts of gambling on Māori gamblers and whānau
* an investigation into Māori input into decision-making on gambling
* a study on the effectiveness of a sinking lid policy for addressing problem gambling and the health and wellbeing of Māori gamblers and whānau
* an evaluation of a financial literacy and budgeting programme for problem gambling in Māori and Pacific people and their whānau
* a study on the impacts of gambling and problem gambling on Pacific families and communities
* an analysis of the gambling module in the 2014 iteration of the Pacific Island Families Study (mothers and children)
* an evaluation of both public health and intervention service delivery
* a study on family violence associated with problem gambling
* a study on the effect of game characteristics, player information display systems, and pop‑ups on gambling and problem gambling
* a feasibility study on a smartphone application for preventing and minimising problem gambling
* an exploratory study on New Zealanders’ attitudes and views of pre-commitment tools for addressing problem gambling
* **commencement** of:
* a clinical trial of face-to-face interventions for people with problem gambling
* **continuation** of:
* a two-year follow-up component and a three-year follow-up component of the 2012 National Gambling Study, including a venue intercept phase
* a study on community-level harm from gambling
* ascholarship programme to encourage research into gambling and problem gambling.

### 2.1.3 Factors considered for 2016/17 to 2018/19

This section discusses a number of factors that the Ministry considered when developing the draft Service Plan for 2016/17 to 2018/19. Some of these factors suggest a changing environment and some potential volatility in service demand. Even so, the Ministry is confident that, overall, the proposed funding will be adequate to meet demand and deliver a high-quality service consistent with the requirements of the Gambling Act 2003 and the Ministry’s service standards and strategic requirements.

#### Update of the New Zealand Health Strategy

At the time of preparing this consultation document, the Ministry was leading an update of the New Zealand Health Strategy. The objectives of the update were to provide a unifying statement of the Government’s direction for the sector; clear priority areas for the sector to focus its efforts on; a commitment to the public as to what they can expect from health services; and a foundation for a safer and more clinically and financially sustainable health sector. The update was being undertaken in conjunction with two external reviews of the health system – one of funding and one of capability and capacity. The strategy to prevent and minimise gambling harm will need to align with the updated New Zealand Health Strategy.

#### The Youth Mental Health Project

The Youth Mental Health Project is running programmes and activities in schools, via health and community services, and online to improve the mental health and wellbeing of young people.

#### [National telehealth services](http://www.health.govt.nz/our-work/national-telehealth-services)

The Ministry is currently developing an integrated national telehealth service to improve public access to a range of triage, advice, counselling and referral services. The Gambling Helpline will be included in this new integrated service.

#### Ongoing impact of the judicial review

The judgment in the judicial review referred to at 2.1.1 was delivered on 23 July 2015. It set aside the Ministry’s decision on the RFP. Given that judgment, and based on its current experience and the Needs Assessment, the Ministry has left its indicative budgets for 2016/17 to 2018/19 largely unchanged from those in its 2013/14 to 2015/16 Service Plan.

#### Ongoing gambling-harm-related inequities

There continues to be compelling evidence that Māori and Pacific peoples are more likely to suffer gambling harm as a result of their own or someone else’s gambling, and are more likely to be at risk of future harm, than people in other ethnic groups. The 2012 NGS concluded in a report published during the 2013/14 to 2015/16 period that ‘ethnic and other disparities in the burden of harm have persisted since the time the first gambling survey was conducted in 1991’. Reducing these health inequities will be a particular focus in the 2016/17 to 2018/19 period.

#### Alignment with other health and social services

Rates of hazardous drinking, tobacco use, other drug use and psychological distress tend to be much higher among problem gamblers (and to a lesser extent, among moderate-risk and low-risk gamblers) than in the general population. Those living in more deprived areas are also more likely to experience gambling harm. Actions to enhance the alignment between services to prevent and minimise gambling harm and other health and social services will continue to be a focus in the 2016/17 to 2018/19 period.

#### The drive for enhanced efficiency and effectiveness

As a general principle, the Government expects all government agencies and the non-government organisations (NGOs) they fund to strive to enhance their efficiency and effectiveness. The Ministry expects this factor to continue to be a key driver throughout the 2016/17 to 2018/19 period.

#### Reporting against indicators in the outcomes framework

The Ministry published the [*Baseline Report*](http://www.health.govt.nz/publication/outcomes-framework-preventing-and-minimising-gambling-harm-baseline-report) in July 2013 (Ministry of Health 2013a). It intends to continue working with its broad sector advisory group to complete update reports for the period to 30 June 2016.

#### Outcomes-focused agreements

The Ministry of Business, Innovation, and Employment has incorporated Results-Based Accountability™ principles into a streamlined contract framework that government agencies and NGOs can use to identify, measure and monitor achievement of outcomes.

The Ministry expects to implement outcomes-focused agreements incorporating these principles for its preventing and minimising gambling harm contracts during the 2016/17 to 2018/19 period.

#### Changes in gambling participation and expenditure

Changes in gambling participation and expenditure tend to have long-term flow-on effects on the prevalence of gambling harm and the number of people seeking help for gambling problems.

There was a gradual increase in the amount gamblers spent on the main forms of gambling in New Zealand, from $1.928 billion in 2009/10 to $2.091 billion in 2013/14. This growth probably reflects a gradual recovery from the effects of the global financial crisis in 2008. However, it is worth noting that the 2013/14 figure was around half a billion dollars below the figure for 2003/04 ($2.039 billion) in inflation-adjusted terms.

Data from 2013/14 and 2014/15 suggest NCGM expenditure might be levelling off, at just over $800 million a year, as noted in section 2.1.1.

There has been a reduction in the percentage of adults participating frequently in continuous forms of gambling, and a reduction in the percentage of adults participating in four or more different types of gambling. These reductions are positive, because both of these patterns are associated with a higher risk of gambling harm.

#### The potential impact of additional casino facilities

The passing of the New Zealand International Convention Centre Act 2013, which grants SKYCITY the right to operate more machines and table games in its Auckland casino in exchange for SKYCITY building and running an international convention centre, is likely to result in some additional casino gambling expenditure during the 2016/17 to 2018/19 period.

On 17 June 2o15, the media reported that SKYCITY had launched a free-play website with gaming machines, poker and blackjack. Promotion of this facility might result in some additional casino gambling expenditure in New Zealand and might also unintentionally result in some additional spending online with overseas operators.

#### Possible growth in online gambling

A number of stakeholders have considered the patterns of online gambling in overseas jurisdictions and raised concerns about the potential for a dramatic increase in New Zealanders’ participation in online gambling, due to proposals to increase internet speed and capacity and increasing use of online payment methods.

The research findings on this topic are inconclusive. Most studies suggest that the majority of online gamblers in New Zealand (of which there are relatively few) still largely purchase only New Zealand Lotteries Commission and New Zealand Racing Board products. The Ministry will continue to monitor developments in this area.

In April 2015, the Minister for Racing, Hon Nathan Guy, announced the establishment of a working group to consider the issue of New Zealanders betting online through overseas-based operators.

#### Technology-based and other innovative interventions

In the 2013/14 to 2015/16 period, the Ministry commissioned a feasibility study on a smart-phone application to prevent and minimise gambling harm and a pilot of a financial literacy programme for Māori and Pacific clients. It also participated in a DIA-led multi-venue exclusions project.

During the 2016/17 to 2018/19 period, the Ministry will continue to pilot technology-based and other innovative interventions, and implement them, if pilot projects show that they are cost-effective.

The Ministry is interested in the potential of pre-commitment technology in offline and online gambling environments, to prevent and minimise harm, by enabling gamblers to set limits on the time or money they spend gambling. It will continue to monitor developments in other jurisdictions in this area; particularly in the Australian state of Victoria, where a state-wide voluntary pre-commitment scheme is to begin operating on all gaming machines, including those at the Melbourne casino, by 1 December 2015.

#### Legislative changes

Amendments to the Gambling Act 2003 in the 2013/14 to 2015/16 period included changes to the gambling venue policy framework that could allow NCGM operators to relocate machines from venues in higher-deprivation areas to venues in lower-deprivation areas, enhancements to those of DIA’s powers that relate to the regulatory aspects of harm prevention and minimisation, and a specific power to make regulations prescribing the use of pre-commitment, player tracking or other similar technology on gaming machines.

These amendments might start having positive effects during the 2016/17 to 2018/19 period.

## 2.2 Service Plan for 2016/17 to 2018/19

The 2015 Needs Assessment (see Part 4) informed the development of this draft Service Plan. A review of the Ministry’s research agenda informed the research and evaluation programme (see section 2.2.3).

The draft Service Plan maintains the existing emphasis on an outcomes-based and results-based approach to funding services to prevent and minimise gambling harm, with a focus on achieving value for money alongside optimal service coverage. There will be further refinements as findings become available from the Outcomes Framework reports and from research and evaluation projects.

The draft Service Plan outlines the services that the Ministry considers it will require over the 2016/17 to 2018/19 period to make further progress towards the objectives set out in the nine-year Strategic Plan. It also sets out indicative budgets for the prevention and minimisation of gambling harm under the Ministry’s four main budget lines:

* public health services
* intervention services
* research and evaluation
* Ministry operating costs.

Table 14 shows indicative 2016/17 to 2018/19 budgets. Sections 2.2.1–2.2.4 discuss each budget line in more detail.

Table 14: Indicative budget to prevent and minimise gambling harm (GST exclusive), 2016/17 to 2018/19

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Service** | **2016/17 ($m)** | **2017/18 ($m)** | **2018/19 ($m)** | **Total ($m)** |
| Public health services | 6.770 | 6.850 | 6.770 | 20.390 |
| Intervention services | 8.461 | 8.461 | 8.461 | 25.383 |
| Research and evaluation | 2.209 | 2.210 | 2.210 | 6.629 |
| Ministry operating costs | 0.957 | 0.990 | 0.990 | 2.937 |
| **Total ($m)** | **18.397** | **18.511** | **18.431** | **55.339** |

### 2.2.1 Public health services

Internationally, the public health approach to preventing and minimising gambling harm is seen as a strength of New Zealand’s integrated strategy.

The indicative budget for public health services for the 2016/17 to 2018/19 period is largely unchanged from the previous period (see Table 15). However, within that overall budget, the Ministry intends to explore the potential for more innovative public health services. For example, it intends to develop and at least start piloting one or more initiatives specifically focused on reducing gambling-harm-related inequities among Māori and Pacific peoples (as the populations that are most vulnerable to gambling harm – see sections 4.3.3 and 4.3.6 in the Needs Assessment).

Table 15: Indicative public health budget (GST exclusive), by service area, 2016/17 to 2018/19

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Service** | **2016/17 ($m)** | **2017/18 ($m)** | **2018/19 ($m)** | **Total ($m)** |
| Primary prevention (public health action) | 4.730 | 4.730 | 4.730 | 14.190 |
| Workforce development | 0.180 | 0.180 | 0.180 | 0.540 |
| Awareness and education programme | 1.680 | 1.680 | 1.680 | 5.040 |
| National coordination services | 0.130 | 0.130 | 0.130 | 0.390 |
| Conference support | ‑ | 0.080 | ‑ | 0.080 |
| Audit activities | 0.050 | 0.050 | 0.050 | 0.150 |
| **Total ($m)** | **6.770** | **6.850** | **6.770** | **20.390** |

Note: All service areas include provision for dedicated Māori, Pacific and Asian services and activities.

#### Primary prevention (public health action)

Primary prevention services include health promotion, increasing community action, raising community awareness about gambling and problem gambling, working with territorial authorities on their gambling venue policies, and supporting the HPA’s awareness and education programme at a local and regional level.

The Ministry will continue to fund dedicated Māori, Pacific and Asian providers to offer primary prevention services.

There are five key service specifications[[7]](#footnote-7) that contribute to the public health approach to gambling harm:

* **policy development and implementation:** engagement with government agencies, social organisations, private industry and businesses to reduce gambling harm
* **safe gambling environments:** to ensure that environments that provide gambling opportunities are actively minimising harm and that individuals are supported to recognise and seek support to minimise gambling harm
* **supportive communities:** people live in communities that provide strong protective factors and that support individuals and family resilience
* **aware communities:** agencies, communities, families and individuals are aware of the range of harms arising from gambling
* **effective screening environments:** to identify individuals at risk of experiencing harm from gambling as early as possible and to ensure they are made aware of where to access appropriate minimising gambling harm intervention services.

Based on its current experience and the Needs Assessment, and given the outcome of the judicial review referred to in 2.1.1 and 2.1.3 above, the Ministry considers it appropriate to maintain funding for primary prevention services at broadly the same level as in the previous period. However, it intends to explore the potential for innovation within that overall budget.

#### Workforce development (public health)

In the 2013/14 to 2015/16 period, the Ministry’s gambling harm public health workforce development provider identified the core competencies (including the cultural competencies) and the minimum qualifications required for that workforce. The focus in 2016/17 to 2018/19 will be the implementation of an ongoing training programme to facilitate their achievement.

#### Awareness and education programme

A key part of the Ministry’s population-focused public health approach is the HPA’s health promotion programme. This programme was originally launched in April 2007, and phase four was launched in May 2014. It includes a national media component, the development of resources to support public health and intervention strategies, and a continued focus on evaluation. It prompts New Zealanders to think and talk about the broad impacts of problem gambling on individuals, communities and families, and to be aware of actions they can take to prevent and minimise gambling harm.

The HPA broadened its core programme of activity during the 2013/14 to 2015/16 period to include a component focusing on NCGM venues. The Ministry intends to continue its additional funding of $200,000 a year for the HPA during the 2016/17 to 2018/19 period, to allow it to implement the new NCGM materials, and to boost its activities focused on Māori and Pacific peoples.

#### National coordination and conference support

National coordination and conference support services provide support to both public health and intervention service capacity and capability. They have been included under public health expenditure because they align with public health principles.

##### National coordination

The national coordination service disseminates knowledge across providers of services to prevent and minimise gambling harm. It informs all service providers of significant developments, and assists collaboration among agencies involved in preventing and minimising gambling harm, including through facilitation of appropriate forums.

##### Conference support

The Ministry contributes funding to a biennial international gambling conference held in New Zealand, and an international think-tank. The conference will take place only once in the 2016/17 to 2018/19 period, in February 2016. The Ministry is budgeting for an $80,000 contribution towards the costs of the conference and think-tank.

Holding international conferences in New Zealand reflects and promotes New Zealand’s role as a world leader in preventing and minimising gambling harm. The conference enables practitioners, researchers, industry representatives and government officials from around the world to meet and exchange ideas specific to gambling harm. Those attending will benefit from exposure to international speakers.

#### Audit activities

The Ministry audits its services periodically. The audits allow for independent review and continuous quality improvement.

### 2.2.2 Intervention services

The indicative budget for intervention services for the 2016/17 to 2018/19 period is largely unchanged from the previous period (see Table 16). However, within that budget, the Ministry intends to explore the potential for more innovative intervention services.

Table 16: Indicative intervention budget (GST exclusive), by service area, 2016/17 to 2018/19

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Service** | **2016/17 ($m)** | **2017/18 ($m)** | **2018/19 ($m)** | **Total ($m)** |
| Helpline and web-based services | 1.100 | 1.100 | 1.100 | 3.300 |
| Psychosocial interventions and support | 7.080 | 7.080 | 7.080 | 21.240 |
| Data collection and reporting | 0.015 | 0.015 | 0.015 | 0.045 |
| Workforce development | 0.200 | 0.200 | 0.200 | 0.600 |
| Audit | 0.066 | 0.066 | 0.066 | 0.198 |
| **Total ($m)** | **8.461** | **8.461** | **8.461** | **25.383** |

Note: All service areas include provision for dedicated Māori, Pacific and Asian services and activities.

#### Helpline and web-based services

Helpline and web-based services provide:

* information
* access to intervention services for people unable to access face-to-face services
* referral to other gambling harm service providers
* information on self-help, peer-to-peer support options and assessment guides.

The Gambling Helpline provides a free 24-hour, 7-day-a-week service, and is a first contact point for people in crisis as a result of problem gambling. It provides a back-up for other services that are not 24/7. It also ensures coverage in rural areas, where there are no face-to-face services. It is critical to the Ministry’s service delivery model.

The current budget for this component will help fund the integrated national telehealth service once the Gambling Helpline is included within that service.

An Asian Gambling Hotline is currently provided by the Problem Gambling Foundation of New Zealand; funding for that Hotline is included within the psychosocial interventions and support component.

#### Psychosocial interventions and support

Psychosocial intervention and support services include a range of interventions delivered to individuals or groups in a variety of settings (including prisons). People affected by a family/ whānau member’s gambling can access the same range of services that is available to the gamblers themselves.

The four core intervention areas are brief intervention, full intervention, facilitation and follow‑up services. (‘Brief intervention’ in this context largely refers to brief screening for problems, typically in a non-clinical environment. It should not be confused with brief clinical interventions, for example by telephone.)

The Ministry remains committed to improving access to services for all people adversely affected by gambling. It recognises that it is crucial to identify people experiencing harm before they reach crisis, to minimise the impact gambling has on individuals and families and lessen their need for more intensive interventions.

The Ministry expects all services to be culturally safe and culturally competent. In addition, dedicated Māori, Pacific and Asian services will continue to cater for those population groups.

Based on its current experience and the Needs Assessment, and given the outcome of the judicial review referred to in 2.1.1 and 2.1.3 above, the Ministry considers it appropriate to maintain funding for psychosocial interventions and support at broadly the same level as in the previous period. However, it intends to explore the potential for innovation within that overall budget.

#### Data collection and reporting

The Ministry largely carries out data collection and reporting internally. The small sum specifically budgeted each year for data collection and reporting allows for an external provider to address data collection issues requiring institutional knowledge and to make small technical adjustments, if required.

#### Workforce development (intervention)

Workforce development will continue to be an important component to support psychosocial intervention services.

During 2016/17 to 2018/19 the Ministry intends to establish an ongoing training programme to ensure that each gambling harm practitioner will be registered as a health practitioner permitted to practise within a relevant scope of practice under the Health Practitioners Competence Assurance Act 2003, or will be registered or endorsed by DAPAANZ as having demonstrated the relevant specific competencies, or will be equivalently registered with another relevant professional organisation.

A key focus is to align the gambling harm intervention workforce with other addiction services. Research shows that alcohol and other drug problems are often an issue for those experiencing harm from gambling.

#### Audit

The Ministry audits its services periodically. The audits allow for independent review and continuous quality improvement.

### 2.2.3 Research and evaluation

The Act states that the strategy must include independent scientific research associated with gambling, including (for example) longitudinal research on the social and economic impacts of gambling, particularly the impacts on different cultural groups. It must also include evaluation.

The research agenda for the Service Plan prioritises methodologies and approaches that ensure Māori and Pacific involvement and participation in all research, and that build Māori and Pacific research capacity.

#### The research and evaluation work programme

Over the 2016/17 to 2018/19 period, the Ministry will fund certain specific projects that it believes best address the objectives of the strategy, as follows:

* an expansion of the 2012 NGS to include an in-depth qualitative phase and a seven-year follow-up focused on risk and resilience factors relating to gambling harm
* a national survey of gambling participation (including specific analyses relating to online gambling) and the prevalence of gambling harm, in 2017
* the collection and analysis of longitudinal data to inform understanding of risk and resilience factors relating to gambling harm for Pacific peoples, through the Pacific Island Families longitudinal study
* a further iteration of the gambling component in the Health and Lifestyles Survey, administered by the HPA
* a national trial of an internet/smart-technology-based system for preventing and minimising gambling harm
* research into a national programme for budgeting and financial literacy for Māori and Pacific problem gamblers
* two further researcher-initiated funding rounds that prioritise innovative, value-for-money research projects to prevent and minimise gambling harm
* a national research project that addresses why Māori and Pacific peoples experience enduring inequities related to gambling harm and that provides evidence on effective ways to reduce these inequities
* support for Māori and Pacific gambling harm research capacity
* continuation of an outcomes monitoring and reporting project to further develop the evidence base for future strategic planning and ongoing quality improvement in public health and intervention service delivery.

Table 17: Indicative research and evaluation budget (GST exclusive), 2016/17 to 2018/19

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Service** | **2016/17 ($m)** | **2017/18 ($m)** | **2018/19 ($m)** | **Total ($m)** |
| Research | 1.989 | 1.990 | 1.990 | 5.969 |
| Evaluation (including outcomes reporting) | 0.220 | 0.220 | 0.220 | 0.660 |
| **Total ($m)** | **2.209** | **2.210** | **2.210** | **6.629** |

### 2.6.4 Ministry of Health operating costs

Ministry operating costs (departmental expenditure) comprise contract management, policy and service development work, management of the research and evaluation programme, and management of the Client Information Collection (CLIC) database.

The budget for these components has remained at around $980,000 a year for many years now. The 2011 KPMG Value for Money Review concluded that the Ministry’s operating costs were reasonable.

In the past, the Ministry devised the budget for its operating costs on the assumption that more funding would be required in the final year of each three-year period, when the strategy for the next three-year period was being developed. In fact, much of this work occurs in the second half of the second year of each three-year period. For 2016/17 to 2018/19 the Ministry has phased the budget accordingly.

Table 18: Indicative budget for Ministry operating costs (GST exclusive), 2016/17 to 2018/19

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **2016/17 ($m)** | **2017/18 ($m)** | **2018/19 ($m)** | **Total ($m)** |
| Total operating costs ($m) | 0.957 | 0.990 | 0.990 | 2.937 |

This Consultation Document refers to recent changes in the legislative environment, including amendments to the Gambling Act and associated regulations and the passing of the New Zealand International Convention Centre Act 2013. These legislative provisions and any associated regulations are not under consideration in this consultation. However, you might wish to comment on any potential implications of any of these provisions in relation to the Strategy.

The draft Strategy includes all four components required by the Gambling Act 2003, and tries to ensure that there is a focus on public health, as required by the Act. These legislative provisions are not under consideration in this consultation. However, you might wish to comment on the overall amount that the Ministry suggests as its appropriation for the Strategy in the 2016/17 to 2018/19 period ($55.339 million), the amount that the Ministry suggests as the indicative budget for each budget line and service area, or the service areas that the Ministry suggests should be funded within each budget line.

Is the total amount of funding suggested in the draft Service Plan appropriate? If not, why not?

Does the draft Service Plan adequately address public health and intervention services, workforce development, research and evaluation? If not, what issues or areas are not adequately covered?

Do you think that the Service Plan would more effectively or more efficiently prevent and minimise gambling harm if some funding were shifted from one budget line to another or from one service area to another? If so, why?

Are there service areas that you think should not be funded, or service areas that are not funded that you think should be funded? If so, why?

# 3 Draft levy rates for 2016/17 to 2018/19

## 3.1 Background

The Ministry is responsible for developing and implementing ‘the integrated problem gambling strategy focused on public health’ (the strategy) that is described in section 317 of the Act.

The Ministry receives funding through Vote Health to develop and implement the strategy. The Crown then recovers this sum through a ‘problem gambling levy’ (the levy) on the profits of the main gambling operators. Section 319(2) of the Act states that the purpose of the levy is ‘to recover the cost of developing, managing, and delivering the integrated problem gambling strategy’.

The levy rates are set by regulation at least every three years. The next levy period is from 1 July 2016 to 30 June 2019, matching the period of the next strategy.

Since the levy was first set in 2004, it has applied to gambling operators in four sectors:

* non-casino gaming machine (NCGM) operators
* casinos
* the New Zealand Racing Board (NZRB)
* the New Zealand Lotteries Commission (NZLC).

The Act anticipates that these sectors might change from time to time.

## 3.2 Proposals to change the levy-paying sectors

There have been suggestions for some years that the NCGM sector should be split into two sectors for levy purposes: club and non-club (referred to as ‘pub’ venues). More recently, the NZRB has suggested that its own NCGMs should also be a distinct sector.

On balance, the Ministry considers that the available evidence no longer supports the club proposal.

As far as it is aware, no evidence has been put forward in support of the NZRB proposal to date.

The 2012 consultation document on the draft strategy for 2013/14 to 2015/16 stated that there was growing research evidence suggesting that club NCGMs were less likely to be associated with harm than other NCGMs. It has since become clear that much of this research does not address a key issue. That is, even if the club NCGM environment were demonstrably less harmful than other NCGM environments, that fact alone would not be enough to justify club NCGMs being a separate sector.

The levy rates are set as percentages of expenditure. That means that if the amount spent on club NCGMs is only, for example, 5 percent of the amount spent on all NCGMs, clubs will pay only 5 percent of the total levy amount paid by all NCGM operators. As a result, a single levy rate for all NCGMs adequately addresses any differences in gambling harm that are either attributable to or reflected in differences in expenditure.

The Ministry is not aware of any research demonstrating both that the club NCGM environment is less harmful than other NCGM environments and that the difference in harm is not either attributable to or reflected in a difference in expenditure. Two Ministry-funded New Zealand research projects, one of them a small exploratory study, suggest this might be the case (SHORE/Whariki 2008; Thomas et al 2012), but there is no firm evidence.

In any case, the formula in section 320 of the Act refers not to research findings, but to each sector’s share of ‘customer presentations to problem gambling services in which a sector that is subject to the levy can be identified’. This essentially means that the club share of NCGM *presentations* has to be substantially lower than the club share of NCGM *expenditure* for the formula to produce a substantially lower levy rate for club NCGMs.

The club share of NCGM expenditure has been relatively stable for many years, at around 13–14 percent of all NCGM expenditure. By contrast, other than a dip in 2010/11, the club share of NCGM presentations has been rising since the Ministry first required the psychosocial intervention services it funds to separately record presentation figures for club and non-club NCGMs (see Table 19 below).

Table 19: Club share of all presentations attributed to NCGMs, 2007/08 to 2014/15

|  |  |
| --- | --- |
| **Year from 1 July to 30 June** | **%** |
| 2007/08 | 8.07 |
| 2008/09 | 10.06 |
| 2009/10 | 10.86 |
| 2010/11 | 9.71 |
| 2011/12 | 12.78 |
| 2012/13 | 14.81 |
| 2013/14 | 15.11 |
| 1 May 2014 to 30 April 2015 | 16.94 |

There are three qualifications to the figures in Table 19.

First, in 2007/08 only around one-half of all NCGM presentations were specifically attributed to either club or non-club NCGMs (or both).

Second, from 1 October 2011, the Ministry simplified its Client Information Collection (CLIC) database by removing a facility to record secondary modes of problem gambling and by changing the criterion for a primary mode from whether the mode was causing ‘significant harm’ to whether the mode was causing ‘harm’ (to align with the wording in the Act). Some have argued that this led to an increase in the club share of NCGM presentations that was not fully reflected in the annual figures until 2012/13.

Third, the figure for 2014/15 relates to the 12 months from 1 May 2014 to 30 April 2015 (the latest figures available at the time of preparing this document), not the standard 1 July 2014 to 30 June 2015 year.

The fact remains that apart from a dip in 2010/11 the estimated club share of NCGM presentations has been rising since 2007/08. Further, the Ministry considers that the later figures are the best figures (see section 3.4.2 below), and if those figures were used in the section 320 formula, a separate levy rate for club NCGMs would actually be *higher* than the levy rate for other NCGMs.

The Ministry also notes that there would be significant time and costs, including opportunity costs, involved in implementing a separate levy rate for club NCGMs, however it was implemented. In fact, the Inland Revenue Department (IRD) has advised that until the high-level design for its business transformation is completed later this year, it is unable even to confirm a timeline for when it might be able to implement a separate levy rate for club NCGMs.

As far as the NZRB’s NCGMs are concerned, the Ministry currently has no information on the number of presentations that are attributable to those machines. Obtaining that information would impose an extra burden on the clinicians who collect it (see section 3.4.2 below).

The Ministry’s view is that the limited size of this subsector does not justify that extra administrative burden on clinicians, let alone the additional complexity and cost that would be involved in calculating, collecting and monitoring a separate levy rate for NZRB NCGMs.

For all these reasons, the Ministry does not propose any changes to the four sectors from which the levy is collected.

## 3.3 Process for setting the levy rates

The Act sets out the process to develop and set the levy rates needed to recover the cost of the strategy is set out in sections 318 to 320.

As part of this process, the Ministry is now consulting on its estimated annual funding requirements and four alternative sets of estimated levy rates for 1 July 2016 to 30 June 2019. The figures in the four alternative levy calculation options below should be considered indicative at this stage. The Ministry will update them before the Gambling Commission’s consultation meeting referred to below.

Following consultation, the Ministry will submit proposed levy rates to Ministers of Health and Internal Affairs and to the Gambling Commission. The Gambling Commission may then obtain its own advice, and will convene a consultation meeting. It will subsequently make recommendations to the responsible Ministers. Cabinet will approve the Strategic Plan and Service Plan, determine the funding that it will recommend to Parliament as the Ministry’s appropriation, and endorse responsible Ministers recommending to the Governor-General regulations setting out the sectors that will pay the levy and the relevant levy rates.

## 3.4 The levy formula

The formula in section 320 of the Act ‘provides a mechanism for allocating among gambling operators, and collecting from them, the approximate cost’ of the strategy.

The formula is:

Levy rate for each sector = ({[A x W1] + [B x W2]} x C) plus or minus R

D

where:

**A** = the estimated current expenditure in a sector, divided by the total estimated current player expenditure in all sectors subject to the levy

**B** = the number of customer presentations to problem gambling services that can be attributed to gambling in a sector, divided by the total number of customer presentations to problem gambling services in which a sector that is subject to the levy can be identified

**C** = the funding requirement for the period for which the levy is payable

**D** = the forecast player expenditure in a sector for the period during which the levy is payable

**R** = the estimated under-recovery or over-recovery of levy from a sector in the previous levy periods[[8]](#footnote-8)

**W1** and **W2** are weights, the sum of which is 1.

The top line of the formula determines the dollar amount to be paid by each sector. The bottom line of the formula determines the levy rate that is necessary for a sector to pay its required contribution.

Since the levy rate calculations ‘must take into account the latest, most reliable, and most appropriate sources of information’ from the Ministry, IRD or DIA, as the case may be, the Ministry will update the figures before the Gambling Commission’s consultation meeting, and will include the updated information in its proposals document for that meeting.

### 3.4.1 Estimated current player expenditure (A)

DIA has estimated current player expenditure using a variety of sources of information, including its NCGM electronic monitoring system, gambling operators’ annual and half-yearly reports and information from IRD.[[9]](#footnote-9) Other data on gambling expenditure are available on the DIA website, [www.dia.govt.nz](http://www.dia.govt.nz).

Note that the data on the DIA website will differ from the IRD figures for money actually collected as used in the levy calculation. This is because there are differences in collection periods, in the application of accounting approaches and in the framing of requests for information. DIA is currently working to minimise these differences.

### 3.4.2 Presentations (B)

The formula in the Act requires the levy rate calculation to take into account the latest, most reliable, and most appropriate sources of information from the Ministry on customer presentations to problem gambling sources.[[10]](#footnote-10)

The Ministry generated the presentation figures used in the levy calculations in this consultation document from data collected by its psychosocial intervention service providers. The figures relate to all clients who received a full, facilitation or follow-up intervention session during the 12-month period from 1 May 2014 to 30 April 2015. For reasons that have been canvassed in detail in documentation of previous levy-setting processes, brief screening interventions and primary problem gambling modes (PPGMs) in gambling sectors that are not subject to the levy are excluded.

The Ministry will update the presentation figures before the Gambling Commission’s consultation meeting, to refer to the year ending 30 June 2015, and will include the updated figures in its proposals document for that meeting. Given that updating the figures will involve substituting only two months (that is, deleting the figures for May and June 2014 and entering the figures for May and June 2015), and given that the intermediate calculations are done to numerous decimal places before being rounded to two places for the levy rates, there should be very little, if any, change to the levy rates as a result of the updated presentations data.

From 1 October 2011, the Ministry simplified the CLIC database by changing the criterion for a PPGM from whether the mode was causing ‘significant harm’ to whether the mode was causing ‘harm’, to align with the Act, and by removing the facility to record secondary modes of problem gambling. The current system for attributing presentations to gambling sectors, after those changes, is described below.

Each qualifying client within each service provider counts as only one presentation for any specified time period (for example, during the course of a given 12-month period).

If a clinician concludes that more than one type of gambling is causing a client harm, the service provider records all those types of gambling (up to a maximum of five) by way of a tick in the session record; as a result, these types become PPGMs. Each PPGM is automatically allocated an equal weighting for that session and subsequent sessions. If a clinician concludes in a subsequent session that the harmful types of gambling for that client have changed, the process is repeated. Each PPGM in the new mix is automatically allocated an equal weighting for the session in which the clinician concludes that there has been a change and for the sessions that follow it.

The share of each presentation (ie, the share of each client) that is attributed to each type of gambling depends on the client’s number of PPGMs and the number of sessions for which each is recorded. All that the service provider needs to do is record the types causing harm as outlined above, then enter the new mix (by again ticking the types causing harm) in the record for any subsequent session in which the clinician concludes that there has been a change. The Ministry’s system automatically performs all the necessary calculations.

Table 20 sets out the presentations attributed to each of the four levy-paying sectors in each year from 2004/05 onwards. Note that the 2014/15 figures are for the 12-month period from 1 May 2014 to 30 April 2015, not for the year ended 30 June 2015.

Table 20: Presentations attributed to the four main sectors, 2004/05 to 2014/15

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **NCGMs** | | **Casinos** | | **NZRB** | | **NZLC** | | **Total** |
| **n** | **%** | **n** | **%** | **n** | **%** | **n** | **%** | **n** |
| 2004/05 | 2386 | 75 | 505 | 16 | 237 | 7 | 52 | 2 | 3179 |
| 2005/06 | 2307 | 71 | 641 | 20 | 243 | 7 | 64 | 2 | 3255 |
| 2006/07 | 2981 | 71 | 814 | 19 | 311 | 7 | 76 | 2 | 4182 |
| 2007/08 | 3063 | 71 | 849 | 20 | 328 | 8 | 97 | 2 | 4337 |
| 2008/09 | 3933 | 69 | 1050 | 18 | 413 | 7 | 304 | 5 | 5700 |
| 2009/10 | 4160 | 69 | 1131 | 19 | 449 | 7 | 332 | 5 | 6072 |
| 2010/11 | 3945 | 68 | 1073 | 18 | 476 | 8 | 332 | 6 | 5825 |
| 2011/12 | 3708 | 64 | 1188 | 21 | 548 | 9 | 339 | 6 | 5783 |
| 2012/13 | 3721 | 59 | 1403 | 22 | 568 | 9 | 652 | 10 | 6344 |
| 2013/14 | 3871 | 59 | 1413 | 22 | 651 | 10 | 590 | 9 | 6525 |
| 2014/15 | 3761 | 57 | 1465 | 22 | 718 | 11 | 597 | 9 | 6541 |

Source: Service user data, Ministry of Health (downloaded May 2015) and 2014/15 CLIC data. The sum of the row entries may not be exactly the same as the relevant total, because of rounding.

The Ministry considers that the new system is both more responsive to subtleties and better aligned with the purposes and wording of the Act than the old system. As a result, the Ministry considers that its presentation figures from 2012/13 onwards are more reliable and more appropriate sources of information than its earlier figures.

There are three qualifications to bear in mind when considering the figures in Table 20.

First, from 1 April 2008, the Ministry formalised a requirement for service providers to enter as PPGMs all forms of gambling that were causing a client ‘significant harm’, and to enter as secondary modes of problem gambling all forms of gambling that were causing a client ‘harm’, up to a maximum of five in each case.

Second, that system was changed from 1 October 2011, as described previously.

Third, the figure for 2014/15 relates to the 12 months from 1 May 2014 to 30 April 2015 (the latest figures available at the time of drafting this consultation document), not the standard 1 July 2014 to 30 June 2015 year.

The *number* of NCGM presentations peaked in 2009/10. The *share* of NCGM presentations peaked in 2004/05, and has been dropping unevenly since. These patterns probably largely reflect reductions in the number of NCGMs and NCGM venues, and in the amount spent on NCGMs, since 2003/04.

With the exception of a small dip in 2010/11, the *number* of casino presentations has increased each year since 2004/05. The *share* of casino presentations has tended to increase, but has fluctuated over the years depending on the number of presentations attributed to the other levy-paying sectors.

The *number* of NZRB presentations has risen in each year since 2004/05. The *share* of NZRB presentations has tended to increase as a result, but has fluctuated a little.

The *number* of NZLC presentations peaked in 2012/13, before dropping off a little. The *share* of NZLC presentations has tended to follow a similar but uneven pattern. There were step changes in the NZLC share of presentations in 2008/09 and 2012/13.

It is worth noting that the changes the Ministry made to its systems from April 2008 and from October 2011 might mean that after those dates some presentations that would previously have been attributed solely to NCGMs were attributed partly to NCGMs and partly to one or more other types of gambling (and vice versa, but to a far lesser extent). If this happened, the Ministry considers that it improved the data, for the reasons outlined above.

### 3.4.3 The weights (W1 and W2)

The Act requires the Ministry to use a weighting between current expenditure and presentations to help determine each sector’s share of the total levy amount. Expenditure is a component of the weighting because of the limitations of relying on presentations alone.

The levy is intended to recover the cost of developing and implementing a strategy to prevent and minimise gambling harm. The definition of ‘harm’ in the Act is very broad. Presentations represent only a small subset of gambling harm, and one that tends to be at the acute end of the continuum. Those who seek help represent only a small proportion of those who experience harm. There can be no assurance that gambling sectors are associated with harm across the continuum of harm in precisely the same proportions as they are associated with presentations to intervention services.

The Act specifies that, in addition to intervention services, the strategy must include measures to promote public health by preventing and minimising the harm from problem gambling. It must also encourage gambling research (not just problem gambling research) and evaluation. The proportion of presentations to intervention services attributable to a particular gambling sector is not necessarily an appropriate indicator for determining the share that sector should bear of public health, research and evaluation costs.

Table 21 shows the proportion of presentations attributed to each levy-paying sector for the 12‑month period from 1 May 2014 to 30 April 2015 and an estimate of each levy paying sector’s proportion of expenditure for the 2014/15 year.

Table 21: Share of presentations and expenditure by sector, 2014/15

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **NCGMs** | | **Casinos** | | **NZRB** | | **NZLC** | |
| **Presentations** | **Expenditure** | **Presentations** | **Expenditure** | **Presentations** | **Expenditure** | **Presentations** | **Expenditure** |
| 0.575 | 0.401 | 0.224 | 0.255 | 0.110 | 0.159 | 0.091 | 0.185 |

The top line of the formula determines the amount to be paid by each sector. When a sector’s proportion of expenditure is substantially different from its proportion of presentations, **W1** and **W2**, the weighting between expenditure and presentations, is critical to the determination of the amount that sector will be required to pay, as follows.

* The higher the weighting on *expenditure*, the higher the share of the levy to be paid by the NZLC (because that sector’s proportion of gambling expenditure is much higher than its proportion of presentations) and the NZRB.
* The higher the weighting on *presentations*, the higher the share to be paid by the NCGM sector (because close to 60% of all presentations are attributed to that sector but its proportion of expenditure is much lower) and the lower the share to be paid by the NZLC and the NZRB.
* The share of the levy to be paid by casinos is not very sensitive to any weighting changes because that sector’s proportion of expenditure is relatively close to its proportion of presentations.

A critical problem with the weighting approach is that there may be no single weighting that could be applied to determine each sector’s fairest share of the levy. However, the Act requires the Ministry to use this approach.

The strategy is intended to prevent and minimise gambling *harm*; it is not intended to address the amount spent by gamblers per se. Therefore, the Ministry considers that any weighting of more than 30 percent on expenditurewould be inappropriate, because it would unfairly penalise operators of relatively benign forms of gambling with high expenditure. A weighting of 30 percent or less on expenditure necessarily implies a weighting of 70 percent or more on presentations.

Each ‘presentation’ represents a person who is seeking help because they have been harmed, either by their own or by someone else’s gambling. Each presentation is attributed across the PPGMs for that client. Therefore, the Ministry considers that presentations, as one indicator of harm, albeit harm at the acute end of the continuum, should be allocated a substantially heavier weighting than expenditure. This also tends to support a weighting of at least 70 percent on presentations and no more than 30 percent on expenditure.

However, as the Gambling Commission noted in its 2009 report,[[11]](#footnote-11) a very high weighting on presentations might mean that ‘diligent host responsibility in detecting problem gambling and encouraging the seeking of assistance is punished not rewarded’.

Presentations are not the only available indicator of harm. Other examples include estimates of problem gambling prevalence using screening instruments such as the Problem Gambling Severity Index (PGSI),[[12]](#footnote-12) or survey questions that directly address the risk of harm (for example, questions about various forms of ‘household harm’) associated with particular gambling products. Some of these measures suggest that the proportion of gambling harm that is properly attributable to the NZRB and the NZLC in particular might be higher than their shares of the presentation figures in earlier years would have suggested. This is one reason why the Ministry considers that the latest presentation figures, in which the NZRB and NZLC shares of presentations are somewhat higher, are the most reliable and the most appropriate.

The Ministry proposed a weighting of 30 percent on expenditure and 70 percent on presentations (referred to as a 30/70 weighting) for the 2010/11 to 2012/13 and 2013/14 to 2015/16 levy periods. It considers that the change in the pattern of presentations from 2012/13 onwards means that the arguments in favour of the 30/70 weighting are no longer as strong. For the 2016/17 to 2018/19 period, and subject to any feedback from the consultation process, the Ministry suggests a 20/80 weighting. However, it also considers that any weighting from 30/70 to 5/95 would be reasonable.

The options set out in this consultation document are 30/70, 20/80, 10/90 and 5/95.

For all four levy periods to date, the weighting has been 0.1 (10%) on expenditure and 0.9 (90%) on presentations.

The Ministry is seeking feedback through this consultation document on which weighting option stakeholders prefer, and why. It is important to note that the levy weighting options do not affect the total amount of the levy. The weighting chosen only affects the share of the levy to be paid by each gambling sector.

### 3.4.4 The funding requirement (C)

The funding requirement represented by **C** in the formula is the amount that the Ministry considers it requires to fund the implementation of the strategy for 2016/17 to 2018/19. For 2016/17 to 2018/19 the Ministry is seeking an appropriation of $55.339 million: the same amount as its appropriation for 2013/14 to 2015/16. More detail is set out in the draft Service Plan (see section 2.2).

### 3.4.5 Estimated levy under-recovery or over-recovery, by sector (R)

Section 107 of the Gambling Amendment Act 2015, which came into effect on 3 March 2015, requires the calculation of each sector’s levy rate to take into account any under-recovery or over-recovery from that sector in previous levy periods. Until this legislative change was made, all four sectors would have received a benefit if any of them had paid more in levy than they were expected to in previous levy periods, and all faced an additional cost if any had paid less in levy than expected in previous periods.

Substantial adjustments are required in the 2016/17 to 2018/19 levy period as a result of this legislative change. This is effectively a one-off sector-by-sector correction for under-payments and over-payments dating back to 1 July 2004.

The Ministry’s total appropriation to prevent and minimise gambling harm from 1 July 2004 to 30 June 2016, as derived from its four service plans to date, was $216.360 million. The Ministry expects its expenditure to 30 June 2016 to total no more than $211.615 million, taking into account any possible expense transfers.[[13]](#footnote-13) This figure was derived by summing the expenditure in its annual reports to 30 June 2014 and an estimate of its likely expenditure for the two years to 30 June 2016. It is the latter figure ($211.615 million) that the levy should have recovered from the four levy-paying gambling sectors.

The Ministry obtained each sector’s expected contribution to the levy requirement for each three-year period by referring to the relevant Cabinet paper. It used that information to calculate each sector’s expected contribution to the Ministry’s appropriation for each period. It then summed those expected contributions across the four periods to arrive at each sector’s expected contribution to the total amount appropriated to the Ministry across the 12 years, and to calculate each sector’s expected share of the total amount appropriated.

The share of the total appropriation (rounded to four decimal places) that NCGMs were expected to pay was 68.4631 percent. The expected share for casinos was 18.6992 percent, for the NZRB 7.8964 percent, and for the NZLC 4.9412 percent.

This means that the total amount of levy that should have been collected from NCGMs over the 12-year period was $144.878 million (that is, 68.4631% of $211.615 million). The equivalent amount for casinos was $39.570 million, for the NZRB was $16.710 million, and for the NZLC was $10.456 million.

The DIA used IRD figures for levy actually collected to the end of the third quarter of 2014/15 to estimate the levy under-recovery or over-recovery for each sector for the 12-year period. Table 22 shows these amounts.

Table 22: Estimated under-collection or over-collection of problem gambling levy, 2004/05 to 2015/16, by sector

|  |  |
| --- | --- |
| **Sector** | **$m (GST inclusive)** |
| NCGMs | -2.138 |
| Casinos | -1.916 |
| NZRB | 1.675 |
| NZLC | 0.805 |

A negative figure indicates under-collection and a positive figure indicates over-collection.

The under-recoveries are added to the amounts required from NCGMs and the casinos in the 2016/17 to 2018/19 period. Similarly, the over-recoveries are deducted from the amounts required from the NZRB and the NZLC.

The under-recovery from NCGMs was largely because the service plan for 2004/05 to 2006/07 forecast that the previous pattern of substantial year-on-year expenditure growth would continue. As a result of reductions in the number of NCGMs from 18 September 2003 and changes to smoke-free legislation that came into effect on 10 December 2004, expenditure actually declined.

There appear to be two factors that were largely responsible for the under-recovery from casinos.

First, the service plan for 2004/05 to 2006/07 forecast that the previous pattern of substantial year-on-year expenditure growth would continue. It did not, probably largely because of the changes to the smoke-free legislation.

Second, the service plan for 2007/08 to 2009/10, which was developed in 2006, forecast a recovery from the effects of the smoke-free legislation followed by vigorous expenditure growth. That too did not happen, possibly because of the 2007 to 2009 global financial crisis.

The service plan forecasts for expenditure on NZRB products were relatively accurate in the 2007/08 to 2009/10 and 2010/11 to 2012/13 levy periods. The NZRB paid too much in levy essentially because the service plan forecasts did not anticipate the expenditure growth that occurred in both the first and the last of the four levy periods.

Expenditure on NZLC products is relatively volatile, depending on the number of large jackpots in any given financial year. The service plan forecasts for expenditure on NZLC products were too low for almost every year of the four levy periods to 30 June 2016, probably as a result of the NZLC’s own published forecasts.

### 3.4.6 Forecast player expenditure (D)

The amounts represented by **D** in the formula are sector-by-sector forecasts of the amounts that DIA expects gamblers to spend on the gambling products of the four levy-paying gambling sectors in the period from 2016/17 to 2018/19. The higher forecast expenditure is, the lower the levy rate necessary for a sector to pay its required contribution (as determined by the top line of the formula).

The reasoning behind the forecast for each sector is set out below

The gambling sector is going through a period of legislative change. The Gambling Amendment Act 2015 came into effect on 3 March 2015. The Gambling Amendment Bill (No 3) is in its final stages. An Offshore Racing and Sports Betting Working Group is due to report by the end of September 2015.

There may be changes in gambling expenditure as a result of these developments, but it is not possible to forecast the extent of any such changes until the nature and impact of any legislative or policy changes are clearer.

#### Non-casino gaming machines

The number of NCGMs is still declining. There were 20,302 NCGMs in New Zealand on 31 March 2007 and 18,484 on 31 March 2011. By 31 March 2015 there were only 16,614.

Expenditure has also declined for most of the last decade. It declined from $854 million in 2011/12 to $826 million in 2012/13 and to $808 million in 2013/14.

Recent electronic monitoring system (EMS) data suggest that expenditure will be around the same level in 2014/15. DIA considers further reductions in NCGM expenditure are less likely, and forecasts a period of relatively stable expenditure.

While the number of NCGMs and NCGM venues may fall further, DIA considers it likely that if machines are removed from one venue, at least some gamblers will shift to another.

Some variation in expenditure from year to year is expected, but the size of that variation cannot be forecast in advance.

Non-club expenditure has been around 86 to 87 percent of total NCGM expenditure every quarter since 30 June 2007, which was the first full quarter after the EMS began operating. Club expenditure has varied from around 13 percent to around 14 percent of the total. This trend is expected to continue throughout the upcoming levy period.

#### Casinos

Over the last three years spending on casino gambling has fluctuated. Figures from DIA show expenditure of $509 million in 2011/12, $520 million in 2012/13 and $509 million in 2013/14. A further increase in expenditure is expected in 2014/15, driven by a significant lift in visitor numbers to New Zealand. However, growth is expected to slow by the beginning of the 2016/17 to 2018/19 period.

The Auckland casino dominates spending on casino gambling in New Zealand. Under the New Zealand International Convention Centre Act 2013, the casino will receive a variety of regulatory concessions in return for SKYCITY building and operating the New Zealand International Convention Centre. These concessions include the right to add 230 single-terminal gaming machines and 40 tables. It is unclear to what extent casino gambling expenditure might increase as a result of the concessions. Some growth in expenditure is anticipated, but the forecast is still conservative.

#### New Zealand Racing Board

Spending on NZRB products was relatively flat for some years. However, it increased from $283 million in 2011/12 to $311 million in 2013/14. This reflects a repositioning of online products and changes in the broadcasting arrangements for race meetings. Indications are that expenditure rose again in 2014/15.

DIA anticipates that the recent period of higher growth may not be sustained, particularly in light of concerns the sector has expressed about competition from offshore betting agencies. The Offshore Racing and Sports Betting Working Group is looking into this issue, and will deliver a report before 30 September 2015. DIA forecasts lower growth in racing and sports betting expenditure over the period from 2016/17 to 2018/19 due to increased competition.

#### New Zealand Lotteries Commission

Spending growth on NZLC products has been relatively high, but volatile, since 2005/06. This volatility appears to relate to the number of large jackpots in a year. Strong growth has continued over recent years; DIA reports expenditure of $418 million in 2011/12, $432 million in 2012/13 and $463 million in 2013/14.

Data for the year to date indicate that expenditure on lotteries will be down in 2014/15, reflecting normal volatility. The forecast is for moderate expenditure growth throughout the 2016/17 to 2018/19 period. This is not expected to be quite at the same rate as in recent years, consistent with the forecasts of the NZLC itself.

Table 23: Forecast expenditure by sector (GST inclusive), 2016/17 to 2018/19

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Forecast expenditure** | **NCGMs** | **Casinos** | **NZRB** | **NZLC** |
| 2016/17 ($m) | 806.809 | 518.579 | 327.211 | 400.163 |
| 2017/18 ($m) | 806.809 | 523.765 | 330.484 | 412.167 |
| 2018/19 ($m) | 806.809 | 531.622 | 333.788 | 422.472 |

## 3.5 Levy calculations

The tables that follow set out the effect of each of the four alternative weightings described above on the draft levy rates for the four levy-paying sectors.

Table 24: Estimated levy rates: 5/95 weighting

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Collection period starts 1 July 2016 (all GST exclusive)** | **NCGMs** | **Casinos** | **NZRB** | **NZLC** |
| Sector levy rates (%) | 1.37 | 0.90 | 0.48 | 0.37 |
| Expected levy ($m) | 33.1598 | 14.1657 | 4.7591 | 4.5688 |

Table 25: Estimated levy rates: 10/90 weighting

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Collection period starts 1 July 2016 (all GST exclusive)** | **NCGMs** | **Casinos** | **NZRB** | **NZLC** |
| Sector levy rates (%) | 1.35 | 0.90 | 0.49 | 0.39 |
| Expected levy ($m) | 32.6757 | 14.1657 | 4.8583 | 4.8157 |

Table 26: Estimated levy rates: 20/80 weighting

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Collection period starts 1 July 2016 (all GST exclusive)** | **NCGMs** | **Casinos** | **NZRB** | **NZLC** |
| Sector levy rates (%) | 1.31 | 0.92 | 0.52 | 0.44 |
| Expected levy ($m) | 31.7076 | 14.4805 | 5.1557 | 5.4331 |

Table 27: Estimated levy rates: 30/70 weighting

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Collection period starts 1 July 2016 (all GST exclusive)** | **NCGMs** | **Casinos** | **NZRB** | **NZLC** |
| Sector levy rates (%) | 1.27 | 0.93 | 0.55 | 0.48 |
| Expected levy ($m) | 30.7394 | 14.6379 | 5.4532 | 5.9270 |

The figures for **A**, **B** and **R** are derived from data held by the Ministry, DIA and IRD. You have the opportunity to comment on **C** (the amount that the Ministry believes it requires to fund the development and implementation of the strategy) in the context of the draft service plan (Part 2 of this Consultation Document).

Are there realistic pairs of weightings (**W1** and **W2**) other than those discussed in this consultation document? Which pair, if any, do you support?

Are the player expenditure forecasts for each gambling sector (**D**) realistic? If not, why not?

Do you have any comment on the estimated levy rates for each sector (bearing in mind the formula itself is set out in legislation and is not under consideration in this consultation)?

# 4 Gambling Harm Needs Assessment 2015

## 4.1 Introduction

The Gambling Act 2003 (the Act) requires the Ministry to undertake and consult on a needs assessment when developing the strategy. This section summarises key information (particularly research findings) that emerged from the 2015 Needs Assessment the Ministry carried out for this purpose. Anyone wishing to consider the issues in more detail may find it useful to refer to the publications cited here.

Two documents prepared in 2009 and 2012 to inform earlier needs assessments are still available on the Ministry’s website (Francis Group 2009; Allen and Clarke 2012). A 2015 update report to inform the strategy for 2016/17 to 2018/19 is also available on the Ministry’s website (Allen and Clarke 2015).

## 4.2 The gambling environment

### 4.2.1 Gambling participation

Numerous studies have examined gambling participation in New Zealand.

From 1985 to 2005, the Department of Internal Affairs (DIA) ran a five-yearly survey of people’s participation in and attitudes towards gambling (summarised in DIA 2008). In 1991 and 1999 it also commissioned national surveys of gambling and problem gambling prevalence, the latter being only one component of the much larger New Zealand Gaming Survey (Abbott and Volberg 1991 and 1992; Abbott and Volberg 2000; Abbott 2001).

In 2002/03, 2006/07 and 2011/12 the Ministry included gambling components in the New Zealand Health Survey (NZHS) (Ministry of Health 2006b, and 2009; Rossen 2014), and in 2012 commissioned the multi-phase National Gambling Study (NGS) (Abbott et al 2014a, 2014b, 2014c and 2015).

In 2006/07 the Gaming and Betting Activities Survey was run by what was then the Health Sponsorship Council and is now the Health Promotion Agency (HPA). This was followed in 2008, 2010, 2012 and 2014 by successive iterations of the New Zealand Health and Lifestyles Survey (HLS), which included gambling components (Gray 2011; Health Sponsorship Council 2012; Tu 2013; HPA in press).

In 2007 Massey University’s Centre for Social and Health Outcomes Research and Evaluation and Te Ropu Whariki undertook a large gambling participation survey, which it subsequently reported in its *Assessment of the Social Impacts of Gambling in New Zealand* (SHORE/Whariki 2008).

Estimates derived from surveys can vary markedly depending on a variety of factors, including the size of the sample, the response rate, how ‘adult’ is defined, how ‘gambling activity’ is defined and how survey questions are presented to participants – for example, by telephone or face-to-face. However, the findings set out below have all tended to emerge from many of the surveys cited.

* Most adults in New Zealand gamble at least occasionally. For example, the 2012 NGS estimated that 80 percent of people aged 18 or over had taken part at least once in at least one gambling activity in the previous 12 months.
* Only a minority participate in any gambling activity other than buying New Zealand Lotteries Commission (NZLC) products or raffle tickets. For example, the 2012 NGS estimated that 62 percent of adults had bought a Lotto ticket at least once in the previous year. However, it also estimated that, in the previous year, only:
* 14 percent had played a non-casino gaming machine (NCGM) at least once
* 12 percent had bet on a horse or dog race at least once
* 8 percent had played a casino gaming machine in New Zealand at least once
* 5 percent had bet on a sports event at least once
* 4 percent had played a casino table game in New Zealand at least once.
* Differences among gambling activities are pronounced when the frequency of participation is considered. For example, the 2012 NGS estimated that 17 percent of adults bought Lotto tickets at least once a week, but only 1.5 percent played an NCGM this frequently.
* Gambling participation has fallen, and frequent participation in riskier forms of gambling has fallen markedly, since the 1990s. For example, the 1991 national survey estimated that 18 percent of adults participated at least once a week in continuous forms of gambling;[[14]](#footnote-14) the equivalent 2012 NGS estimate was 6 percent. As another example, DIA’s 1990 participation and attitudes survey estimated that 5 percent of adults played an NCGM at least once a week, while the equivalent figure in the last such survey in 2005 was 3 percent, and the 2012 NGS estimate was 1.5 percent. Results from the HLS suggest that these trends have levelled off.
* Most surveys report demographic differences in gambling participation, but they do not always agree on the details of these differences. The following are some of the findings common to a number of surveys.
* Asian and Pacific adults are less likely to participate in gambling than European/Other and Māori adults (the figures in the 2012 NGS were 61 percent, 75 percent, 82 percent and 85 percent respectively).
* Patterns of gambling participation among Pacific and Asian populations appear to be bi‑modal: adults in these populations are less likely to participate in gambling, but those that do tend to gamble relatively heavily.
* Adults under 35 are more likely than older adults, and Māori adults are more likely than adults of other ethnicities, to play NCGMs. Pacific adults are more likely than Māori or European/Other adults to play casino gaming machines. Some segments of the Asian population are more likely than adults of other ethnicities to gamble on casino tables.
* Adults under 35 are more likely than older adults to bet on sports events.
* Males are more likely than females to bet on sports events and possibly horse or dog races, casino gambling and card games. Females are more likely than males to play housie and possibly to purchase Instant Kiwi or other scratch tickets.
* Māori adults are more likely than European/Other and Asian adults to participate frequently in continuous forms of gambling.

### 4.2.2 Number and location of gambling outlets

Analyses in 2005, 2009, 2012 and 2015 (Ministry of Health 2006a; Francis Group 2009; Allen and Clarke 2012 and 2015) show an association between numbers of NCGM venues, numbers of NCGMs and NCGM expenditure on the one hand and higher deprivation on the other. Analyses in some of these reports also suggest that NZLC and New Zealand Racing Board (NZRB) retail outlets tend to be located in higher deprivation areas.

The number of licensed NCGM venues in New Zealand peaked at more than 2200 in the late 1990s, and has been declining relatively steadily ever since. The quarterly total of licensed NCGMs peaked at 25,221 on 30 June 2003, the end of the last quarter before the passing of the Act. The number of licensed machines dropped by around 2000 shortly after the Act was passed, and has been falling relatively steadily since. As at 31 March 2015 there were 1277 venues and 16,614 machines.

There are currently six casinos in New Zealand: one each in Auckland, Hamilton, Christchurch and Dunedin, and two in Queenstown.

Table 28 shows the number of machines and tables currently licensed for each casino.

Table 28: Gaming machines and tables in New Zealand’s six casinos

|  |  |  |
| --- | --- | --- |
| **Casino** | **Gaming machines** | **Tables** |
| SKYCITY Auckland | 1647 | 110 |
| SKYCITY Hamilton | 339 | 23 |
| Christchurch Casino | 500 | 36 |
| Dunedin Casino | 180 | 12 |
| SKYCITY Queenstown | 86 | 12 |
| SKYCITY Wharf (Queenstown) | 74 | 6 |
| **Total** | **2826** | **199** |

Source: New Zealand Gambling Commission 2015.

The Hamilton casino was the last to open, in 2002. Changes to the law in 1997, when there were already two casinos and four licence applications, imposed a moratorium on any further applications. The Act subsequently prohibited any new casinos and any increase in opportunities for casino gambling in the existing casinos.

The casino sector is dominated by the Auckland casino, which generates around three-quarters of New Zealand’s casino gambling expenditure. The New Zealand International Convention Centre Act 2013 might increase that dominance (see 2.1.3 and 3.4.6 above). As a result of that Act, the Auckland casino is likely to add as many as 230 single-terminal gaming machines and 40 tables during the 2016/17 to 2018/19 period, which is likely to lead to some increase in expenditure on casino gambling.

The NZLC *Annual Report* for the year ended 30 June 2014 said that its retail network encompassed more than 1300 outlets. The NZRB *Annual Report* for the year ended 31 July 2014 said that its TAB retail outlets totalled around 675, and that 33 of those venues hosted NCGMs.

The only other venue-based gambling of any significance in New Zealand is housie. It is scarcely mentioned in this Needs Assessment because there is clear evidence (most recently from the 2012 NGS) that rates of participation in housie are low and the amount spent by housie players is only a fraction of the amount spent in the next smallest gambling sector (NZRB products).

### 4.2.3 Online gambling

Estimates of the number of people in New Zealand who gamble online are the subject of considerable debate. When considering different estimates of participation in online gambling, it is worth noting that, all other things being equal, larger surveys are more reliable than smaller surveys. It is also worth noting that online surveys tend to produce higher estimates than face-to-face or telephone surveys, probably because (by definition) those who respond to online surveys are more active online than adults in the general population.

The 2012 NGS was a large face-to-face survey (involving 6,251 respondents aged 18 or over). It estimated that 5 percent of adults had used the NZLC MyLotto website to buy a Lotto ticket, and 0.7 percent had used it to buy a Keno ticket, at least once in the previous year. It also estimated that 3 percent of adults had bet on a horse or dog race, and 2 percent had bet on a sports event, with the NZRB by telephone, online or by interactive television, at least once in the previous year.

There is external validation for these estimates in the form of NZLC online sales figures and MyLotto account numbers from the NZLC’s May 2012 *Statement of Intent 2013–2015* (see pp 9 and 14 respectively),[[15]](#footnote-15) and in reports of a recent surge in the number of TAB account holders in the NZRB’s *Annual Report* for the year ended 31 July 2012 (see pp 6 and 10).[[16]](#footnote-16)

It is also worth noting that the NZRB reported spending of $283 million on its race betting and sports betting products in 2011/12. The estimate for a similar period arrived at by aggregating the typical monthly spending on those products reported by respondents to the 2012 NGS (excluding one particularly large spender) was $329 million. These two figures are remarkably close.

In regard to cross-border gambling, the 2012 NGS estimated that in total 1.7 percent of adults had participated at least once in at least one form of cross-border gambling online or by telephone in the previous year (excluding those who had only bought a ticket in an overseas raffle or lottery, some of whom would have done so online). It estimated that 0.4 percent of adults had bet on a horse or dog race and 0.4 percent on a sports event with an overseas organisation by telephone or online at least once in the previous year. It also estimated that 0.4 percent of adults had played poker for money or prizes online, and 0.6 percent had paid to participate in other forms of gambling online through an overseas website, at least once in the previous year. (Note that the estimates reported here are a little lower than those in the published NGS report, because the current estimates use 2013 Census adjustments that were not available at the time the NGS report was prepared.)

With one exception, the online gambling estimates from the 2010 HLS (Devlin 2011) support the 2012 NGS estimates. The exception is the 2010 HLS figure for the percentage of adults buying tickets through the MyLotto website, which looks a little lower than the 2012 NGS estimate. Once again, however, there is external evidence that the number of MyLotto registered players and sales did actually grow over this two-year period, and continued to grow subsequently (NZLC *Annual Report* to 30 June 2010, p 20[[17]](#footnote-17) and *Annual Report* to 30 June 2014, pp 6 and 16).[[18]](#footnote-18)

Growth in the number of TAB accounts seems to have been far more modest (NZRB *Annual Report* for the year ended 31 July 2014, p 5).[[19]](#footnote-19)

The 2012 NGS estimate of the total amount New Zealanders spent gambling with overseas gambling operators online or by telephone in the previous year (derived by aggregating the typical reported monthly spending) was around $41 million. This estimate excludes the amount spent online on overseas lotteries, and excludes one large spender. The estimate for betting on races and sports events specifically was around $16 million. This estimate is likely to be reasonably accurate, because the 2012 NGS estimate of the amount New Zealanders spent with the NZRB is reasonably accurate, as discussed above. By contrast, the 2012 NGS estimates for online spending with overseas gambling operators on other more continuous forms of gambling are less likely to be accurate, because of a known tendency for people to under-report spending on those forms of gambling.

The HLS is far smaller than the NGS but it has the advantage of being conducted regularly. Like the NGS, it is a face-to-face survey. The 2010 HLS estimated that 2.1 percent of adults had gambled online through an overseas website at least once in the previous year. The figure in 2012 was 1.4 percent. In 2014 a slightly different HLS question produced an estimate just under 4 percent.

At first glance, this figure looks like a large increase. However, because the HLS is a small survey (involving fewer than 3000 respondents), confidence intervals can be relatively wide. For example, the 2012 figure might actually have been as high as 2.6 percent, and the 2014 figure might actually have been as low as 2.4 percent. This fact, the fact that the 2012 HLS estimate was lower than the equivalent 2010 estimate and the change to the HLS question in 2014 all suggest that the percentage of adults gambling online with an overseas-based gambling operator probably did not increase between 2010 and 2014.

As discussed above, the equivalent 2012 NGS figure was 1.7 percent (which is very similar to the 2012 HLS estimate of 1.4%). The second wave of the NGS in 2013 (Abbott et al 2015) produced an estimate of 1.2 percent for this measure. These figures also suggest that the percentage of adults gambling online with an overseas-based gambling operator is not increasing.

Table 29: Percentage of adults gambling at least once in the previous year online with an overseas operator (point estimate and 95% confidence interval)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **2010** | **2012** | **2013** | **2014** |
| HLS (n < 3000) | 2.1% (0.7% to 3.4%) | 1.4% (0.6% to 2.6%) | – | 4.0% (2.4% to 6.0%) |
| NGS (n = 6251 in 2012; = 3745 in 2013) | – | 1.7% (1.2% to 2.1%) | 1.2% (0.8% to 1.7%) | TBA |

In regard to specific gambling activities, the 2014 HLS estimated that 1.7 percent of adults had bet on horse or dog races, 1.6 percent had bet on sports events, 1.2 percent had played casino games such as blackjack or roulette and 1 percent had played internet poker online, with an overseas operator, at least once in the previous year. It also estimated that 1.4 percent of adults had ‘played an internet game to win money’ at least once in the previous year.

The largest differences between the 2012 NGS and the 2014 HLS estimates relate to percentages of people betting on horse or dog races (0.4% in the 2012 NGS, compared with 1.7% in the 2014 HLS) and betting on sports events (0.4% in the 2012 NGS, compared with 1.6% in the 2014 HLS). This suggests the possibility of an increase between 2012 and 2014 in the percentage of adults participating at least once in either or both of these two *specific forms* of betting. (It is worth noting that the 2014 HLS estimated that around half of those who bet on horse or dog races or bet on sports events online with an overseas operator bet on both types of activity at least once.) However, for the reasons outlined above, it would be preferable to wait for similar findings from a future iteration of the NGS before concluding that such an increase has occurred.

It is possible that most cross-border online betting from New Zealand on horse races, dog races and sports events involves Australian gambling operators. In 2012 the New Zealand dollar typically bought 70 to 80 Australian cents. In 2014 and 2015 it typically bought over 90 Australian cents. If there has been an increase in cross-border online betting on these activities, changes in the exchange rate might be a relevant factor.

The number of people gambling online is likely to increase in future to at least some extent as smartphone access and broadband speed and capacity increase, and as online methods of transferring funds become more secure and more trusted. The likely impacts of such changes are difficult to forecast.

### 4.2.4 Gambling expenditure[[20]](#footnote-20)

Total gambling expenditure (player losses) in the four main gambling sectors increased almost every year from 1983/84 to a peak of $2.039 billion in 2003/04, before dropping slightly in 2004/05 to $2.027 billion. Between 2004/05 and 2013/14, annual expenditure in these four sectors ranged around the $2 billion mark, from $1.928 billion (in 2009/10) to $2.091 billion (in 2013/14). In inflation-adjusted terms, the 2013/14 figure of $2.091 billion was around half a billion dollars below the $2.039 billion figure for 2003/04.

Much of the growth over the past 25 years is attributable to spending on NCGMs, which were first licensed in 1988. Spending on NCGMs rose every year, from $107 million in 1990/91 to a high of $1.035 billion in 2003/04, when it accounted for more than half the annual total for the four sectors.

Over the ten years from 2004/05 to 2013/14, spending in the NCGM sector fell from $1.027 billion to $808 million, even without adjusting for inflation. Spending dropped after changes to smoke-free legislation came into effect on 10 December 2004, and dropped again in early 2008 after the global financial crisis struck. The reduction in machine numbers since September 2003 might also have led to an underlying trend of declining spending. However, it is worth noting that NCGM spending in Canterbury increased after the earthquake in February 2011, despite the number of functioning machines and venues dropping substantially.

Some of the growth in spending between 1984 and 2004 was attributable to New Zealand’s six casinos, the first of which opened in 1994 and the last in 2002. Casino spending increased every year until 2003/04. It declined a little in 2004/05, probably as a result of the smoke-free amendments, increased a little in 2005/06, then decreased and remained relatively flat until 2011/12. It is worth noting that the Christchurch casino was closed for some months after the earthquake in February 2011. The three years 2011/12 to 2013/14 were the highest to date for casino spending.

There has been increased spending on NZLC products in recent years, perhaps resulting from an increase in the number of Powerball balls from October 2007 (making large jackpots more likely), the availability of some products online since May 2008 and an increase in the number of Big Wednesday balls from September 2011 (again making large jackpots more likely) (see Table 30).

Table 30 shows gambling expenditure statistics for 2005/06 to 2013/14 in actual dollars (not inflation-adjusted) for the four main gambling sectors. In each of the nine years covered by the table, NCGMs and casinos together made up between 62 percent and 71 percent of total expenditure in these four main gambling sectors.

Most casino gambling expenditure also derives from gaming machines. For example, SKYCITY Entertainment Group’s *Annual Results Presentation* for the year ended 30 June 2014[[21]](#footnote-21) suggested that spending on gaming machines in its Auckland casino totalled almost $218 million; this figure represents more than 40 percent of the total amount DIA says was spent on all casino gambling activities in all six New Zealand casinos in that year ($509 million).

The 2014 HLS estimated that 13.5 percent of adults in New Zealand had played an NCGM, and 7.3 percent had played a casino machine, at least once in the previous year. Comparing the expenditure information in this section with the gambling participation information from that survey is enlightening. The comparison indicates that most of the money spent on gambling in New Zealand comes from a relatively limited number of people who play non-casino or casino gaming machines, or both. DIA’s gambling expenditure statistics and the findings from its ‘Participation in, and Attitudes Towards, Gambling’ Surveys suggest that this has been the case for more than a decade.

Table 30: Gambling expenditure in the four main sectors, 2005/06 to 2013/14

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Gambling sector** | **2006 ($m)** | **2007 ($m)** | **2008 ($m)** | **2009 ($m)** | **2010 ($m)** | **2011 ($m)** | **2012 ($m)** | **2013 ($m)** | **2014 ($m)** |
| NCGMs | 906 | 950 | 938 | 889 | 849 | 856 | 854 | 826 | 808 |
| Casinos | 493 | 469 | 477 | 465 | 454 | 471 | 509 | 520 | 509 |
| NZLC | 321 | 331 | 346 | 404 | 347 | 404 | 419 | 432 | 463 |
| NZRB | 258 | 269 | 272 | 269 | 278 | 273 | 283 | 294 | 311 |
| **Total** | **1977** | **2020** | **2034** | **2028** | **1928** | **2005** | **2065** | **2072** | **2091** |

Source: Gambling expenditure statistics, DIA (downloaded 17 June 2015). The sum of the column entries may not be exactly the same as the relevant total, because of rounding.

## 4.3 Harm and the risk of harm from gambling

Most adults in New Zealand gamble at least occasionally. Most of those who gamble enjoy doing so, and do so without causing harm to themselves or others. As noted above, most of those who gamble do not participate in activities like gaming machine gambling, yet those are the forms of gambling on which most money is spent.

Harm from gambling can include, among other things, relationship breakdown, depression, suicide, reduced work productivity, job loss, bankruptcy, and various types of gambling-related crime (including family violence, crime committed to finance gambling, and using gambling to launder the proceeds of crime).

In 2010, the Australian Productivity Commission noted that the potential for significant harm from some forms of gambling is what distinguishes gambling from most other enjoyable recreational activities (Productivity Commission 2010). The following are some of the other important points made in the Productivity Commission report.

* There are ‘ripple effects’: harms can and often do extend beyond gamblers to encompass family members, friends, employers, colleagues and whole communities.
* The core objective of a public health or consumer approach to gambling (which the Productivity Commission considered to be the best approach) is the prevention and mitigation of harm, which also entails the mitigation of risk factors that might be associated with future harm.
* People categorised as ‘problem gamblers’ by any one of a variety of screening instruments remain a central policy concern, because the harms associated with their gambling are more intense and damaging to themselves and others.
* However, a narrow focus on ‘problem gamblers’ (in the sense of people scoring above a certain threshold on a screening instrument) is not appropriate, because:
* it ignores substantial existing harm and risks of future harm among, and/or associated with the gambling of, gamblers who would not be categorised as ‘problem gamblers’ by screening instruments
* it can lead to an excessive focus on individual traits (such as prior mental health conditions) that may *sometimes* precipitate gambling problems.
* People playing gaming machines face much greater risks than people who gamble on other forms: the likelihood of harm rises steeply with the frequency of gaming machine gambling and with gaming machine expenditure levels.

### 4.3.1 Prevalence of at-risk gambling

This section discusses behaviour that would be categorised as ‘problem’ gambling, ‘moderate-risk’ gambling ‘or ‘low-risk’ gambling on the basis of answers to questions in standard problem gambling screens, such as the Problem Gambling Severity Index (PGSI). In interpreting figures in this section, it is worth noting that:

* although the percentages are relatively small, they represent a substantial number of people
* as the Productivity Commission noted, and as responses to individual PGSI items suggest, even low-risk gamblers may suffer some harm from their own gambling
* figures for at-risk gambling based on screening instruments typically do not include ‘ripple’ effects – the harm suffered by others as a result of one person’s gambling
* responses to screening instruments are not the only way of estimating the current extent of gambling harm or the risk of future harm (see section 4.3.2).

It is difficult to make definitive statements about trends in the prevalence of at-risk gambling in New Zealand. This is partly because the segment of the population that exhibits this sort of behaviour is relatively small; partly because the available studies do not all use the same screening instruments; and partly because the available studies differ in terms of methodology, response rate and sample size.

Using the PGSI, the 2012 NGS estimated that:

* 0.7 percent of adults in New Zealand (approximately 24,000 people) were current problem gamblers
* 1.8 percent (60,000 people) were current moderate-risk gamblers
* 5.0 percent (168,000 people) were current low-risk gamblers
* 92.6 percent (3.109 million people) were current non-problem (‘recreational’) gamblers or non-gamblers.

Estimates from the 2010, 2012 and 2014 HLS are broadly similar.

Responses to individual PGSI items are also informative. For example, the 2012 NGS estimated that gambling had caused health problems, including stress or anxiety, for 1.4 percent of adults at least sometimes in the year before the Survey. Equivalent estimates were 4.7 percent for low-risk gamblers, 37.1 percent for moderate-risk gamblers, and 85.3 percent for problem gamblers.

After considering a wide variety of studies conducted in New Zealand over the previous three decades, the 2012 NGS considered it likely that the prevalence of problematic gambling (defined as moderate-risk gambling and worse) had reduced during the 1990s and since remained at around the same level (see Abbott et al 2014b, pp 109–15).

A comparison of the 2006/07 and 2011/12 iterations of the NZHS discloses a significant reduction in the prevalence of low-risk gambling between the two studies, but no statistically significant change in the prevalence of moderate-risk or problem gambling. A comparison of the 2010, 2012 and 2014 iterations of the HLS discloses apparent reductions in the proportion of low-risk gamblers and the proportion of the combined moderate-risk/problem gambler group between 2010 and 2012, but no apparent reductions between 2012 and 2014.

There is compelling evidence from both New Zealand and international research that the prevalence of at-risk gambling is associated with the number and nature of the gambling activities in which people participate, the frequency with which they participate, the amount they spend and the average length of a typical gambling session. The following are typical examples of associations that emerge from numerous studies.

* Those who participate in four or more different types of gambling in a year are more likely to be at-risk gamblers.
* Those who only buy lottery tickets are less likely to be at-risk gamblers.
* Those who gamble frequently on continuous forms of gambling are more likely to be at-risk gamblers.
* Those who participate in casino gambling and those who play NCGMs are more likely to be at-risk gamblers.
* Those who play gaming machines for more than three hours on an average playing day are more likely to be at-risk gamblers.
* Those who typically spend more than $500 a month on gambling are more likely to be at-risk gamblers.

### 4.3.2 Numbers experiencing harm from gambling

This section discusses findings from survey questions (other than formal problem gambling screens) designed to elicit information about people’s experience of gambling harm.

The 2006/07 NZHS estimated that 2.8 percent of adults (around 87,000 people) had experienced problems due to ‘someone’s’ gambling in the year before the survey. The 2011/12 NZHS produced an almost identical estimate for the number of adults affected by ‘someone else’s gambling’. Neither survey included an equivalent question for children who had experienced problems due to someone’s gambling.

In the 2006/07 NZHS, over half (53%) of the adults who reported experiencing problems due to someone’s gambling reported that NCGMs were at least one of the forms of gambling involved, and 33 percent named casino machines. These two figures were almost identical in 2011/12. The next-highest figure in 2006/07 was 16 percent for betting on horse or dog races, followed by Lotto at 14 percent. In 2011/12, the next-highest figure was 22 percent for betting on horse or dog races and betting on sports events combined, followed by 10 percent for casino tables.

The HLS asks respondents about ‘overdoing’ gambling by spending more time or money gambling than intended; about arguments in the wider family or household over time or money spent on gambling; and about someone in the wider family or household going without something they needed or bills not being paid because too much was spent on gambling. All these indicators of harm appeared to reduce between 2010 and 2014 (although the wide confidence intervals mean that some of the reductions might not be statistically significant). The following are some of the findings.

* The 2010 HLS estimated that 6 percent of adults had ‘overdone’ their own gambling at least once in the year before the survey (a figure that was significantly lower than the estimate in the similar 2006/07 Gaming and Betting Activities Survey). The figure in 2014 was 2 percent.
* The 2010 HLS estimated that almost 22 percent of adults had experienced someone close to them ‘overdoing it’ in the previous year. The figure in 2014 was 13 percent.
* The 2010 HLS estimated that 5 percent of adults had experienced some argument about gambling in the previous year. The figure in 2014 was under 4 percent. The 2012 NGS estimate was a little lower.
* The 2010 HLS also estimated that 5 percent of adults had ‘gone without’ because of a person’s gambling in the previous year. Once again, the figure in 2014 was under 4 percent, and the 2012 NGS estimate was a little lower.
* In both 2010 and 2014, NCGMs were by far the most common gambling form on which people reported themselves or someone else ‘overdoing it’, and were the form most often associated with an argument or with ‘going without’ (estimates were between 49 percent and 55 percent, depending on the question). Other forms that figured prominently in one or more questions were betting on horse or dog races, casino gaming machines, NZLC products and casino table games.
* Reports of ‘overdoing it’, arguments and ‘going without’ were much more common among frequent continuous gamblers and among the combined moderate-risk/problem gambler group.

### 4.3.3 Ethnicity and harm from gambling

There continues to be compelling evidence that Māori and Pacific peoples are more likely to suffer gambling harm (whether as a result of their own or someone else’s gambling), and more likely to be at risk of future harm, than people in other ethnic groups. For example, the 2006/07 NZHS (a survey consisting of face-to-face interviews with 12,488 people aged 15 and over) reported the following estimates.

* Even after controlling for key demographic and socioeconomic variables, Māori still had over five times the risk of being a problem gambler compared to people who were not of Māori or Pacific ethnicity.
* Despite having significantly lower gambling participation rates, Pacific peoples had over five times the risk of being a problem gambler compared to people who were not of Māori or Pacific ethnicity, even after controlling for key demographic and socioeconomic variables.
* Approximately 1 in 16 Māori and Pacific males and 1 in 24 Māori and Pacific females were either moderate-risk or problem gamblers.
* After adjusting for age, Māori males were two times more likely and Pacific males almost three times more likely to have experienced problems due to someone’s gambling in the previous year than males in the total population.
* After adjusting for age, Māori and Pacific females were 2.5 times more likely to have experienced problems due to someone’s gambling in the previous year than females in the total population.

The overall situation for Māori and Pacific peoples had changed very little by the time of the 2011/12 NZHS (a survey consisting of face-to-face interviews with 12,596 people aged 15 and over). For example, the 2011/12 NZHS estimated that Māori and Pacific people were approximately three times more likely than European/Other people to be categorised as moderate-risk/problem gamblers, and found that these estimates had not changed significantly since the 2006/07 NZHS.

Most of the estimates from the 2010, 2012 and 2014 iterations of the HLS and most of the estimates from the 2012 NGS (involving 6251 face-to-face respondents) lead to similar conclusions. For example, like the analyses in the 2006/07 and 2011/12 iterations of the NZHS, multivariate analyses in the 2012 NGS concluded that even after taking into account key demographic and socioeconomic variables, Māori and Pacific peoples were significantly more likely to experience gambling harm. In addition, estimates from the 2012 NGS suggested that close to 50 percent of problem gamblers and close to 40 percent of moderate risk gamblers are Māori or Pacific. The 2012 NGS also concluded that ‘ethnic and other disparities in the burden of harm have persisted since the time the first gambling survey was conducted in 1991’ (Abbott et al 2014b, p 18).

Māori and Pacific populations are generally younger, and their proportion of the total population is predicted to grow in future. As a result, it is important that the issue of Māori and Pacific vulnerability to gambling harm be given priority.

The SHORE/Whariki (2008) study used a different method, but reported similar results. It reported that Māori and Pacific people were more likely than either Pākehā or Chinese/Korean people to have participated heavily in gambling other than lottery products (defined as participating for more than three hours a week in such gambling, or losing more than 5 percent of their personal income) in the previous year. For Pākehā and Chinese/Korean people, the associations between various forms of gambling and the 13 domains of life examined in the study were mixed, but sometimes positive. For Māori and Pacific people, by contrast, higher levels of gambling, and particularly gambling on gaming machines in bars and casinos, were overwhelmingly associated with negative impacts and on many domains of life.

That study also reported that Chinese/Korean people were the least likely of four ethnic groups to have gambled at all in the previous year, and were the least likely to have participated in 8 of the 11 forms of gambling considered (the exceptions being casino tables, casino gaming machines and poker).

A few measures in the 2010 HLS suggested higher risks of gambling harm among Asian peoples. Most other studies, including most measures in the 2014 HLS, have suggested that the risks of gambling harm are no higher for Asian people than for the European/Other group.

Like most other studies, the 2012 NGS found lower rates of gambling participation among the Asian group. However, it also suggested that the prevalence of at-risk gambling among the Asian group varied significantly by gender. After adjusting for age, it found that Asian and European/Other females were less likely to be moderate-risk gamblers or problem gamblers than Māori or Pacific females. By contrast, it found that Asian males (like Māori and Pacific males) were more likely to be moderate-risk gamblers or problem gamblers than European/Other males.

Apart from differences by gender, another key difficulty is that the category ‘Asian’ (like the word ‘Pacific’) encompasses a variety of different population groups, in which proportions of heavy gamblers vary substantially.

Recent research has examined the impact of gambling on the health and wellbeing of Pacific families and communities, how gambling participation and the prevalence of gambling harm differs among different Pacific peoples, why some Pacific people are more vulnerable to gambling harm than others, and the factors that might protect Pacific people from gambling harm (see, for example, Bellringer et al 2013). The series of gambling and problem gambling reports from the Pacific Island Families longitudinal study is likely to become increasingly important and useful (to date: Bellringer et al 2008 and 2012).

Other research commissioned by the Ministry suggested that gambling harm might be a particular issue for specific Asian subgroups (for example, recent migrants and international students) rather than for Asian people in general (Sobrun-Maharaj et al 2012), and suggest quite specific risks. New Zealand’s Asian population is growing, international education is an important sector and many international students are Asian, and both migrants and international students may lack ready access to family or community networks that help mitigate the risk of gambling harm.

### 4.3.4 Gender and harm from gambling

Several decades ago, researchers tended to consider that problem gambling was largely restricted to males.

Current evidence suggests that there are now fewer significant differences between males and females in gambling participation, the prevalence of problem gambling, gambling harm, the risk of gambling harm or help-seeking. It also suggests that remaining differences are diminishing. However, males are still more likely to bet on sports events (and possibly horse or dog races, casino gambling and card games), and females are still more likely to play housie (and possibly to purchase Instant Kiwi or other scratch tickets). Further, females are probably still more likely to report, and still make up most of those who seek help for, problems associated with someone else’s gambling. Finally, there are still likely to be some significant differences by gender within particular ethnic groups.

### 4.3.5 Age and harm from gambling

Numerous studies have found that early exposure to gambling increases the risk of developing gambling problems later in life (for example, Abbott and Volberg 2000). However, there is some debate about the extent of participation in gambling by young people, and considerable debate about the extent of problematic gambling among young people.

Rossen, Butler and Denny reported in 2011 that in overseas studies youth problem gambling rates have often been found to be higher than equivalent adult rates. They also referred to claims that the variability in youth problem gambling rates is much greater than that reported for adult problem gambling.

Rossen’s unpublished PhD thesis had found that gambling was widespread among young people in New Zealand, but was generally of low importance to them. It also found that youth preferred to gamble on lottery products and ‘informal’ modes of gambling (Rossen 2008, discussed in Rossen et al 2011).

Youth’12, the third national health and wellbeing survey of secondary school students in New Zealand, surveyed 8500 year 9 to 13 students (13 to 17 years of age) in 2012. It included a gambling component (Rossen et al 2013). The survey estimated that around 24 percent of students had gambled at least once in the previous year, and 10 percent in the previous four weeks. Both rates were higher for males than for females. However, all these rates are far lower than the rates for adults.

Youth’12 found that, of those youth who had gambled at least once in the previous year, around 11 percent reported one indicator of ‘unhealthy gambling’, and a further 5 percent reported two or more indicators. Students who were male, students who were Māori, Pacific or Asian, students who lived in higher deprivation neighbourhoods and students who lived in urban neighbourhoods were more likely than their counterparts to report these indicators.

Multivariate analyses found that students with signs of unhealthy gambling were more likely to have a family member who had done something because of gambling that could have got them in serious trouble; to usually gamble with someone other than friends or family members; to have more accepting attitudes towards gambling; to have gambled on NCGMs, casino gaming machines or tables, or with the TAB, in the previous year; and to have attempted suicide in the previous year.

The survey also asked students about harm within their families as a result of someone else’s gambling in the previous year. Around 0.8 percent said that someone in their family had done things that could get them into serious trouble (eg, stealing) because of gambling; 1.3 percent said that their family had had to go without something they needed because of gambling; 1.7 percent said that some bills had not been paid because of gambling; and 3.0 percent said that there had been arguments or fights in their families about time or money spent on gambling. Students who lived in higher deprivation neighbourhoods and students who lived in urban neighbourhoods were more likely than their counterparts to report these indicators.

The rate of people reporting arguments in the family because of gambling appears similar to the rate reported in the 2012 NGS. The estimated rates for family members ‘going without’ because of gambling and arguments because of gambling in the previous year for those aged 15 to 17 in the 2014 HLS were both 0.7 percent; that is, lower than the earlier figures. However, the confidence interval for each of those estimates included the equivalent point estimate from Youth’12, indicating that there might not have been any change.

Both the 2005 DIA ‘Participation in, and Attitudes Towards Gambling’ Survey and the 2006/07 NZHS concluded that rates of gambling participation among youth (defined as those aged 15 to 19 and those aged 15 to 17 respectively) were low. The 2006/07 NZHS estimated that only 0.4 percent of those aged 15 to 17 were problem or moderate-risk gamblers, compared to 1.7 percent of the total adult population.

The 2012 NZHS estimated that around 95 percent of 15–17-year-olds had not gambled at all in the year before being surveyed. The 2014 HLS estimated that 89 percent of 15–17-year-olds were non-gamblers, and the remaining 11 percent were non-problem (‘recreational’) gamblers. (The 2012 NGS only surveyed people aged 18 and over.)

When considering younger adults rather than youth, some studies in the past found that younger adults (those aged 18 to 24) were more likely than older adults to be at-risk gamblers. However, in recent studies the results have been more mixed.

Findings from recent studies include the following.

* In the 2012 NGS, the estimates for gambling participation at least once in the previous year were highest for those aged 18 to 24 and second-highest for those aged 25 to 34 in the case of card games; bets with friends or workmates; Instant Kiwi tickets or other scratch tickets; sports betting; casino gambling generally; casino table games specifically; and NCGMs. For casino gaming machines, the order of the two age groups was reversed. For betting on horse and dog races, the estimate for those aged 18 to 24 was highest, followed by those aged from 55 to 64. Perhaps surprisingly, the estimate for the percentage of frequent continuous gamblers was highest for those aged 65 and over, followed by those aged 55 to 64, then those aged 18 to 24, but the confidence intervals for all age groups overlapped.
* The 2012 NZHS found that those aged 18 to 24 and those aged 25 to 34 were more likely than other age groups to have participated at least once in four or more gambling activities during the previous year. In the 2012 NGS, this pattern did not clearly emerge until participation in seven or more activities was considered.
* In the 2012 NGS, estimates for the percentage in the combined moderate-risk/problem gambler group decreased with age – the estimate was highest for those aged 18 to 24, and reduced for each age group through to those aged 65 and over. In the 2012 NZHS, adults in the combined moderate-risk/problem gambling group were more likely to be aged 25 to 34 or 45 to 54, and people in these two age groups were also more likely to be affected by someone else’s gambling. However, in both cases, the 2012 NZHS did not report rates for those aged 18 to 24 – those aged 15 to 24 comprised the first age group. The inclusion of those aged 15 to 17 might have lowered the rates for this age group.

Estimates from the 2014 HLS tended to suggest that participation in four or more different gambling activities during the previous year; problematic gambling; and reports of a family member ‘overdoing’ their gambling, family arguments and family members ‘going without’ were all more likely in the 18 to 24 and 25 to 44 age groups. However, both the associated confidence intervals and the age groups themselves were so wide that it is difficult to draw any firm conclusions.

### 4.3.6 Geography and harm from gambling

As noted in some of the results reported above, people living in more deprived areas are disproportionately affected by, or at risk of, gambling harm. This is consistent with the geographical analyses discussed in Francis Group 2009, Allen and Clarke 2012 and Allen and Clarke 2015. These analyses showed that people living in more deprived areas were at greater risk of developing problems with gambling, that most NCGM expenditure occurred in higher deprivation areas and that Māori and Pacific peoples were over-represented in these areas, suggesting that they were more likely to be affected. The studies also found that, although there were fewer NCGMs than there had been historically, they were still concentrated in more deprived areas.

A 2014 journal article based on the 2008, 2010 and 2012 iterations of the HLS (Tu et al 2014) concluded that the experience of gambling harm at the household level was significantly higher in 2012 compared with 2008 and 2010. It also concluded that the increase in harm was experienced disproportionately by those in more deprived areas. The 2014 HLS also suggested that moderate-risk/problem gambling and reports of family members ‘overdoing’ it, family arguments and family members ‘going without’ were all more common among those living in higher deprivation areas.

Fringe lenders also tend to focus on people in more deprived areas. Research in 2007 by Auckland Uni Services for the Ministry of Consumer Affairs indicated that some Pacific people in South Auckland borrowed money from such lenders in order to gamble (Auckland UniServices Ltd 2007).

The Gambling Act 2003 required each territorial authority to develop gambling venue policies for NCGM and NZRB venues. These policies were to be developed (and must be reviewed at least every three years) following a specified consultation process. Policies for NZRB venues must specify whether new TABs may be established in the territorial authority district, and, if so, where they may be located. An NCGM venue policy must specify whether new gaming machine venues (defined as venues that have been without a licence for six months or more) may be established, and, if so, where they may be located. They may also specify restrictions (within statutory limits) on the number of machines that may be operated at a venue. Once a territorial authority has granted consent, it cannot withdraw it.

Territorial authorities may decline an application for consent on the basis of their venue policies, and may limit or prohibit any increase in the number of machines that may be operated in existing venues. A territorial authority cannot reduce the number of machines that may be operated in an existing venue; nor can it require that an existing venue stop operating machines. This limits any potential for territorial authorities to reduce the numbers of venues and machines in more deprived areas.

Amendments to the Act in September 2013 required territorial authorities to consider developing a ‘relocation policy’. A relocation policy allows a territorial authority to consent to machines being operated in a venue that is intended to replace an existing venue. Whenever a territorial authority is considering whether to include a relocation policy in its gambling venue policy, it must consider the social impact of gambling in high-deprivation communities within its district. A relocation policy presents an opportunity to agree to machines being moved from high-deprivation areas to lower-deprivation areas, but without reducing the overall number of NCGMs in a territorial authority district. Even if a territorial authority has a relocation policy, an application for consent may be made only with the agreement of the venue operator of the existing venue. Territorial authority gambling venue policies are typically renewed only every three years, so there has been limited opportunity to date to evaluate what effect these statutory amendments will have.

### 4.3.7 Co-morbidities

There is compelling evidence from New Zealand and international research that at-risk gambling is associated with higher levels of smoking, hazardous alcohol consumption, other drug use and depression, and with poorer self-rated health. For example, the 2011/12 NZHS reported the following estimates (which are supported by similar findings from the 2012 NGS).

* Low-risk gamblers were three times more likely and moderate-risk/problem gamblers over four times more likely to be current smokers than people with no gambling problems.
* Low-risk gamblers were twice as likely and moderate-risk/problem gamblers over six times more likely to be hazardous drinkers than people with no gambling problems.
* Low-risk gamblers were almost three times more likely and moderate-risk/problem gamblers almost four times more likely to have used other drugs for recreational purposes or to have ‘got high’ in the year before being surveyed than people with no gambling problems.
* Low-risk gamblers were twice as likely and moderate-risk/problem gamblers almost six times more likely to have an anxiety or depressive disorder. Further, moderate-risk/problem gamblers were almost three times more likely to have been diagnosed with a common mental disorder than those with no gambling problems, and were three times more likely to have been diagnosed with depression specifically.
* Moderate-risk/problem gamblers were two-and-a-half times more likely to report fair or poor health (rather than good, very good or excellent health) than those with no gambling problems.

It is worth noting that at-risk gambling also tends to be associated with higher usage of health and allied services. For example, the 2011/12 NZHS found that moderate-risk/problem gamblers were twice as likely as those with no gambling problems to have consulted a GP in the year before being surveyed.

## 4.4 Intervention service demand

In funding services to prevent and minimise gambling harm, the Ministry prioritises the capacity of intervention services to meet demand. While numbers of clients receiving full, facilitation or follow-up interventions increased in 2013/14, current intervention service provision is meeting demand for services.

### 4.4.1 Response

This Needs Assessment indicates that the patterns evident at the time the previous Needs Assessment was prepared (in 2012) remain largely unchanged.

In its Preventing and Minimising Gambling Harm Service Plan for 2013/14 to 2015/16, published in May 2013, the Ministry noted its intention to test the market for the primary prevention component of its public health services and for the psychosocial intervention and support component of its intervention services. The Ministry subsequently issued a request for proposals (RFP), on 24 July 2013. The aim of the RFP was to obtain the appropriate mix and coverage of services to meet the needs indicated by the 2012 Needs Assessment. On 21 May 2014, an existing service provider applied for judicial review of the Ministry’s decisions on the proposals submitted in response to the RFP. The judgment, which was delivered on 23 July 2015, set aside the Ministry’s decisions. As a result, the Ministry had not been able to implement its preferred service mix at the time this 2015 Needs Assessment was being prepared.

### 4.4.2 Intervention service data

Intervention service data for clients who received a full, facilitation or follow-up session in 2013/14 indicate the following.

* There were 12,627 clients, including brief interventions (the highest number since 2009/10 and the second highest since the Ministry assumed responsibility for problem gambling services on 1 July 2004).
* There were 2528 new gambler clients, excluding brief interventions (up from 2451 in 2012/13 and 2384 in 2011/12).
* There were 4936 gambler clients, excluding brief interventions (up from 4882 in 2012/13 and 4657 in 2011/12). (This represents around 2o percent of the 23,504 current problem gamblers estimated by the 2012 NGS, or around 6 percent of the estimated 83,944 adults that study considered to be in the combined moderate-risk/problem gambling group.)
* There were 1355 new family/affected other clients, excluding brief interventions (up from 1345 in 2012/13 and 1022 in 2011/12).
* There were 2264 family/affected other clients, excluding brief interventions (up from 2049 in 2012/13 and 1561 in 2011/12).
* Excluding numbers for brief interventions, the total number of clients was the highest since the Ministry assumed responsibility for problem gambling services, as were the total number of gambler clients, the total number of family/affected other clients and the number of new family/affected other clients. The number of new gambler clients was higher only in 2008/09 and 2009/10.
* Comparing this pattern of increasing presentations against the apparently unchanged prevalence of gambling harm suggests that more people who need help are seeking it.

Excluding numbers for brief interventions, Māori made up 29.4 percent of clients, Pacific peoples 23.1 percent and East Asian 6.6 percent. Since 2004/05, the figure for Māori has ranged between 26.9 percent and 36.0 percent. By contrast, 2012/13 and 2013/14 figures for Pacific peoples were the highest since the Ministry assumed responsibility for these services. Until 2012/13, the highest previous figure had been 13.7 percent, in 2011/12. The high level of service use by Māori has always been encouraging; the recent substantial increase in uptake of services by Pacific peoples is also encouraging.

At more than 54 percent, NCGMs continued to be the primary mode of problem gambling cited by new gambler clients in 2013/14. However, this figure was over 70 percent in 2004/05, and until 2011/12 was always over 60 percent.

## 4.5 Conclusions

This Needs Assessment provides a range of information and research indicating that gambling harm continues to be a social and health issue in New Zealand. While the number of adults exhibiting at-risk gambling behaviour is relatively small compared, for example, to the estimated number of adults with hazardous drinking behaviour or who are current smokers, there is still a substantial burden of gambling harm in New Zealand communities.

It is worth reiterating that harms can and often do extend beyond gamblers to encompass their families/whānau members, friends, employers, colleagues and whole communities. It is also worth reiterating that there is substantial harm and risks of future harm resulting from or associated with the gambling of people who would not be categorised as ‘problem gamblers’ by screening instruments.

This Needs Assessment informed the development of the draft strategy, including the nature and mix of public health and intervention services and the research agenda. Its preparation also highlighted some gaps in the research to date (for example, research with a view to obtaining more detailed understanding of online gambling and gambling trajectories).

Gambling services currently achieve geographic coverage and 24-hour, 7-day-a-week availability, either through face-to-face or telephone services.

Key ongoing issues include:

* the disproportionate levels of harm experienced by Māori and Pacific people
* the effects of higher levels of exposure to gambling products on people living in more deprived areas
* high rates of co-morbidities among problem gamblers, and correspondingly high usage of health and allied health services
* the possibility of an increase in online gambling
* the involvement of younger people in gambling.

What other information, if any, do you think is crucial for the Needs Assessment?

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# Making a submission

**Submissions close on Friday 11 September 2015 at 5 pm.**

The Ministry of Health must have your submission by this time. Any submissions received after this time will not be included in the analysis of submissions, even if they have been posted earlier. You might prefer to email your submission to ensure that the Ministry receives it before the cut-off time.

In making your submission, please include or cite relevant supporting evidence if you are able to do so.

The following questions may help you to focus your submission. However, you do not have to answer the questions if you prefer to structure your submission in some other way.

1. Does the draft Strategic Plan adequately address the strategic context for the draft Service Plan? If not, what issues or areas are not adequately covered?
2. Are there any objectives or priority actions that you particularly agree with or disagree with, and if so why? Are there other objectives that you think would be preferable or other priority actions that you think would more effectively or more efficiently prevent and minimise gambling harm, and if so why?
3. Is the total amount of funding suggested in the draft Service Plan appropriate? If not, why not?
4. Does the draft Service Plan adequately address public health and intervention services, workforce development, research and evaluation? If not, what issues or areas do you think are not adequately covered?
5. Do you think that the Service Plan would more effectively or more efficiently prevent and minimise gambling harm if some funding were shifted from one budget line to another or from one service area to another? If so, why?
6. Are there service areas that you think should not be funded, or service areas that are not funded that you think should be funded? If so, why?
7. Are there realistic pairs of weightings (**W1** and **W2**) other than those discussed in this consultation document? Which pair, if any, do you support?
8. Are the player expenditure forecasts for each gambling sector (**D**) realistic? If not, why not?
9. Do you have any comment on the estimated levy rates for each levy-paying gambling sector (bearing in mind that the formula itself is set out in legislation and is not under consideration in this consultation)?
10. What other information, if any, do you think is crucial for the Needs Assessment?

There are two ways you can make a submission.

* Fill out the submission form that makes up the last few pages of this document and that is also available in the problem gambling section of the Ministry’s website, [www.health.govt.nz](http://www.health.govt.nz), and email it with your submission to:

gamblingharm@moh.govt.nz

**OR**

* Fill out the submission form that makes up the last few pages of this document and that is also available in the problem gambling section of the Ministry’s website, [www.health.govt.nz](http://www.health.govt.nz), and post it with your submission to:

Derek Thompson

Preventing and Minimising Gambling Harm Submissions

Ministry of Health

PO Box 5013

WELLINGTON 6145.

Please send only *one* copy of your submission.

The Ministry will hold a series of public meetings at which interested parties can discuss this consultation document and ask questions to inform their written submissions. The dates, times and locations of these meetings will be published on the problem gambling section of the Ministry’s website.

A copy of all submissions received will be forwarded to the Gambling Commission to assist its independent consultation process. In addition, your submission may be requested under the Official Information Act 1982. If this happens, the Ministry will release your submission to the person who asked for it.

Individuals can ask the Ministry not to release their personal details to the Gambling Commission or to anyone requesting their submissions under the Official Information Act.

The Ministry of Health will acknowledge all submissions and a summary of submissions will be sent to all those who request a copy. The summary will include the names of all those who made a submission except for the names of individuals who have requested that their names not be published.

## Submission form

You do not have to answer all the questions or provide personal information if you do not want to.

|  |  |
| --- | --- |
| This submission was completed by: *(name)* |  |
| Address: *(street/box number)* |  |
| *(town/city)* |  |
| Email: |  |
| Organisation (if applicable): |  |
| Position (if applicable): |  |

Are you submitting this as *(tick one box only in this section)*:

An individual or individuals (not on behalf of an organisation)

On behalf of a group or organisation(s)

If you are an individual or individuals, the Ministry will remove your personal details from your submission, and your name(s) will not be listed in the published summary of submissions, if you check the following box:

I do not give permission for my personal details to be released.

Please indicate which sector(s) your submission represents *(you may tick more than one box in this section)*:

Māori  Families/whānau

Pacific  Consumer

Asian  District health board

Education/training  Local government

Service provider  Funder

Non-government organisation  Professional association

Academic/research  Other *(please specify)*:

Do you wish to receive a copy of the summary of submissions?

Yes

No

## Questions

1 Does the draft Strategic Plan adequately address the strategic context for the draft Service Plan?

Yes

No

If not, what issues or areas are not adequately covered?

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2 Are there any objectives or priority actions that you particularly agree with or disagree with, and if so why?

|  |  |
| --- | --- |
| **Agree** | **Disagree** |
|  |  |
| **Reasons** | |
|  | |

Are there other objectives that you think would be preferable or other priority actions that you think would more effectively or more efficiently prevent and minimise gambling harm, and if so why?

|  |  |
| --- | --- |
| **Other objectives that would be preferable** | **Reasons** |
|  |  |
| **Other priority actions that would be more effective or efficient** | **Reasons** |
|  |  |

3. Is the total amount of funding suggested in the draft Service Plan appropriate?

Yes

No

If not, why not?

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| --- |
|  |

4. Does the draft Service Plan adequately address public health and intervention services, workforce development, research and evaluation?

Yes

No

If not, what issues or areas do you think are not adequately covered?

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5. Do you think that the Service Plan would more effectively or more efficiently prevent and minimise gambling harm if some funding were shifted from one budget line to another or from one service area to another?

Yes

No

If so, why?

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6. Are there service areas that you think should not be funded, or service areas that are not funded that you think should be funded, and if so, why?

|  |  |
| --- | --- |
| **Service areas that should not be funded** | **Reasons** |
|  |  |
| **Service areas that should be funded** | **Reasons** |
|  |  |

7. Are there realistic pairs of weightings (**W1** and **W2**) other than those discussed in this consultation document?

Yes

No

Which pair, if any, do you support?

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|  |

8. Are the player expenditure forecasts for each gambling sector (**D**) realistic?

Yes

No

If not, why not?

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9. Do you have any comment on the estimated levy rates for each levy-paying gambling sector (bearing in mind that the formula itself is set out in legislation and is not under consideration in this consultation)?

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10. What other information, if any, do you think is crucial for the Needs Assessment?

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|  |

1. <http://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/health-quality-and-safety-indicators/>, accessed 17 June 2015. [↑](#footnote-ref-1)
2. <http://www.health.govt.nz/system/files/documents/publications/ministry-of-health-statement-of-intent_2015-to-2019.pdf>, accessed 1 July 2015. [↑](#footnote-ref-2)
3. <http://www.who.int/gender-equity-rights/understanding/equity-definition/en/>, accessed 17 June 2015. [↑](#footnote-ref-3)
4. A national study of gambling participation, gambling harm and problem gambling, and attitudes towards gambling, with one-year and two-year follow-up components focusing on the incidence of problems related to gambling. [↑](#footnote-ref-4)
5. <http://www.ssc.govt.nz/better-public-services>, accessed 17 June 2015. [↑](#footnote-ref-5)
6. <http://www.werrycentre.org.nz/professionals/current-workforce-projects/copmia>, accessed 17 June 2015. [↑](#footnote-ref-6)
7. <http://www.nsfl.health.govt.nz/apps/nsfl.nsf/pagesmh/346>, problem gambling services, accessed 17 June 2015. [↑](#footnote-ref-7)
8. **R** was added to the formula by section 107 of the Gambling Amendment Act 2015, which came into effect on 3 March 2015. [↑](#footnote-ref-8)
9. IRD provides gaming duty and problem gambling levy data to DIA. The Tax Administration Act 1994 requires DIA to use its best endeavours to protect the integrity of the tax system by (among other things) maintaining the confidentiality of the affairs of taxpayers. [↑](#footnote-ref-9)
10. This section outlines the Ministry’s views on the latest, most reliable, and most appropriate sources of information on presentations. These views are canvassed in detail in the Ministry’s evidence for *Clubs New Zealand Inc v Minister of Internal Affairs* (8 April 2014), an unsuccessful application for a judicial review of the last levy-setting process. [↑](#footnote-ref-10)
11. <http://www.gamblingcommission.govt.nz/GCwebsite.nsf/wpg_URL/Reports-Publications-Proposed-Problem-Gambling-Levy-(November-2009)!OpenDocument>, accessed 17 June 2015. [↑](#footnote-ref-11)
12. <https://www.problemgambling.ca/EN/Documents/ProblemGamblingSeverityIndex.pdf>, accessed 17 June 2015. [↑](#footnote-ref-12)
13. An expense transfer makes money that was appropriated for a particular purpose in a particular financial year, but that was not spent in that year, available for spending on that purpose in a future financial year. [↑](#footnote-ref-13)
14. Continuous forms of gambling offer the opportunity for rapidly repeated cycles of risking money, determining the result, collecting winnings and again risking money. Examples of continuous forms of gambling include NCGMs, casino table games and betting on horse or dog races. [↑](#footnote-ref-14)
15. <https://mylotto.co.nz/assets/footer-pages/downloads/Statement-Of-Intent/Statement-of-Intent-2012-FINAL.pdf>, accessed 17 June 2015. [↑](#footnote-ref-15)
16. <http://www.nzracingboard.co.nz/annual/>, accessed 17 June 2015. [↑](#footnote-ref-16)
17. <http://www.treasury.govt.nz/commercial/resources/pdfs/nzlc/nzlc-ar-09-10.pdf>, accessed 17 June 2015. [↑](#footnote-ref-17)
18. <https://mylotto.co.nz/assets/footer-pages/downloads/Annual-Reports/LOT0550-Annual-Report-2014-WEB.pdf>, accessed 17 June 2015. [↑](#footnote-ref-18)
19. <http://www.nzracingboard.co.nz/annual/>, accessed 17 June 2015. [↑](#footnote-ref-19)
20. The expenditure figures in this section are sourced from the DIA website: http://www.dia.govt.nz/diawebsite.nsf/wpg\_URL/Resource-material-Information-We-Provide-Gambling-Expenditure-Statistics (accessed 17 June 2015). [↑](#footnote-ref-20)
21. <http://media.corporate-ir.net/media_files/IROL/16/162796/FY14PresentationFINAL.pdf>, accessed 17 June 2015. [↑](#footnote-ref-21)