

Strategy to Prevent and Minimise Gambling Harm

2019/20 to 2021/22

Proposals document

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1 Introduction

The Gambling Act 2003 sets out requirements for an ‘integrated problem gambling strategy focused on public health’. The Ministry of Health (the Ministry) is responsible for developing and refreshing this strategy at three-yearly intervals, and for implementing it. The Act specifies consultation requirements for the development of the strategy and the levy rates.

Earlier this year, the Ministry produced a draft *Strategy to Prevent and Minimise Gambling Harm for 2019/20 to 2021/22 consultation document*, including draft levy rates, and invited submissions. It then engaged Allen + Clarke, an independent consultancy firm, to prepare a report analysing these submissions. This proposals document sets out the Ministry’s response, having considered:

- the submissions on the consultation document and the Allen + Clarke report
- the Sapere *2018 Gambling Harm Reduction Needs Assessment* (see Section 2.6)
- the *Gambling Outcomes Monitoring Report 2007–2017* (in publication)
- reflections on the results of previous analysis of submissions and submissions themselves.

The Ministry acknowledges that the submissions it received comprise multiple stories representing a range of perspectives on gambling and gambling harm minimisation. The analysis found that the stories entailed certain common themes according to the point of view of the submitter, as follows:

- submissions from the non-casino gaming machines (NCGM) sector, also known as pokies, and the gambling industry (other) sector presented the views of legitimate businesses operating in the entertainment space
- submissions from service providers and the health and local government sectors, and some individual submissions, reflected the purpose of those people and agencies: to help people whose gambling is causing harm
- the submissions of individuals with personal experience of gambling harm focused on the need to reduce the potential for harm and allow gamblers to get better help more quickly.

At times, these storylines came close together or even intersected, but the points of view were shaped by very different aims and objectives. For example, the perspective of a small business that hosts a gambling venue had relatively little in common with the perspective of the partner of a person whose gambling had resulted in the family seeking the support of a treatment services provider.

The Ministry acknowledges that all these perspectives are real and valid, and the goals and outcomes of the Strategy matter to all submitters. Nevertheless, differing perspectives result in different interpretations. We have tried to acknowledge this within this document. For example, the commentary on levy weightings (expenditure/ presentations) takes into account that opposing points of view each used the concept of ‘fairness’ to argue their case within submissions – but this definition itself differs.

We observed that different submitters interpreted the question ‘Do you think operators of [NCGM] venues should be incentivised to move from lower socioeconomic areas to higher socioeconomic areas?’ differently – not entirely by sector:

- for some submitters, the question asked whether the strategy should focus on moving NCGM venues from lower socioeconomic areas – and many submitters thought that it should. But some of these submitters stated that these venues should be closed down rather than relocated: they favoured the ‘sinking lid’ approach.
- for other submitters, the question focused on ‘incentivisation’. Some of these submitters equated incentivisation with financial assistance from the Ministry and sometimes they assumed that this financial assistance would be funded via the levy. This was not supported broadly across submissions.

In this proposals document no guidance is provided in response to the question of NCGM venue location, as this topic is on a separate work programme for the Ministry and the Department of Internal Affairs (DIA), and the Associate Minister of Health and the Minister of Internal Affairs respectively.

Over the last two to three consultation rounds, submissions have demonstrated a steadily increasing awareness of, and concern about, the growth of online gambling (since approximately 2009) and its effects. They also reflected increasing concern about the convergence of electronic gaming with gambling elements, ready access to gambling products via electronic means, increasingly ready access to addictive gambling products among young people and youth exposure to gambling advertising through a range of media. The need to act on these concerns is acknowledged.

The Ministry’s Addictions Team is grateful for the passion and compassion evident in submissions from people who frankly shared their experiences of gambling harm, drawing on these experiences to constructively contribute to the consultation. While it is impossible for this proposals document to reflect every individual’s point of view, the Ministry hopes that these submitters can see themselves in these proposed responses.

1.1 Structure of this document

The structure of this proposals document reflects the structure of the *Strategy to Prevent and Minimise Gambling Harm 2019/20 to 2021/22: Consultation Document*. Changes have been made when the Ministry considers they were warranted. The Ministry will publish a submissions analysis report on its website consultation page.

This document is divided into sections as follows.

The proposed Strategy to Prevent and Minimise Gambling Harm for 2019/20 to 2021/22 comprises the:

- draft three-year strategic framework 2019/20 to 2021/22 (Section 3). This strategic framework sets out the Ministry's approach to the prevention and minimisation of gambling harm, high-level objectives and priorities for action. It forms the strategic context for the proposed three-year service plan
- draft three-year service plan 2019/20 to 2021/22 (Section 4). The proposed service plan sets out the Ministry's service priorities to prevent and minimise gambling harm, and the costs of those services, for the three years from 1 July 2019 to 30 June 2022.

The proposals document also includes:

- a strategic overview (Section 2). This section provides relevant background and context about the strategy, the nature of gambling in New Zealand, gambling related harms and the public health approach to gambling harm
- draft levy rates for 2019/20 to 2021/22 (Section 5). This section sets out the proposed levy rates for the three-year period corresponding to the term of the proposed service plan, and describes the Ministry's reasoning for the levy rates it proposes and the process by which the rates were calculated.

1.2 Next steps

The Ministry has submitted this document to responsible Ministers, and to the Gambling Commission, as required by section 318(2) of the Act.

The Gambling Commission undertakes its own analysis of the proposed strategy, and will convene a meeting to consult invited stakeholders on the Strategy and the levy rates. It will subsequently provide advice to the responsible Ministers.

After considering the Gambling Commission's advice, the responsible Ministers will take a paper to Cabinet seeking its endorsement of Ministers' decisions on the shape of the Strategy and the levy. While that is likely to happen in March 2019, the Government will not make the new Strategy public nor promulgate the levy regulations until around late May 2019, when the 2019 Budget has been tabled in Parliament.

The new Strategy and new problem gambling levy regulations should take effect on 1 July 2019.

Inquiry into Mental Health and Addiction

Services to prevent and minimise gambling harm are not included in the scope of the Inquiry into Mental Health and Addiction. However, the Ministry of Health understands that the Inquiry panel has explored gambling harm as a risk factor for other mental health and addiction issues. The Inquiry is due to report back in November 2018. If the Inquiry report includes any findings relevant to gambling harm, the Ministry may incorporate them into the Strategy before the Government finalises the Strategy in early 2019.

2 Strategic overview

2.1 Background

This section provides the context and background that inform the strategy and the strategic framework and service plan that together make up the strategy.

2.1.1 The gambling environment

Participation in gambling

Most New Zealanders gamble at least occasionally. The Health and Lifestyles Survey (HLS) 2016 showed that:

- 70 percent of respondents (about 2.7 million New Zealanders aged 15 years and older) had participated in some form of gambling in the past 12 months. The overall past-year gambling rate decreased between 2006/07 and 2017, but remained unchanged after 2012
- levels of gambling participation reduced between 2006/07 and 2016 across all age groups; rates for 15–17-year-olds showed the greatest reduction, and rates for people aged 45 years and over showed the least reduction. Rates for Māori and Pacific peoples also showed decreasing participation trends.

The most popular forms of gambling in 2016 were New Zealand Lotteries Commission products (61%), followed by informal gambling (35%), sports, dog- or horse-race betting (12%), gaming machines at a pub or club (10%), gaming machines at casinos (5.1) and table games at casinos (3.3%).

The Act defines ‘gambling’ and regulates various forms of gambling activities. It also identifies four types of gambling that contribute significantly to gambling harm and are subject to the problem gambling levy:

- non casino gaming machines (NCGM or pokies operated by clubs, societies and some TAB venues
- the mixture of table games and gaming machines provided by casinos
- sports and race betting provided by the New Zealand Racing Board (NZRB) at raceways and through TAB venues (some TAB venues also operate NCGMs)
- a range of lottery products provided by the New Zealand Lotteries Commission (NZLC), including the national lottery, Keno and instant kiwi (scratch) tickets.

Gambling outlets

Traditionally gambling has required participation at a venue or retail outlet, but this is changing as gambling providers make use of internet access and develop internet-based products, as summarised below.

The Department of Internal Affairs (DIA) reports that, as at 30 June 2018, there were 1,140 licensed NCGM venues active, operating 15,420 machines. This reflects a trend of venues and machines decreasing since venues peaked at more than 2,200 in the late 1990s and machines peaked at 25,221 in June 2003. Despite the decline in venue and machine numbers, total NCGM expenditure continues to increase.

The NZLC's 2017/18 annual report states that in that year there were 1,472 lottery outlets in its retail network and 746,000 registered MyLotto account holders.

The NZRB's 2016/17 annual report states that in that year there were 680 retail TAB outlets, and that more than 190,000 TAB account holders placed a bet in 2016/17. It also reports that 43 of the 78 TAB Board operated venues hosted NZRB gaming machines (compared with 33 venues hosting gaming machines in 2013/14).

There are six casinos in New Zealand: one each in Auckland, Hamilton, Christchurch and Dunedin and two in Queenstown. They operate a total of just over 2,800 gaming machines and just under 200 table games. The Christchurch Casino was the first to open, in 1994. The Hamilton casino was the last, in 2002. The Act prohibits any more casinos. The Auckland casino generates approximately three-quarters of New Zealand's casino gambling expenditure.

Since 2005, several analyses (most recently the Gambling Harm Reduction Needs Assessment Sapere undertook in 2018) have shown an association between numbers of NCGM venues, numbers of NCGMs and NCGM expenditure on the one hand and higher deprivation on the other. The 2018 Gambling Harm Reduction Needs Assessment shows that gambling outlets tend to be located in areas with a higher social deprivation rating; for example, about 50 percent of all NCGMs are located in areas with a high social deprivation rating. Section 2.9 discusses this further.

Online gambling

Significantly, an increasing number of people in New Zealand purchase NZLC products or place bets on NZRB products online.

There are concerns about the growing opportunities for online gambling, including those offered by overseas-based gambling operators, and their potential to increase harmful gambling behaviour. Submissions to this consultation from service providers and health groups expressed concerns about the ubiquitous nature of online gambling and gaming convergence (see below): particularly in terms of the potential impact on vulnerable groups including Māori and Pacific youth.

Observation of patterns of online gambling in overseas jurisdictions has led stakeholders to express concerns that New Zealanders' participation in online gambling could dramatically increase. Increase in online gambling overseas is attributed to the growth in online providers and products facilitated by rapid changes in technology, increasing ease of access to the internet and the widespread prevalence of digital devices.

Previous research into New Zealanders' overseas gambling patterns has shown very low participation rates and levels of reported expenditure.¹ Recently, however, the availability of smart, internet-based technologies and devices (and gaming convergence, discussed below) has steadily grown, and with it the risk of increased gambling harm.

Gaming convergence

For the purposes of the strategy, 'gaming convergence' refers to the merging of gambling and gaming elements in a single product. There are two main examples:

- where gambling takes on the visual and aural queues associated with gaming; for example, virtual reality-enabled Instant Kiwi tickets here in New Zealand. These forms of gambling are also an example of continuous gambling, which research shows poses an increased risk of harm
- where video games include elements of what appears to be gambling (but does not currently meet the definition of gambling under the Act); for example, opening loot boxes and spinning wheels to unlock 'power ups'.

Gaming convergence, when coupled with associated increased levels of advertising and internet-based payment systems that make it easier to spend money on gambling products, represents the emergence of new levels of exposure to high-risk gambling products in New Zealand, and the associated probability of related gambling harm.

Associated with gaming convergence is the potential harm from increasing opportunities to play games that simulate gambling; that is, they look and feel like gambling, but do not meet the definition under the Act (because there is no opportunity to stake, win or lose real money). For example, many online gambling websites promote their services with free-to-play games that appear to be gambling, but do not involve 'real money'. These free-to-play sites appear to avoid the Gambling Act 2003 prohibition on advertising as, by definition, no gambling is taking place on the site advertised. For example, SKYCITY launched a free-to-play online gaming site in 2015 with virtual gaming machines (simulated pokies) and table games.

Gambling providers in New Zealand, including SkyCity, have expressed interest in broadening their gambling products (eg, by moving online or increasing competitiveness with overseas markets).

¹ In 2012, 2013 and 2014, AUT reported rates of 1.7%, 1.2% and 0.9% respectively. For the same years Bellringer et al (2015) found a nationwide self-reported annual expenditure on offshore online/remote gambling of \$47.6 million, \$14.6 million and \$36.2 million respectively.

Submissions from service providers and health groups expressed concerns about gaming convergence, particularly in terms of the potential impact on vulnerable groups including Māori and Pacific youth.

Gambling expenditure

According to the DIA, total gambling expenditure (player losses) on the four main forms of gambling is continuing a trend of increasing each year: refer to Section 4 for details. In particular, it has found the following.

- Total gambling expenditure in 2016/17 (the most recent year surveyed for all four gambling sectors) was \$2,334 million for the four main forms of gambling. This represented an increase of 5.6 per cent on the 2015/16 year and an increase of approximately 15% on the 2014/15 year.
- Expenditure on NCGMs continues to increase from a low in 2013/14, with increases of around 3 percent per year since 2014/15. For 2017/18 the total was \$895 million.
- Expenditure on NZLC products in 2016/17 increased significantly, after a number of years averaging smaller increases (note: annual expenditure on Lotto products is volatile, depending on the number and size of Powerball jackpots).
- In contrast, annual expenditure on casinos and NZRB products remains fairly steady; both experienced small reductions in 2016/17.

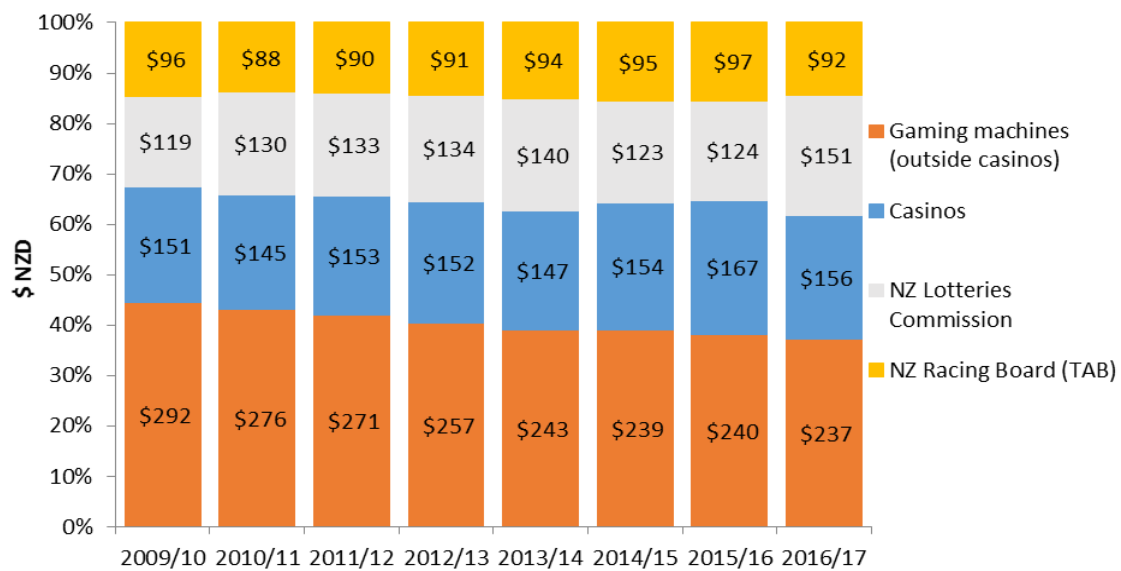
Figure 1 below shows the average per-capita gambling expenditure for each of the four main forms of gambling. Note that actual expenditure levels are higher than the figure suggests, since the levels in the figure apply to all people in New Zealand, including the 30 percent of the population who report that they do not gamble.

While gambling expenditure trends show an increase in real terms across all four gambling sectors, adjusting for inflation by type of gambling shows that spending levels have remained relatively unchanged in recent years, except for the most recent period, in which inflation-adjusted spending on NZLC products increased and on NCGMs decreased.²

Most casino gambling expenditure also derives from gaming machines. Comparing the gambling participation and expenditure information confirms that most of the money spent on gambling in New Zealand comes from the relatively limited number of people who play non-casino or casino gaming machines, or both. This has been the case for more than a decade.

² DIA. Gambling Expenditure Statistics. URL: https://www.dia.govt.nz/diawebsite.nsf/wpg_URL/Resource-material-Information-We-Provide-Gambling-Expenditure-Statistics (accessed 16 November 2018).

Figure 1: Inflation (2017)-adjusted expenditure per capita (adults aged over 18 years), by type of gambling, 2009/10–2016/17



2.1.2 The nature of gambling harm

While most New Zealanders gamble without experiencing any apparent harm, a significant minority do experience harm from their gambling, including negative impacts on their own lives and the lives of others.

The Act defines a problem gambler as a person whose gambling causes harm or may cause harm, and defines 'harm' as:

- a) harm or distress of any kind arising from, or caused or exacerbated by, a person's gambling; and
- b) includes 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.

Harm may include damage to relationships, emotional and psychological distress, disruptions to work or study, loss of income, the financial impacts of gambling, and potentially fraud and related crimes, which can also impact negatively on the gambler's family/whānau and community.

Measurement of gambling harm

We can measure gambling harm by various means.

The Problem Gambling Severity Index (PGSI) differentiates between different types of harm and frequency of harm occurring, as reported by survey respondents. The PGSI is commonly used to screen and categorise three levels of harm: severe or high risk (problem gambling), moderate risk and low risk. While the proportion of the New Zealand population at risk of gambling harm as measured by the PGSI is currently at the lowest level seen for 25 years, the level of harm in the overall population has remained relatively stable for the last five to seven years (at about 5%) (Abbott et al 2018; Thimasarn-Anwar et al 2017). This plateau effect has also been observed overseas (Abbott 2017).

Another measure of gambling harm is the burden of harm impact on health-related quality of life. Research shows that the total burden of harms gamblers experience, in terms of the decrease to health-related quality of life years, is greater than that people with common health conditions (such as diabetes and arthritis) experience, and approaches the levels seen with anxiety and depressive disorders. Importantly, the harm attributable to gamblers partaking in low-risk gambling was significant, at nearly 50 percent of all gambling harm.³ Recent research shows that one in five New Zealand adults (22%) is affected some at time in their lives by their own gambling or the gambling of others. Estimates suggest that, in New Zealand in 2017, 37,000 people aged 15 years or older were at high risk of harm from gambling or are 'problem gamblers', about 47,000 were at moderate-risk and a further 106,000 were at low risk but would experience gambling-related harm during their lifetime.⁴

Forms of gambling associated with gambling harm

Some features and/or modes of gambling are particularly associated with harm. Research both internationally and in New Zealand clearly shows that gambling harm is far more likely to be associated with continuous forms of gambling (in which a gambler can immediately 'reinvest' winnings in further gambling, such as NCGMs and casino table games) than with any other mode of gambling. Online gambling and gaming convergence products usually allow a gambler the ability to play continuously, and therefore present higher risks of forming harmful gambling behaviours.

Gambling provided through the four gambling sectors levied pose the greatest risks of gambling harm in New Zealand. The most harmful form of gambling in New Zealand is NCGMs at pubs/clubs (defined in the Act as class 4); this has been the case for many years.

³ The 2017 study Measuring the Burden of Gambling Harm in New Zealand estimated that years of life lost to incapacity as a result of harms from gambling was 161,928 in 2012. Of this number, 67,928 were lost to gamblers themselves and 94,729 were lost to people effected by someone else's gambling.

⁴ New Zealanders' Participation in Gambling: Results from the 2016 Health and Lifestyles Survey meta-analysis.

Most money spent on gambling in New Zealand comes from the relatively limited number of people who play NCGMs, and most clients accessing problem gambling intervention services cite pub/club pokies as a primary problem gambling mode. The National Gambling Study (NGS) 2014 found that at-risk and problem gamblers accounted for over half of total (estimated) electronic gaming machine (EGM) expenditure in 2015 (moderate-risk and problem gamblers 28%; low-risk gamblers 24%). Similarly, the HLS 2016 found that almost half (49%; 37, 61%) of people who played NCGMs in pubs or clubs at least once a month had at least some level of gambling harm.

Groups vulnerable to gambling harm

Research shows that Māori and Pacific peoples, some Asian communities and people on lower incomes disproportionately experience gambling harm.

The HLS 2016 found that gambling harm is experienced disproportionately by those living in areas with a high social deprivation index score (8/10 or higher), who were 4.5 times as likely to experience gambling-related arguments or money problems related to gambling.

The study found that Māori and Pacific adults were more likely to develop problems from gambling (ie, to become a low-risk, moderate-risk or problem gambler) than European/other New Zealanders. Asian people also experienced a slightly higher risk. Importantly, while inequalities between population groups by age, social deprivation, gender and ethnicity have reduced in absolute terms, in relative terms, disparities in exposure to gambling and experience of gambling-related harm persist, and have been relatively static over the past five years.

Māori, Pacific peoples and Asian peoples are each more than twice as likely to experience moderate to severe gambling harm than the (European/other) population.

Women and children

Harmful gambling behaviour may impact significantly on women and children. There is a strong correlation between gambling and family/whānau or partner violence: 50 percent of problem gamblers also experience family/whānau violence.⁵ Women, who are commonly the primary caregivers within their family/whānau, are also particularly vulnerable to the economic strain caused by problem gambling.

The recent AUT report *Pacific Islands Families Study 2014: Mother and youth gambling* found that risk factors for gambling among mothers studied included alcohol consumption, being a victim of verbal abuse, and increased deprivation levels (Bellringer et al 2016). Pacific people make up 21 percent of all people seeking treatment for gambling harm.

⁵ Auckland University of Technology. 2017. *Problem Gambling and Family Violence in Help-Seeking Populations: Co-Occurrence, Impact and Coping*. Wellington: Ministry of Health.

There is evidence that children and young adults are exposed to considerable gambling messaging; for example, through advertising, which can help to normalise gambling behaviours.⁶

As noted above, submissions on the draft strategy from health and service providers also raised concerns about the accessibility of online gambling and gaming convergence and these impacts on the wellbeing of children, youth and young adults.

Co-morbidities

Harmful gambling typically presents with other health issues, and has been consistently associated with a range of co-existing health issues such as higher levels of smoking, hazardous alcohol consumption and other drug use, as well as higher levels of depression and poorer self-rated health. Comorbidity is an indication that a person may require holistic services.⁷

Intervention service data

Every year, some of these people seek help from services funded by the Ministry of Health (the Ministry) for problems due to their own or someone else's gambling. In the 2016/17 year, over 6,200 people sought help from services funded by the Ministry of Health for problems due to their own or someone else's gambling. Most of these people were in crisis. If brief interventions in non-clinical settings were included in the analysis, the total would increase to more than 11,600.⁸

Over the last seven years gambling harm intervention services have seen approximately 10,000 clients (including family/whānau and affected others). Of these, about 4,000 were for brief interventions.

Analysis of Ministry gambling service administrative data shows that of the approximately 5,900 gamblers who sought treatment in 2016:

- 44% identified as European/other
- 31% identified as Māori
- 14% identified as Pacific peoples
- 11% identified as East-Asian
- 60% were men
- the average age was 42 years.

Of the 2,050 who were screened for co-existing problematic alcohol and drug use, 45% were identified as having a co-existing issue.

⁶ Kids Cam GAME Study, Signal, et al. 2017. Health Promotion and Policy Research Unit, University of Otago, Wellington.

⁷ Auckland University of Technology. 2017. *Problem Gambling and Family Violence in Help-Seeking Populations: Co-Occurrence, Impact and Coping*. Wellington: Ministry of Health.

⁸ Ministry of Health Intervention **client data website**.

The current levels of people presenting for services are substantively lower than expected, representing only 16 percent of the number estimated to be affected by moderate to severe gambling harm.⁹

Early intervention

It is apparent that a number of New Zealanders who would benefit from gambling harm intervention are not seeking help. Likely causes for this (identified in submissions to this consultation from health and service providers) are the high level of stigma associated with gambling harm and societal attitudes towards gambling, as well as cultural, language and other barriers.

While it is necessary to address the needs of those who have already developed a serious gambling problem and who need specialist help, it is clear that earlier prevention-focused interventions could help individuals and their families/whānau and communities avoid developing harmful gambling behaviours and associated higher risks of harm.

This approach aligns closely with public health programmes in the mental health and addictions areas of alcohol, tobacco and drug use, and family/whānau and partner violence prevention.

Conclusions

The key issues underpinning the strategy include:

- the disproportionate levels of harm experienced by Māori and Pacific peoples, and by some segments of the Asian population
- the higher levels of exposure to gambling products and the disproportionate levels of harm experienced by people living in areas with high social deprivation index scores
- the high rates of co-morbidities among at-risk gamblers, and low levels of treatment uptake and screening to minimise and prevent gambling harm
- the harm experienced by children and the involvement of younger people in gambling
- the possibility of a significant increase in online gambling.

⁹ This level of service use equates to approximately 16% of those in the moderate-risk and problem gambling categories. Estimates of the number of 'problem gamblers' (0.5%) and 'moderate-risk gamblers' (1.5%) in the total New Zealand population over 15 years of age are approximately 23,000 and 60,000 people respectively (Thimasarn-Anwar et al 2017).

2.2 The role of the Ministry of Health

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

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's definition of gambling harm is set out above.

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.

2.3 Role of the Department of Internal Affairs

The DIA is the main gambling regulator and policy advisor to the Government on gambling regulatory issues. The DIA administers the Act and its regulations, issues licences for gambling activities, ensures compliance with the legislation, works with the gambling sector to encourage best practice and publishes statistical and other information concerning gambling. It is also responsible for limiting the opportunities for crime and dishonesty associated with gambling and ensuring gambling proceeds benefit the community.

The DIA's role includes key regulatory aspects of gambling-harm prevention and minimisation. It works with a range of stakeholders, including the gambling industry and gambling-harm service providers, to encourage and support venues to provide a 'culture of care' towards gamblers.

2.4 Key principles underpinning the strategy

A number of key principles have guided the development of both elements in the proposed strategy: the strategic plan and the corresponding three-year service plan. These are:

- to reflect the relationship between the Crown and Māori under Te Tiriti o Waitangi, and in particular to apply the principles of partnership, participation and protection
- to achieve health equity:
 - to maintain a comprehensive range of public health services based on the World Health Organization's (WHO's) Ottawa Charter for Health Promotion and New Zealand models of health (particularly Māori models, such as Pae Ora – healthy futures, Te Pae Mahutonga, Te Wheke 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.

2.5 Functions of the strategy

The strategy comprises a rolling six-year strategic plan and a three-year service plan and is refreshed every three years. Together, the strategic and service plans set out the Ministry's proposed approach and the range of activities it plans to undertake to minimise gambling harm from 2019/20 to 2021/22.

The strategy sets out the statutory requirements for an integrated problem gambling strategy and the aim for gambling harm minimisation, and specifies 11 strategic objectives.

It reflects the Ministry's responsibility for a public health approach to gambling harm minimisation and its relationship to the complementary responsibility of the DIA in regulating gambling activity. Other key Ministry strategic documents inform the strategy and align with it.

The draft strategic plan provides the strategic context and direction for the draft three-year service plan.

The Ministry proposes to make some alterations to the strategic plan to reflect changes in the minimising gambling harm and wider addiction and mental health sector landscape. It proposes more substantial changes for the next three years of the service plan, to address areas highlighted by the needs assessment and outcomes monitoring summarised below.

2.6 Gambling harm needs assessment

The Act requires the Ministry to undertake a needs assessment to inform the development of the strategy. The needs assessment looks at facts and figures about gambling-related harm in New Zealand to highlight any gaps between the research evidence, population needs, service provision and the strategy's goal. This helps to determine the most appropriate distribution of health services to promote better health outcomes for the population.

To help prepare the 2018 needs assessment, the Ministry contracted an independent research organisation, Sapere Research Group, to review needs in the sector. The Sapere needs assessment report (Rook et al 2018) is available on the Ministry's website¹⁰ together with a table listing the report's recommendations and the Ministry's proposed response to them. Together, these documents form the Ministry's needs assessment that has informed the strategy's development.

In summary, the needs assessment identifies that the key needs are much the same as they were when the Ministry developed the service plan for 2016/17 to 2018/19 in 2015. There is provision for dedicated Māori, Pacific and Asian services and activities, as these are the most vulnerable populations. The needs assessment also suggests there is value in strengthening research and evaluation and in piloting new initiatives to address harm caused by persistent and relapsed moderate-to-high risk gambling. It addresses concerns about the growth of internet-based gambling and the convergence between gambling and gaming; the Ministry proposes this as a research priority.

Opportunities to learn

Overall, Sapere found that:

There are many opportunities to learn from best practice within New Zealand and create pilot service models to address service gaps. Work is needed to improve inter-sectorial relationships and make best use of the skills available within the industry as a whole to support those harmed by gambling (Rook et al 2018).

¹⁰ Ministry of Health. Gambling Harm Reduction Needs Assessment. URL: <https://www.health.govt.nz/publication/gambling-harm-reduction-needs-assessment> (accessed 17 November 2018).

In response, the Ministry notes the strategic goal for gambling harm reduction is 'Government, the gambling sector,¹¹ communities and families/whānau working together to prevent and minimise gambling harm, and to reduce related health inequities' (Ministry of Health 2016). The Ministry's statutory responsibility is to promote harm minimisation through an informed, research-based public health approach.

In collaboration with the DIA, the Ministry aims to identify and use opportunities for diverse perspectives to clarify what gambling harm minimisation means for different parts of the health sector and to work with the health sector to implement the strategy through the future service plan.

The proposed service plan provides more detail about the Ministry's response to the recommendations identified in the Sapere needs assessment.

2.7 Outcomes monitoring

The Ministry has recently reviewed progress towards gambling harm reduction outcomes to assess what has been achieved over time in gambling harm minimisation. This review complements the needs assessment discussed above and provides information about the nature of gambling harm in New Zealand and changes over time.

Research shows that while the proportion of the population at risk of gambling harm, as measured by the PGSI is at the lowest levels seen for 25 years, the level of harm in the overall population has remained relatively stable for the last five to seven years (at about 5%) (Abbott et al 2018; Thimasarn-Anwar et al 2017). This plateau effect has also been observed overseas (Abbott 2017).

Similarly, the number of people presenting for gambling support and treatment has not increased in line with population growth. Yet, this figure represents only a small fraction of the estimated numbers affected by gambling harm. In fact the overall number of 'at risk' gamblers in the population has increased in line with population growth.

Importantly, while inequalities between population groups by age, social deprivation, gender and ethnicity have reduced in absolute terms, in relative terms, disparities in exposure to gambling and experience of gambling related harm persist and have been relatively static over the past five years.

¹¹ In this context, 'the gambling sector' includes commercial and non-commercial gambling operators (including the NZRB and the NZLC), member associations such as Clubs New Zealand Inc and Hospitality New Zealand, operators of gambling venues (including publicans and operators of retail outlets), providers of services to prevent and minimise gambling harm and gambling researchers.

A refocusing and revitalisation of activities is warranted

The outcomes review and the needs assessment together suggest that, while there has been some success in reducing gambling harm since the first strategy in 2005, in the past few years, the number of people affected by gambling harm has been growing. We need to refocus and revitalise gambling harm responses within future service plans if we are to make further gains in reducing gambling harm and health inequalities and inequity in the experience of gambling harm by a range of population groups; particularly Māori and Pacific peoples.

Inequalities and inequity in health

We usually refer to differences in health experience occurring between population groups as 'health inequalities'. A 'health inequity' is an inequality that we can attribute to social, cultural and economic factors, rather than biomedical ones.

Inequalities and inequity in health occur between groups because of a range of well-recognised socioeconomic, cultural and biological factors. The most common factors are sex, age, social deprivation, ethnicity and education.

Similarly, the components of the service plan for the next three years should focus on each service area (public health, intervention services and research and evaluation) to support the plan's key actions and priorities.

In addition, given the long-term patterns in gambling participation and harm that have been reported through the HLS, the Ministry proposes that future outcomes reporting on the strategy should occur every three years, to better inform revisions to the service plan.

2.8 A population-based public health approach

The Act recognises the importance of prevention and a public health focus in addressing gambling harm. The Ministry proposes to continue using the continuum-of-harm approach, which aligns a spectrum of gambling behaviour with a harm reduction framework, as first developed by Korn and Shaffer in 1999 (Korn and Shaffer 1999).

This approach recognises that people experience varying levels of harm from gambling. The framework, represented in Figure 2 below, brings together the ideas of different levels of individual gambling behaviour, associated levels of harm and types of health intervention.

The approach describes levels of gambling behaviour and associated harm as non-problem (none), mild and moderate through to severe (problem) gambling. These categories can be overlaid with the three broad categories of population public health interventions: 'primary', 'secondary' and 'tertiary' interventions. Figure 2 also shows examples of the related types of activity that have been delivered through each current service plan.

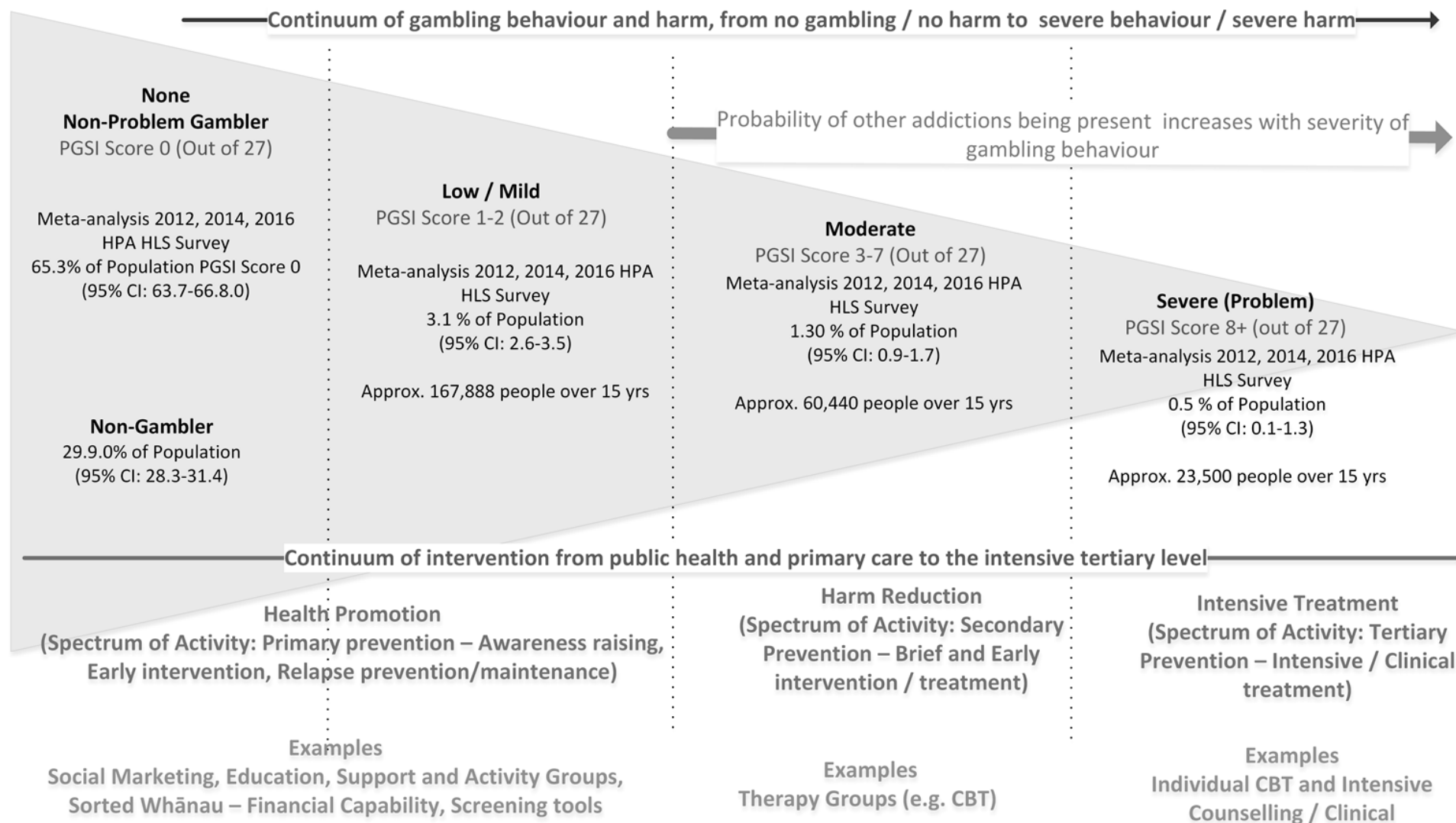
The categories of behaviour and harm have been aligned with the PGSI, which the Ministry uses to monitor the level of harmful gambling behaviour occurring in the New Zealand population.¹² Figure 2 includes the most robust estimates of the harm occurring for each category. The estimates are from a statistical meta-analysis of the pooled responses to the PGSI questions in the 2012, 2014 and 2016 HLS. It is important to note that the PGSI measures the level of reported harm that is associated with the individual gambler and their immediately affected 'others' (eg, family/whānau, employers, and community groups).

While it is necessary to address the needs of those who have already developed a serious gambling problem and who need specialist help, early prevention interventions can help individuals and their family/whānau and communities avoid developing more risky gambling behaviours and associated harm.

This approach aligns closely with other public health programmes in the mental health and addictions areas of alcohol, tobacco and drug use, and family / whānau and partner violence prevention.

¹² The estimates have been produced through the HLS – Gambling module and the NGS, both of which the Ministry funds through the gambling levy.

Figure 2: Gambling behaviour and harm: the continuum of prevention and harm reduction



2.9 Gambling harm inequality and inequity

Improved health and equity for all New Zealand population groups is a government priority.

To focus and prioritise gambling harm reduction activities in the next strategy period, the Ministry proposes to continue using a health inequality and inequity lens, which complements the public health approach by identifying areas where there are large differences in gambling harm experience between population groups.

What the research tells us

Gambling research has shown the presence of inequalities and inequities attributable to gambling harm both in the New Zealand population and internationally (Canale et al 2017; Kolandai-Matchett et al 2017; Rintoul et al 2013; Tu et al 2014; van der Maas 2016).

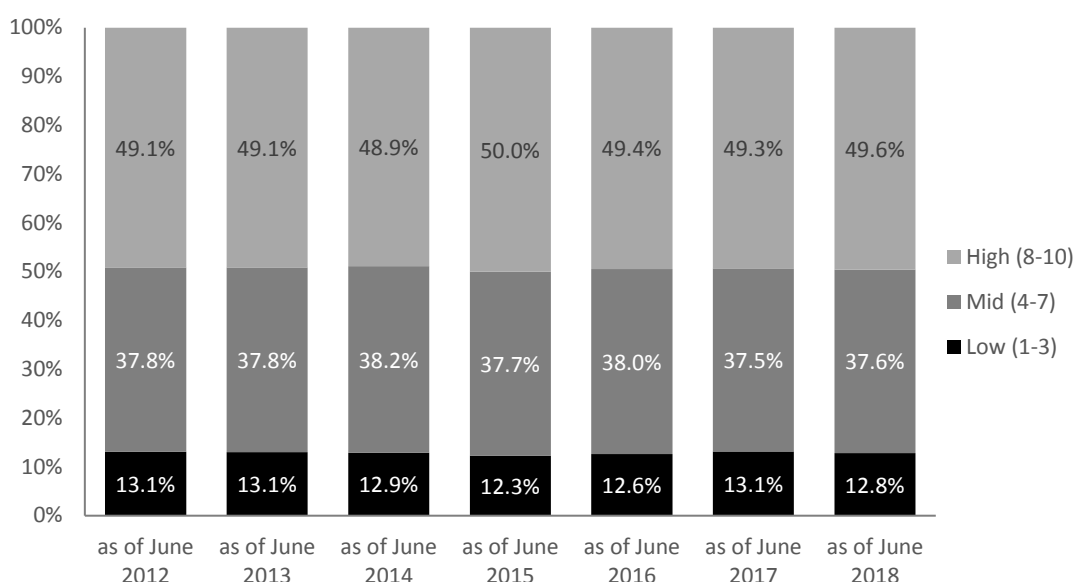
An analysis of the responses to the 2016 HLS by a range of gambling predictors and population groups of interest (eg, ethnicity, gender, social deprivation) shows that inequalities and inequities have persisted for some time (Thimasarn-Anwar et al 2017). The HLS results for the period 2010–2016 also show that while absolute levels of health inequality and inequity have reduced over time, relative levels of inequality and inequity between ethnic groups remain.

In terms of overall gambling service use, analysis indicates that there is substantive underuse of services by the Pacific and Asian groups. Similarly, an analysis using the social deprivation index shows significant inequality, disparity and inequity between New Zealand populations groups by socioeconomic status.

Research also shows higher concentrations of class 4 electronic gaming machines (NCGMs (ie, pokies) located in lower socioeconomic areas: see Figure 3.¹³ The following figure shows that approximately 50 percent of all NCGMs (which is the source of the highest risk of harmful gambling activity) are located in the most socioeconomically deprived areas (ie, the poorest areas of the country). Economically, people in these areas can least afford financial losses from gambling.

¹³ Based on NZDep 2013 census area units: University of Otago Wellington. Socioeconomic Deprivation Indexes: NZDep and NZiDep, Department of Public Health. URL: <https://www.otago.ac.nz/wellington/departments/publichealth/research/hirp/otago020194.html> (accessed 17 November 2018).

Figure 3: Distribution of class 4 NCGMs by low-, mid- and high-deprivation census area units, 2012–2018



Source: Department of Internal Affairs

How do inequities come about?

Inequities are not random; they are typically due to structural factors present in the society and local community that cannot be explained by biomedical differences between population groups. This means their causes are often complex and multifaceted and are outside the scope of the health system to address on its own. For example, income inequality (poverty) has been shown to be strongly associated with differences in health outcomes, including gambling (Canale et al 2017; Kolandai-Matchett et al 2017; Rintoul et al 2013; Tu et al 2014; van der Maas 2016). This means that achieving gambling harm minimisation equity requires a strong evidence base and a strategic, integrated approach from the health sector and other sectors.

The Ministry will use strategies and frameworks such as He Korowai Oranga (Ministry of Health 2014c); *Equity of Health Care for Māori: A framework* (Ministry of Health 2014b); *‘Ala Mo’ui: Pathways to Pacific Health and Wellbeing 2014–2018* (Ministry of Health 2014a) and the New Zealand Health Strategy (Minister of Health 2016) to focus on minimising gambling harm-related inequities. It will support this focus through health literacy activities.

The Ministry’s health literacy framework and guide aim to improve the quality of services delivered to individuals, families/whānau and communities by raising awareness of issues such as the importance of screening and the presence of inequities and harm in service use (Ministry of Health 2015). It has applied the approach in gambling harm minimisation services; more broadly to promote screening in drug, alcohol and mental health services; and in the ‘navigator’ approach to accessing health services.

Any Ministry publication that outlines the concepts and evidence from research to inform the approach to reducing gambling harm will help raise awareness in the gambling sector of the knowledge base that informs the strategy.

3 Draft strategic framework 2019/20–2021/22

The Ministry proposes relatively minor changes to the strategic plan/framework that was published in 2016/17, to better target reductions in health inequities. The strategic framework is based on an outcomes framework agreed by both the gambling industry and gambling harm services in 2012/13. The Ministry expects to revisit the strategic aim and objectives during the next levy period, to ensure they remain fit for purpose.

Most submissions the Ministry received on the consultation document supported the general direction of the strategy and strategic objectives; many also commented in detail on matters that were of particular importance to them. The Ministry has made some changes to the consultation document's priorities, where it considered this was warranted to highlight specific matters, bearing in mind the objectives are intended to be set at a high level, and the service plan (see Section 4) addresses operational matters.

3.1 Overall goal of the strategic plan

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 in 2005. 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.

3.2 Eleven strategic objectives

The following 11 strategic objectives guide the strategic direction for the actions in the service plan.

Objective 1: There is a reduction in gambling-harm-related inequities between population groups (particularly Māori, Pacific and Asian 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 activities in their communities that prevent and minimise gambling harm.

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

Objective 5: People 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: Services enhance people's mana and build life skills and resiliency to improve healthy choices that prevent and minimise gambling harm.

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

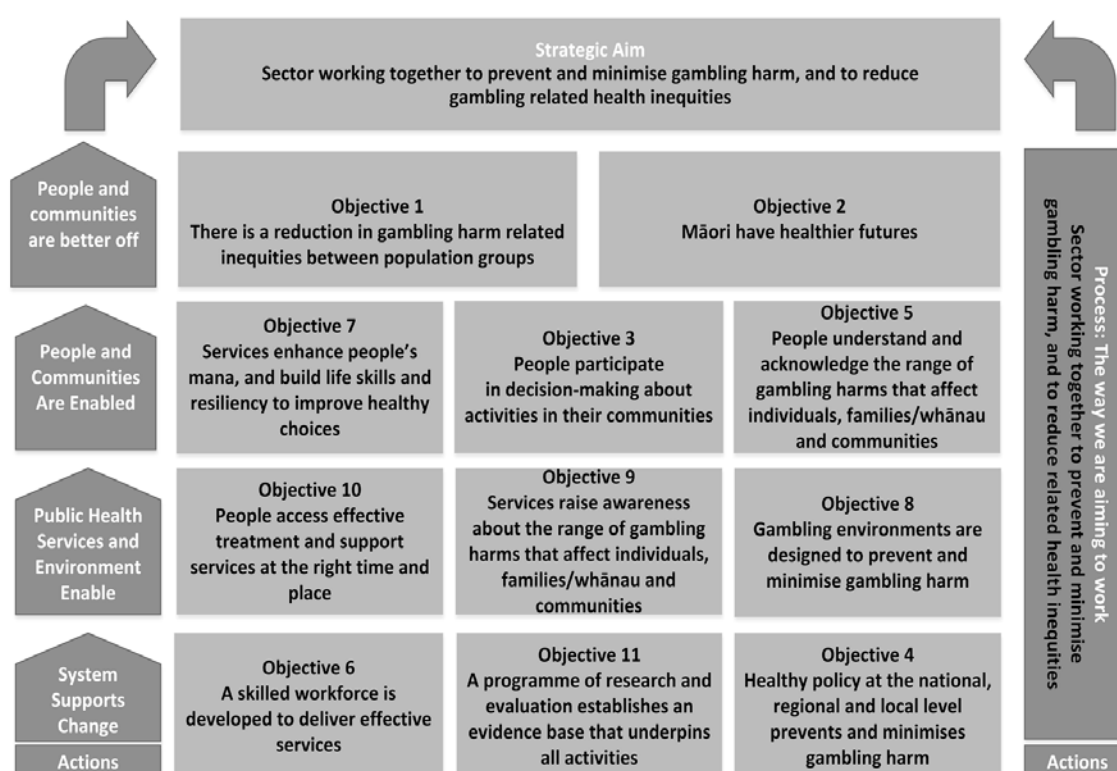
Objective 9: Services raise awareness about the signs and range of gambling harms that affect individuals, families/whānau and communities, and how to respond.

Objective 10: People access effective treatment and support services at the right time and place.

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

Figure 4 shows how the strategic objectives described above contribute to the strategy's key outcomes and goal.

Figure 4: Framework for organising the strategic objectives



No substantive change proposed to the 11 strategic objectives

The Ministry proposes no substantive changes to the 11 strategic objectives. However, based on insights from the HLS 2016, it has included a focus on reducing inequalities and inequities in Objectives 9 and 10, and identified Asians as an at-risk group in Objective 1.

Alignment with other strategic documents

The proposed strategic plan continues to align with and complement a range of other strategic documents, including:

- New Zealand Health Strategy (Ministry of Health 2016)
- He Korowai Oranga (refreshed in 2014; Ministry of Health 2014c)
- *'Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014–2018* (Ministry of Health 2014a).

3.3 Outline of each of the strategic objectives

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

The short-, medium- and long-term priorities for action have been altered; in particular:

- DIA activities that align with the strategic objectives are included, demonstrating the DIA's increased focus on harm prevention and minimisation
- the underlying principles supporting each strategic objective have been updated to reflect the key strategic themes of the New Zealand Health Strategy (Ministry of Health 2016)
- new priority actions have been included to address areas highlighted in the strategic overview, the needs assessment and submissions
- some language has been updated from the previous strategic plan, and, in other cases, some slight alterations have been made to the language for consistency or clarity, or to better reflect current practice.

Sections 3.4 and 3.5 below compare this strategy's alignment with He Korowai Oranga and *'Ala Mo'ui: Pathways to Pacific Health and Wellbeing*.

Objective 1: There is a reduction in gambling-harm-related inequities between population groups

The Ministry propose to enhance its focus on reducing avoidable differences in levels of gambling harm, and the determinants of gambling harm, among different population groups. The population health approach will continue to target at-risk populations, including Māori, Pacific peoples, 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 ensure that dedicated Māori, Pacific and Asian services are available where appropriate, and that all services are accessible; provide appropriate language support; and are culturally relevant, health literate, high quality and effective, with culturally competent staff. It will also identify factors that contribute to gambling harm-related inequities and develop, pilot, evaluate and implement one or more initiatives specifically focused on reducing these inequities.

Other specific groups at risk of harm include international students (primarily from Asia) and youth (particularly in terms of risk through online gambling and gaming convergence) and children.

Table 1: Objective 1 priorities for action

Objective 1: There is a reduction in gambling-harm-related inequities between population groups	
Priorities for action	
Short- to medium-term priorities	Long-term priorities
Provide and monitor dedicated services for Māori, Pacific and Asian peoples where appropriate, including services for both gamblers, their families/whanau and communities.	
Ensure that all services provided to prevent and minimise gambling harm are culturally appropriate and 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 these inequities (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, Pacific and Asian peoples	

Underlying principles: value and high performance/te whāinga hua me te tika o ngā mahi

We need to do better for the population groups that do not enjoy the same health as the general New Zealand population. In relation to gambling harm, these groups include Māori and Pacific peoples and the growing Asian population in particular. To achieve better outcomes, our focus must be on removing barriers to delivering high-quality health services, including cultural, language, physical and financial barriers. The

Ministry will consider tailoring services so that they are available in more accessible places or at more suitable times and are delivered in more culturally appropriate ways.

The Health Quality and Safety Commission's Triple Aim framework provides a systems approach to improving the quality of health services for individuals and populations. It can help us balance our goals to achieve the New Zealand Triple Aim of improved health and equity for all populations; improved quality, safety and experience of care; and best value for public resources.

Objective 2: Māori have healthier futures

Objective 2 aims to improve Māori health through the prevention and minimisation of gambling harm. This objective reflects the relationship between the Crown and Māori under the Te Tiriti o Waitangi. It aligns with objective 1 and is supported by all the other objectives.

This objective recognises gambling harm-related inequities both for Māori as a population and within the Māori population group. For example, while the prevalence of moderate-risk (problem) gambling is relatively high for both Māori men and Māori women, Māori women are more likely than Māori men to experience harm from someone else's gambling.

The Ministry also recognises the role Māori women have as the cornerstone of Whānau Ora and the likely implications of this on the wellbeing of rangatahi and tamariki, in particular regarding issues such as child poverty and access to sufficient safe, nutritious food.

The Ministry will enhance its focus on reducing avoidable differences in levels of gambling harm, and in the determinants of gambling harm, for Māori. It will ensure that dedicated services are available where appropriate and that all services are culturally competent, health literate, high quality and effective. The Ministry will also continue work 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. This may include piloting delivery models that incorporate te ao Māori and He Korowai Oranga.

Table 2: Objective 2 priorities for action

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/whanau.	
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 these inequities (eg, differences in the gambling environment by geographical area).	
Encourage all services to prevent and minimise gambling harm (both public health and intervention) to align with He Korowai Oranga, including through service design, and monitor the extent of that alignment.	
Maintain and improve mechanisms to support a Māori voice to provide advice to the Ministry and the DIA on the prevention and minimisation of gambling harm, and in developing appropriate models of care and support.	
Develop, pilot, evaluate and implement one or more initiatives specifically focused on reducing gambling-harm-related inequities for Māori.	

Underlying principles: Pae Ora – healthy futures

Pae Ora – healthy futures is the Government’s vision for Māori health. It provides a platform for Māori to live with good health and wellbeing in an environment that supports a good quality of life. Pae Ora is a holistic concept, and includes three interconnected and mutually reinforcing elements: mauri ora – healthy individuals, whānau ora – healthy families, and wai ora – healthy environments.

Objective 3: People participate in decision-making about activities 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 strategic plan. This objective acknowledges the important role of people and communities participating in decision-making about local activities that prevent and minimise gambling harm. It also recognises the important role of Māori in providing leadership in community decision-making.

The Ministry expects a high level of interaction among services, their client populations (particularly Māori, Asian and Pacific peoples, as the populations that are most vulnerable to gambling harm), other public and mental health and addiction treatment services, and community groups to prevent and minimise gambling harm.

The local government gambling venue policy process (set out in sections 101 to 102 of the Act) allows communities to address their councils and discuss the effectiveness of councils' venue policies. This includes the availability and accessibility of class 4 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.

The Ministry and the DIA play an important role in providing relevant timely information to communities, to empower them to participate effectively in decisions about their communities.

Table 3: Objective 3 priorities for action

Objective 3: People participate in decision-making about activities in their communities that prevent and minimise gambling harm	
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: <ul style="list-style-type: none"> • participate in decision-making about the availability and accessibility of gambling and the allocation of gambling profits in their areas • develop and implement policies that prevent and minimise gambling harm to individuals, families/whānau and communities • take action on gambling-harm-related issues in their areas. 	
Provide relevant timely information to local communities about gambling activities and the location of gambling venues, the allocation of gambling profits and gambling-related harms in their communities.	

Underlying principles: people-powered/mā te iwi hei kawē

Language barriers, different worldviews, lack of knowledge and lack of understanding all affect people's opportunities to participate meaningfully in New Zealand's range of formal decision-making processes to improve outcomes that contribute to the prevention and minimisation of gambling harm.

We need to address these and other barriers to empower individuals and their communities to engage and participate effectively in gambling harm-related responses in their local communities.

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 at the national, regional and local levels.

The Ministry will continue to comment on gambling issues based on the objectives of the strategic plan and available research and, where appropriate, will work collaboratively with the 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 support 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.

The Ministry will also work with the DIA to provide information, clearer direction and guidance from central to local government about gambling impacts, and to consider whether to set minimum standards for managing gambling-related harm.

Table 4: Objective 4 priorities for action

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
Develop and maintain a joint work programme with the DIA on significant areas of mutual interest.	
Work closely with the DIA in developing gambling policy and regulations to ensure that harm minimisation continues to be a core aspect in both organisations' work.	
Continue to provide information to other government sectors and agencies (eg, Local Government New Zealand; Te Puni Kōkiri; Department of Corrections; Oranga Tamariki: Ministry for Children and the Ministries of Business, Innovation and Employment, Education, Justice and Social Development) to increase understanding and acknowledge the need to link policies across related areas to prevent and minimise gambling harm, 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 levels that prevent and minimise gambling harm.
	Work with the DIA to ensure local authorities can access quality information to help them develop effective gambling policies at the local level.
Work with the DIA to assess the future levy formula and the national/local policy in relation to NCGM location.	Work with the DIA to implement matters arising from review of levy formula and NCGM location policy.

Underlying principles: closer to home/ka aro mai ke te kāinga

Good health begins at home and in communities. Public health and population-based strategies can help to better identify and prevent long-term conditions, provide earlier interventions, shape environments and make better quality healthier choices easier for all New Zealanders.

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

This objective acknowledges that people need to have the life skills and 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. Certain groups, including Māori, Pacific peoples, Asian communities, youth, migrants and older people are particularly vulnerable to gambling harm for a variety of reasons. For example, some ethnic groups who have not been exposed to large-scale, commercial gambling previously are particularly vulnerable to such forms of gambling harm.

The Ministry will continue to design public health programmes, and allocate resources, for vulnerable groups in the population, including resources to raise awareness and develop resilient life skills to prevent or minimise gambling harm.

The Ministry will continue to provide information to support making healthy choices at an individual and community level. This includes raising awareness about how to recognise low to moderate levels of gambling harm, the support available and the actions people can take to mitigate these risks and address this harm.

The Ministry will develop and draw on learning from projects that promote related life and financial skills and resilience, such as Sorted Whānau, for their potential application to people exposed to or at risk of gambling harm.

The proposed co-design approach and use of consumer networks and peer support will give consumers (people with lived in experience of gambling harm), including those from vulnerable communities, a stronger voice in the design and delivery of these activities.

Table 5: Objective 5 priorities for action

Objective 5: People 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
Ensure education and messaging and actions cover the full spectrum of harm, including low to medium problem gambling.	
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 and signs of harmful gambling and what to do to mitigate these risks and obtain help.	
Identify ways to provide effective support to people who are seeking to independently moderate or manage their gambling behaviour (or the behaviour of their families/whānau) in some way and provide that support.	
Continue to enhance the links between gambling harm services and other social and health services to ensure that services work together to support people experiencing gambling harm and their families/whānau. This will include trialling collective impact and collaborative approaches.	
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 and pilot 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.

Underlying principles: people-powered/mā te iwi hei kawē

The health system plays an important role in health literacy – providing people with the information they need to fully understand issues to do with health and wellness, including how to be healthy, access health services and manage their own health care.

To improve health literacy, service providers need to work in partnership with service users, supporting and encouraging them to be ‘health smart’.

Objective 6: A skilled workforce is developed to deliver effective services

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

The Ministry has worked with the gambling harm sector to identify the core competencies (including cultural competencies) required for the public health workforce. The focus for the draft strategic plan is to increase uptake of a training programme to ensure that all the workforce can demonstrate those core competencies by 2019 and will have achieved, or be on a pathway to achieving, appropriate NZQA level seven qualifications. The Ministry is currently reviewing *Te Uru Kahikatea: The Public Health Workforce Development Plan* (Ministry of Health 2007). It will ensure that the strategic plan takes into account any changes resulting from that review.

For the intervention workforce, the Ministry will prioritise new service models that address cultural barriers, such as the use of service co-design with community stakeholders, incorporating cultural models, and focus on training to ensure that all practitioners demonstrate the gambling harm competencies under the Addiction Intervention Competency Framework (DAPAANZ 2011).

The Ministry's expectation is that all intervention practitioners 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
- registered or endorsed by the Addiction Practitioners' Association Aotearoa New Zealand (DAPAANZ) as having demonstrated the relevant specific competencies, or
- equivalently registered with another relevant professional organisation (eg, a counsellor registered with the New Zealand Association of Counsellors).

The Ministry aims to increase the diversity of the workforce by introducing peer support in the short to medium term. While it will encourage the development of the peer support workforce, the peer support workers will not be subject to the same requirements listed above.

Table 6: Objective 6 priorities for action

Objective 6: A skilled workforce is developed to deliver effective services	
Priorities for action	
Short- to medium-term priorities	Long-term priorities
Continue and increase uptake of training 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 all staff demonstrate the required competencies and have relevant qualifications, registration or endorsement.
Support the introduction and training for peer support, other allied health workers kaiāwhina support.	
Work with workforce training providers and the DIA to ensure cultural competence training materials are appropriate to clients most likely to be affected by gambling harm.	

Underlying principles: one team/kotahi te tīma

Our workforce needs the capacity and capability to meet New Zealand's current and future needs. This means developing and strengthening people's capability and skills; in particular, the capability of smaller community-based non-governmental organisation (NGO) providers. It involves developing both people and infrastructure to enable people to work to their full potential and deliver efficient and effective gambling harm reduction services.

Objective 7: Services enhance people's mana and build life skills and resiliency to improve healthy choices

This objective recognises that Government, the gambling sector, communities, families/whānau and individuals must understand and be able to address the range of gambling harms that can affect individuals, families/whānau and communities.

Service development will reflect the principle of manaakitanga (acting in a mana-enhancing way). People entering into treatment services often have a diminished sense of mana, and may feel services do not treat them as part of the solution but as a problem. Services that demonstrate a shared culture of manaakitanga will benefit people, and groups by:

- recognising and accepting people's worldviews and situations
- informing people and developing programmes about mana
- ensuring interactions uplift, uphold and enhance the mana of people and relationships.

The Ministry intends that Māori-informed values and principles will be guidelines for thinking and acting in ways that will benefit others, and thereby confer benefits upon individuals, groups and communities.¹⁴

A key aspect of the Ministry's public health activity has been raising awareness of the signs of harmful gambling. The Ministry will continue to fund a multi-media drive to raise awareness, de-stigmatise harmful gambling and encourage people to seek help. Highlighting the actions expected and required of gambling venues as responsible hosts will also be a key focus.

The Ministry will continue to focus on increasing buy-in from the wider government sector at a central level, to better address the wider issues associated with gambling harm. It will also continue to work closely with other government agencies. There is still considerable scope for wider screening of individuals and populations at risk of gambling harm, through work with other agencies.

¹⁴ As an example, Te Rau Matatini provides a practitioner resource for mana enhancing in the area of substance addiction: Te Rau Matatini. Mana Enhancing & Mana Protecting Practice. URL: <http://teraumatatini.com/news/mana-enhancing-mana-protecting-practice> (accessed 17 November 2018).

Table 7: Objective 7 priorities for action

Objective 7: Services enhance people's mana and build life skills and resiliency to improve healthy choices	
Priorities for action	
Short- to medium-term priorities	Long-term priorities
Identify, monitor and provide information and education on the impacts of gambling, including the signs and range of harmful gambling that affect individuals, families/whānau and communities, and how to respond.	
Introduce service co-design and consumer networks to inform and evaluate activities to enhance mana and build resiliency.	
Support communities to incorporate a robust understanding of gambling harm into community social initiatives and public service delivery.	
Together with the Health Promotion Agency (HPA) and the DIA, support gambling operators and gambling venue operators to incorporate a robust understanding of gambling harm into their operations and activities, to improve their ability to recognise and respond to indicators of gambling harm.	
Pilot initiatives that enhance people's mana and build life skills and resiliency to improve healthy choices.	

Underlying principles: one team/kotahi te tīma

The Ministry is working to build a more cohesive, integrated and collaborative approach across the health and disability system, towards shared goals and beyond organisational boundaries, to proactively help people and populations in need.

Building on the experience in the addictions sector in particular (addressing harms from alcohol, tobacco and drugs), the Ministry will encourage appropriate collaborative partnerships among services providers and related stakeholders; for example, by promoting co-design and including consumer networks.

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 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. It intends to focus on greater use of technology to monitor and manage gambling environments and gambling behaviours over the course of this strategic plan, and has set aside resources to pilot new and innovative uses of technology that may include:

- technology-based support for people at risk of or affected by harmful gambling, such as online self-help and support services
- tools to support gamblers and host venues to monitor for signs of harmful gambling and enable gamblers to set limits on their gambling activity
- facial recognition tools to promote venue exclusion policies and/or related administrative efficiency.

Gambling venues are one of the best environments in which to observe, identify and intervene in potentially harmful gambling. The Ministry, the DIA and the HPA are committed to working with operators to maximise venues' potential for offering safe gambling environments and detecting harmful gambling at an early stage. The Ministry will also support the DIA to judiciously and effectively use its regulatory tools to deal with operators or venues that do not meet legal requirements.

The location of EGMs in high-risk areas (most notably areas of high deprivation) is a long-standing area of concern. The Ministry will continue to support promoting awareness of safe gambling environments, to improve access to gambling harm prevention services in high-risk areas and to work with the DIA on its risk-based regulatory approach that guides where regulatory actions should be applied. A particular focus in the next levy period will be NCGM locations and guidance to local authorities and other regulators.

Host responsibility training will continue to be an important part of work under this objective. There will be a renewed emphasis on materials related to cultural competence, and how to effectively and appropriately engage with gamblers and their family/whānau from diverse cultural backgrounds.

Table 8: Objective 8 priorities for action

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 the DIA, gambling operators and gambling venue operators and communities to encourage safer gambling environments.	
In collaboration with the DIA and other stakeholders, promote innovative use of technology (eg, such as for facial recognition) to help monitor the gambling environment, to make gambling environments less harmful and to support gamblers at risk of or experiencing gambling harm.	
Support the DIA in the proportionate and effective use of its regulatory tools to prevent and minimise gambling harm, including a continued focus on harm prevention and minimisation in gambling venues; for example, through inspections and the DIA's Mystery Shopper campaign. ¹⁵	
Encourage consumer and service involvement in monitoring gambling operators' and gambling venue operators' compliance with their harm prevention and minimisation responsibilities.	
Encourage the DIA and HPA to engage with the consumer network and service providers to develop and evaluate host responsibility training; particularly training in culturally appropriate ways to engage with gambling patrons and to recognise when this is required.	
Continue to work with the DIA and HPA to encourage and support regional gambling harm service providers to work with venues in their area and to educate and support their harm minimisation practices.	
Ensure training or train-the-trainer materials include appropriate cultural competence and cultural awareness materials, to enable staff to intervene in a culturally appropriate manner	
Support the HPA and the DIA to embed work with class 4 gambling operators to identify potentially harmful gambling behaviour and take effective action to prevent and minimise harm.	Develop and refine guidelines/train-the-trainers training to promote host responsibility in other gambling environments (including online environments) so operators can identify potentially harmful gambling behaviour and take effective action to prevent and minimise gambling harm and create safer gambling environments.

Underlying principles: closer to home/ka aro mai kit e kāinga

Good health begins at home and in communities, so it makes sense to promote the development and implementation of regulatory and policy settings that create safer gambling environments, particularly for people and communities at greater risk of moderate to high levels of gambling harm. This involves enabling systemic changes to innovate and deliver more effective services that will minimise and prevent gambling harm occurring, to keep people and communities well and to reduce the level of gambling harm people experience.

¹⁵ https://www.dia.govt.nz/diawebsite.nsf/wpg_URL/Services-Casino-and-Non-Casino-Gaming-Mystery-Shopper-campaign URL accessed 19 November 2018

Objective 9: Services raise awareness about the range and signs of gambling harms that affect individuals, families/whānau and communities

Families/whānau of problem gamblers can be badly affected by gambling harm. The Ministry therefore places great importance on improving health literacy, to drive behavioural change by helping families/whānau to recognise and address issues associated with gambling harm and to apply appropriate self-help or help-seeking behaviours.

The Ministry will continue to work with the HPA and other relevant organisations to target at-risk and vulnerable communities to increase awareness, reduce gambling harm and encourage associated positive behaviours. These are typically communities with a high social deprivation score, who are at increased risk because of increased access to NCGMs and vulnerable because they lack access to resources that would help improve their resiliency. The Ministry of Health will use evaluation activities, the consumer network and results-based accountability reporting to ensure that all organisations are working in the right way, with the right people.

The Ministry expects the services it funds to have a robust health equity, cultural competency and health literacy focus, as well as input from consumer networks once established. It also expects service providers to build relationships with other relevant organisations and communities in the areas in which they operate. This is one way of sharing relevant information and increasing the overall awareness of gambling harm and indicators of potentially harmful gambling.

Submissions noted that services needed to better address the cultural and language differences of their target audiences. The Ministry expects that the proposed co-design approach and use of consumer networks will give consumers from vulnerable communities a stronger voice in the design and evaluation of services.

Table 9: Objective 9 priorities for action

Objective 9: Services raise awareness about the range and signs of gambling harms that affect individuals, families/whānau and communities	
Priorities for action	
Short- to medium-term priorities	Long-term priorities
Target promotional activities to reduce gambling harm and increase awareness of the range and signs of gambling harms at high-risk communities.	
Work to increase access to services among people experiencing gambling harm and their families/whānau, including in rural areas.	
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 gambling harm as part of general health screening and day-to-day delivery.	

Underlying principles: people-powered/mā te iwi hei kawē

The health system plays an important role in providing people with the information they need to fully understand issues around health and wellness, including how to be healthy, access health services and manage their own health (health literacy). To improve health literacy, services need to work in partnership with service users, supporting and encouraging them to be 'health smart' and to mitigate language and cultural barriers to accessing information.

In this partnership between providers and users, different groups of people will need different forms of support, depending on factors such as age; ethnicity; different worldviews, expectations and religious beliefs; location; and existing conditions or disabilities.

Gambling harm can be associated with mental illness, other addictions and substance abuse, family violence and a range of other social issues. Enhancing awareness of the signs of harmful gambling, and opportunities for screening, among services that address these other health and social issues will help enhance the accessibility of services to prevent and minimise gambling harm.

Objective 10: People access effective treatment and support services at the right time and place

Provision of high-quality, effective and accessible services to prevent and minimise gambling harm requires staff who are appropriately qualified and services that are culturally relevant to the communities they serve. Access to intervention services should be available in all areas where there is access to gambling venues.

Continuing to provide dedicated Māori, Pacific and Asian services is crucial to help reduce gambling-harm-related inequity and inequality. The Ministry will increase the emphasis on including consumer perspectives in service design and delivery (informed by research and evaluation). It will also explore culture-specific delivery models (where cost-effective) with consumer networks and service providers.

While it is not financially feasible to provide face-to-face services in every location where gambling occurs, the Ministry will explore ways to provide more limited support, such as through online and telephone support and satellite clinics. New Zealand has a large rural population that does not always receive the level of service it requires. Also, many rural areas have a comparatively high Māori population. To address discrepancies, the Ministry will work with intervention and public health service providers to ensure equity of access, both for rural populations and for Māori and other vulnerable groups.

The Ministry will look to enhance the accessibility and availability of telephone-based services, such as the toll-free helpline offering referrals to face-to-face services and other intervention services, for those who cannot access face-to-face services or prefer a helpline service. The Ministry will also explore technology-based options and work to increase the range of self-help online tools available, to further support hard-to-reach populations.

The Ministry is committed to 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: Objective 10 priorities for action

Objective 10: People access effective treatment and support services at the right time and place	
Priorities for action	
Short- to medium-term priorities	Long-term priorities
Ensure that problem gamblers and their family/whānau have access to a range of client-centred culturally appropriate and responsive services, including by introducing peer support.	
Broaden the range of organisations and community groups screening for gambling harm, by supporting intervention providers to use standardised gambling screens.	
Continue to identify and validate best-practice interventions and alignments that address the range of gambling harms that affect individuals, families/whānau and communities.	
Increase consumer input into the design and evaluation of services.	
Develop and enhance accessible and culturally responsive online tools, including self-help tools, to help prevent and minimise gambling harm, for example to ensure that language is not a barrier for Asian and Pacific people, including new migrants and international students.	

Underlying principles: value and high performance/te whāinga hua me te tika o ngā mahi

Making services more accessible and culturally appropriate will improve health service use by at-risk groups and those experiencing gambling harm. Research suggests that improving the health service experience for Māori also tends to improve service experience for other population groups.

A greater community focus, delivering service interventions closer to groups at risk, is likely to improve service use. Typically those who find health services hard to access describe difficulties including time and transport issues, unresponsiveness, and discord with their worldviews where such views are different from the 'mainstream'.

Objective 11: A programme of research and evaluation establishes an evidence base that underpins all activities

The Ministry's research programme addresses the requirements of the Act for 'independent scientific research associated with gambling' and for 'evaluation'. It fulfils both short- and long-term strategic research priorities, and includes longitudinal studies.

The Ministry will increase its emphasis on evaluation and action research to determine what works best. This will include assessments of service design, delivery and outcomes (in terms of both public health and clinical services). This work will incorporate a consumer experience perspective and evaluation of pilots. This research and evaluation will inform best practice and future service options for both intervention and public health services.

Priority areas include research or evaluation of new pilots and a number of current activities to assess:

- their impact on health inequities, to better understand persistent and relapse gambling behaviour and
- the use of specific technology solutions to monitor and limit exposure to harmful gambling.

Research will also focus more on current issues, such as the impact of online gambling and gaming convergence, and, potentially, the impact of local authorities' policies on NCGM location and gambling harm.

Table 11: Objective 11 priorities for action

Objective 11: A programme of research and evaluation establishes an evidence base that underpins all activities	
Priorities for action	
Short- to medium-term priorities	Long-term priorities
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.	
Ensure that research and evaluation projects funded by the Ministry contribute to strategic outcomes, including supporting opportunities for innovation and enhancing the quality, responsiveness, effectiveness and value for money of services to prevent and minimise gambling harm.	
Ensure that all pilots are evaluated.	
Increase the evidence on why vulnerable groups, particularly Māori and Pacific and Asian peoples, continue to experience gambling harm-related inequities, and on effective ways to reduce those inequities.	Develop and pilot initiatives specifically focused on: <ul style="list-style-type: none"> • reducing gambling harm-related inequities among Māori, Pacific peoples, Asian peoples and other vulnerable groups • addressing persistent and relapse gambling • improving vulnerable groups' access to services.

Underlying principles: smart system/he atamai te whakaraupapa

Research should reflect the different linguistic and cultural contexts that provide different ways of understanding gambling and its effects. Results should be communicated in a variety of ways that are appropriate for and understood by the intended audience.

The Ministry will fund gambling harm minimisation research and evaluation that:

- researchers undertake with integrity, independence and accountability
- uses appropriate methods for the research or evaluation question and resources available
- is delivered in a timely manner to inform policy and operational decision-making and public debate
- is commissioned with transparency, follows best research management practices and complies with the government policy direction about the ownership and use of research deliverables funded by government
- represents value for money
- encourages collaborative design and consumer input.

3.4 Aligning the strategy with He Korowai Oranga

He Korowai Oranga is New Zealand's Māori Health Strategy. It is a 'living document' that was most recently updated in 2014. Figure 5 below summarises the strategy.

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 draft strategic plan with He Korowai Oranga, in acknowledgement of the fact that the Strategy to Prevent and Minimise Gambling Harm contributes to Pae Ora.

Figure 5: Summary of He Korowai Oranga

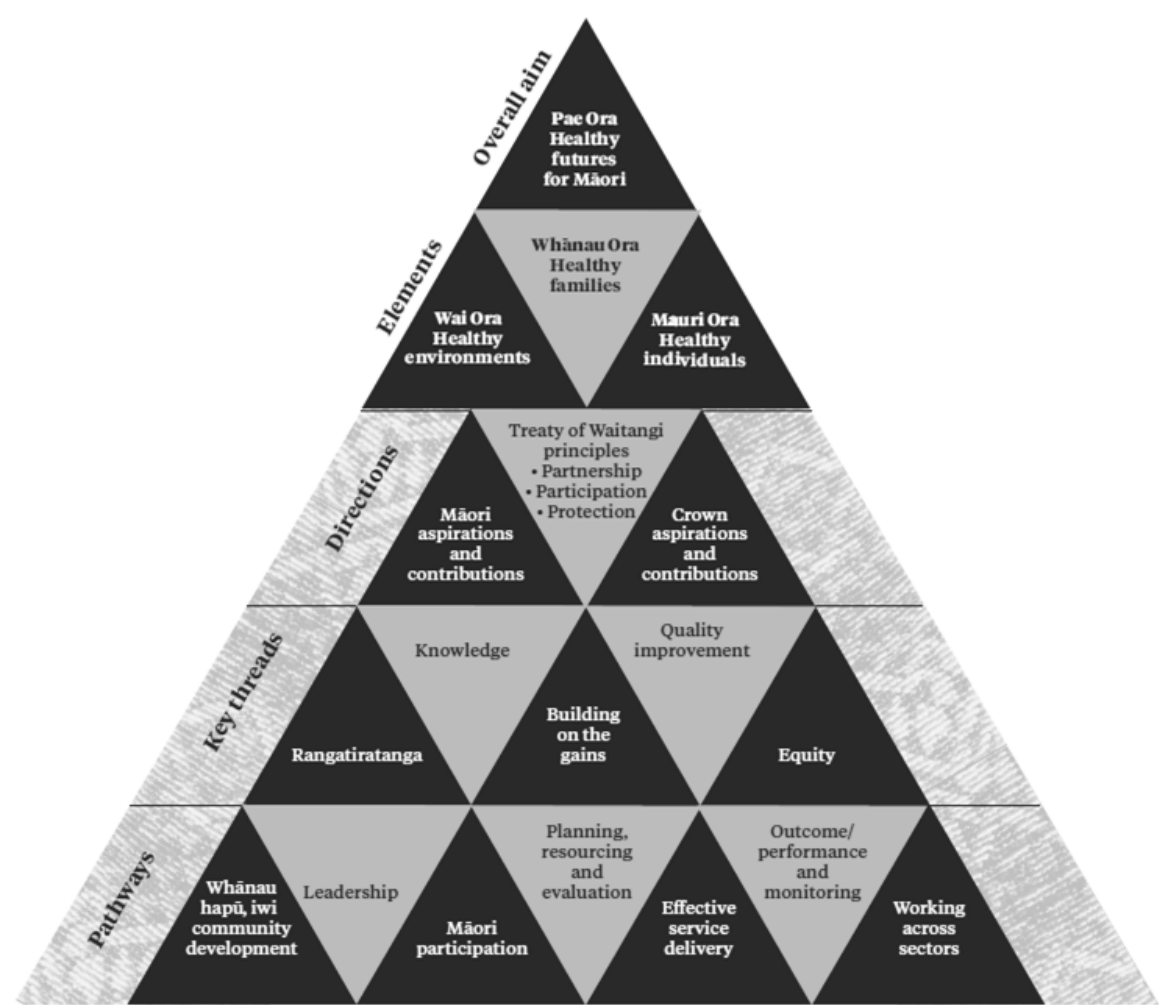


Table 12: Aligning the strategy with He Korowai Oranga

He Korowai Oranga	Examples of the strategy's alignment
Overall aim	
Pae ora	Principles underpinning the strategy – a focus on improving Māori health Objective 2 – a specific Pae Ora objective
Elements	
Wai ora	Principles underpinning the strategy – public health services based on the Ottawa Charter for Health Promotion 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)
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
Mauri ora	Public health service specification purchase unit 5 (effective screening environments) Free intervention services for individuals harmed by their own or someone else's gambling Intervention service specification purchase units: <ul style="list-style-type: none"> • 1 – helpline and information service • 2 – helpline and information service – brief interventions • 3 – full interventions • 4 – facilitation of access to other relevant services • 5 – follow-up
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

He Korowai Oranga	Examples of the strategy's alignment
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 gains 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 <i>Equity of Health Care for Māori: A framework</i> (Ministry of Health 2014b) 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, hapū, 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
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)

He Korowai Oranga	Examples of the strategy's alignment
Core components	
Principles of Te Tiriti o Waitangi	<p>Partnership – Māori representation on key forums and bodies</p> <p>Participation – dedicated Māori services using Māori-derived beliefs, values and practices</p> <p>Protection – objective 2: priority actions related to health equity for Māori</p>
Knowledge	<p>Gambling Act 2003 requirement for independent, scientific research</p> <p>Objective 11</p> <p>A national coordination service and service provider hui to share best-practice examples and stories of innovation</p> <p>The Ministry's Client Information Collection (CLIC) database – includes accurate ethnicity information</p> <p>Funding for provider-initiated research projects that address issues of equity for Māori</p> <p>Funding for research scholarships for Māori researchers</p>
Quality improvement	<p>Infrastructure intervention and public health service specification purchase unit 2 (workforce development)</p> <p>Overall goal of the strategy, principles underpinning the strategy and objective 1</p> <p>The Act's requirements for a specified consultation process to develop the strategy and the problem gambling levy rates to ensure best value for resources</p>
Leadership	<p>Māori representation on key forums and bodies</p> <p>Health system leadership – an expectation that all New Zealanders will have health equity</p> <p>Infrastructure intervention and public health service specification purchase unit 2 (workforce development)</p>
Planning resourcing and evaluation	<p>The Act's requirements for the process to develop the strategy – a consultative process for planning and resourcing</p> <p>The Act's requirement for evaluation</p> <p>Research and audit projects evaluating intervention and public health services, which assess effectiveness and responsiveness for Māori</p>
Outcome/performance and monitoring	<p>Outcomes framework baseline and update reports, which specifically address outcomes for Māori</p>

3.5 Aligning the strategy with 'Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014–2018

'Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014–2018 is the government's plan for improving health outcomes for Pacific peoples (Ministry of Health 2014a). The long-term vision of 'Ala Mo'ui is that: 'Pacific 'āiga, kāiga, magafaoa, kōpū tangata, vuvale and fāмили experience equitable health outcomes and lead independent lives' (page 1). Figure 6 summarises the 2014 (most recent) version of 'Ala Mo'ui.

The Ministry has aligned the draft 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 6: Summary of 'Ala Mo'ui

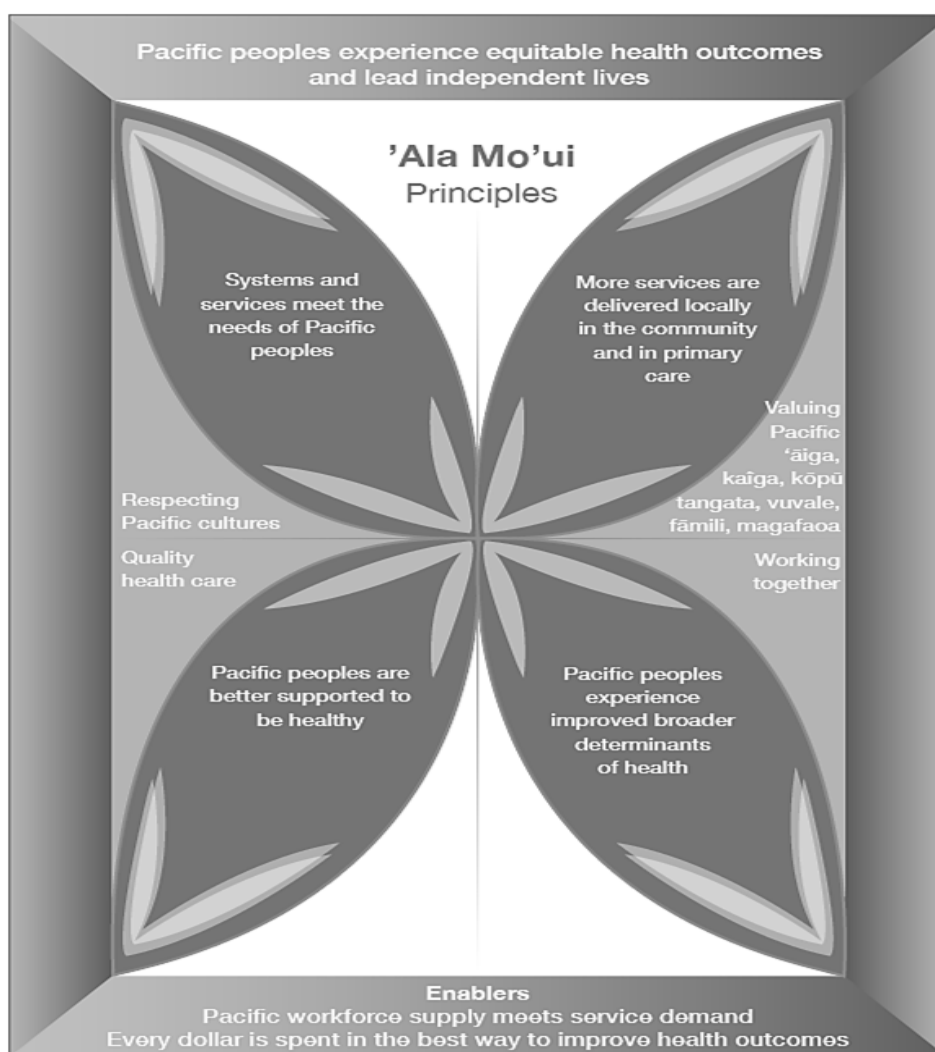


Table 13: Aligning the strategy with 'Ala Mo'ui

'Ala Mo'ui	Examples of the strategy's alignment
Overall aim	
Health equity for all Pacific peoples	<p>Overall goal of the strategy – entails a reduction in health inequities related to gambling harm</p> <p>Principles underpinning the strategy – reduce health inequities</p> <p>Objective 1 – a specific health equity objective</p> <p>Planning and prioritisation processes – mapping need based on population-specific prevalence and access rates</p>
Pacific principles	
Respecting Pacific culture	<p>Objectives 5 and 7 and public health service specification purchase unit 4 (aware communities)</p> <p>Public health service specification purchase unit 3 (supportive communities)</p> <p>Requirements for general services – meeting cultural needs of service users and supporting them to access dedicated Pacific services where available</p>
Valuing Pacific 'āiga, kāiga, magafaoa, kōpū tangata, vuvale and fāмили	<p>Objectives 5 and 7 and public health service specification purchase unit 4 (aware communities)</p> <p>Public health service specification purchase unit 3 (supportive communities)</p> <p>Free intervention services for families</p>
Quality health care	<p>Free intervention services for individuals and families</p> <p>Overall goal of the strategy, principles underpinning the strategy and objective 1</p> <p>Dedicated Pacific services and requirements for general services – meeting cultural needs of service users and supporting them to access dedicated Pacific services where available</p> <p>Infrastructure intervention and public health service specification purchase unit 2 (workforce development)</p> <p>The Act's requirements for research and evaluation – research and audit projects evaluating intervention and public health services</p>
Working together – integration	<p>Principles underpinning the strategy – intersectoral approach</p> <p>Objectives 4 and 5 and associated priority actions</p> <p>Public health service specification purchase units 1 (policy development and implementation), 2 (safe gambling environments) and 5 (effective screening environments)</p> <p>Intervention service specification purchase unit 4 (facilitation services)</p>
Enablers of outcomes	
Pacific workforce supply meets demand	<p>Dedicated Pacific services based in a Pacific cultural paradigm and using Pacific-derived beliefs, values and practices</p> <p>Planning and prioritisation processes – mapping need based on population-specific prevalence and access rates</p> <p>Infrastructure intervention and public health service specification purchase unit 2 (workforce development)</p>

'Ala Mo'ui	Examples of the strategy's alignment
Every dollar is spent in the best way to improve health outcomes	<p>The Act's requirements for a specified consultation process to develop the strategy and the problem gambling levy rates to ensure best value for resources</p> <p>The Act's requirements for research and evaluation – research and audit projects evaluating intervention and public health services</p>
Priority outcomes	
Systems and services meet the needs of Pacific peoples	<p>Dedicated Pacific services based in a Pacific cultural paradigm and using Pacific-derived beliefs, values and practices</p> <p>Requirements for general services – meeting cultural needs of service users and supporting them to access dedicated Pacific services where available</p>
More services are 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

4 Draft three-year service plan 2019/20–2021/22

4.1 Background

This section provides background and further context to inform development of the draft service plan, covering:

- a summary of developments in the service environment over the previous service plan period
- brief comments on service delivery points to note from the previous service plan
- key factors contributing to the design of the proposed new service plan.

4.1.1 Developments in the service environment 2016/17 to 2018/19

There were a number of significant developments in the service environment over the 2016/17 to 2018/19 period, including the following:

- Service providers made public health presentations to hundreds of organisations, and conducted hundreds of workshops on reducing gambling harm and related risks.
- There was growth in venue development and the implementation of host responsibility policies and practices, and related staff awareness of gambling harm minimisation.
- Many workplaces have implemented gambling harm reduction policies (eg, no gambling while at work, no gambling on workplace technologies).
- Officials reviewed the multi-venue exclusion (MVE) processes, leading to a pilot of a national standardised process.
- Twenty-five percent of local authorities had sinking lid policies in place for NCGMs. (While the numbers of NCGM venues and machines have decreased, the average spending on NCGM has increased.)
- The Ministry introduced group therapy into service contracts, recognising the value of this form of treatment.
- Analysis of Pacific peoples' gambling behaviours, using the Pacific Island Families Study, identified particular areas of risk for mothers and children.

- The Ministry negotiated and implemented service outcome agreements, incorporating results-based accountability measures from 1 January 2018.
- The Ministry prepared the Gambling Outcomes Monitoring Report 2007–2017 (in publication), which reviewed progress towards gambling harm outcomes since 2010.

4.1.2 Service delivery in 2016/17 to 2018/19

This section discusses service delivery during the 2016/17 to 2018/19 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

Effective health promotion is central to the Ministry's national public health activity. In the context of gambling, the Ministry's public health promotion aims are to raise awareness of the signs of harmful gambling and encourage more at-risk people to check whether their gambling is OK before harm escalates in severity, and to motivate those who are at risk to get help earlier (or change their behaviour through self-help).

The HPA's health promotion programme focuses on encouraging positive behaviour change among at-risk gamblers and raising awareness about the signs of harmful gambling and risky gambling behaviours. Health Promotion Agency-led developments have included enhancing national awareness-raising campaigns, developing and implementing host responsibility policies and practices, and increasing staff knowledge of gambling harm minimisation. Over 2016/17–2018, the HPA continued to promote the Gambling Helpline, Choice Not Chance¹⁶ and face-to-face support services.

National and regional service providers delivered a variety of health promotion activities to minimise gambling-related harm in communities, including advocating and supporting hundreds of organisations and workplaces to adopt reducing gambling harm policies, run workshops and presentations on recognising gambling harm and learn how to support someone who wants help to stop gambling, and thousands of awareness-raising activities in communities. A regionally led campaign to 'Turn Off The Pokies' was well supported by class 4 venues. Many service providers also provided a community perspective into the reviews of local gambling venue policies undertaken by territorial authorities. Currently about 25 percent of local authorities have either gaming machine caps or sinking-lid policies in their areas.

In line with the objectives of the strategy, the Ministry funded dedicated Māori, Pacific and Asian public health services to provide appropriate and relevant services within their communities.

¹⁶ www.choicenotchance.org.nz/the-latest-campaign

The national Multi Venue Exclusion Advisory Group led a review of multi-venue exclusion (MVE) processes for gamblers who want to be stopped from entering gambling venues. As a result of the review, a pilot national standardised process for supporting this process is under way.

Intervention

In the 2017/18 year, over 5,400 people sought help from Ministry-funded services, for problems due to their own or someone else's gambling. Most of these people were in crisis. If brief interventions in non-clinical settings are included in this analysis, the total increases to more than 10,500 people.

In the three years 2015/2016 to 2017/2018, there was a slight decrease in the total numbers of reported interventions. The decline over the period is attributable to fewer new clients coming forward. The numbers of existing clients receiving interventions has been relatively static over the period. Going further back, the number of people seeking interventions has been relatively stable for five to seven years. Similarly, the proportion of people reporting some form of harmful gambling behaviours in the HLS surveys remained static, at 5 percent of the population, between 2012 and 2016.

Importantly, these static rates belie the fact that the actual number of people affected by harmful gambling is increasing in line with population growth, and intervention services growth is flat.

Similarly, needs assessment and outcomes monitoring reports show that only 16 percent of potential clients for gambling support services (that is, people whose reported harm results in a moderate to high PSGI score) actually access or present at these services. This low service use is also evident for other forms of addiction.

Improving intervention and service utilisations rates remains a challenge. It will require further work to address systemic or persistent barriers to access and inequities based on ethnicity or socioeconomic factors.

Accessibility for Māori, Pacific and other vulnerable groups

Analysis of Ministry gambling service administrative data for 2017/18 and 2016/17 shows that the number of gamblers seeking treatment continues to decline, despite the increase in real numbers of people experiencing gambling harm. Table 14 shows the composition of gamblers who sought treatment.

Table 14: Composition of people seeking treatment for gambling-related harm, 2016/17–2017/18

Year	2016/17	2017/18
Total seeking treatment	6,300	5,400
Percent identifying as European/other	38.1	39.3
Percent identifying as Māori	33.0	31.0
Percent identifying as Pacific	21.2	21.2
Percent identifying as East-Asian	7.7	8.5
Percent who were male	53.1	56.1

From the review of outcomes and research noted earlier, the following is evident.

- The number of Māori accessing intervention services has remained relatively high (in line with the relatively high vulnerability of Māori to gambling harm) since 2008.
- Māori are accessing services at a rate roughly equivalent to their proportion of reported risky gambling behaviour and harm.
- The number of Pacific people accessing intervention services has increased substantially since 2012, so that the figure now more closely reflects the relatively high vulnerability of Pacific people to gambling harm.
- The number of Asian people and those under 25 years of age reporting service use is lower than one might expect based on research estimates.

Submissions on the strategy indicated that cultural and linguistic barriers to accessing public health and intervention services persist.

Research and evaluation

In the 2016/17 to 2017/18 period, work in research and evaluation included:

- completing the fourth data collection wave and associated report for the NGS, which comprises a longitudinal cohort study of gambling participation and harm
- the biennial gambling module in the HLS (additional meta-analysis comprising analysis of pooled data, change over time and evidence for inequalities in gambling harm has been commissioned and reported)
- the University of Auckland's development and trial of a smartphone-based app that provides timely messages to at-risk gamblers who have sought help (the SPAGeTTI Trial)
- clinical evaluation by AUT of a range of interventions
- the Central Queensland University Australia and AUT study on the Burden of Gambling Harm, which used the disability-adjusted life year measure to understand the level of harm associated with gambling in the population (this approach is novel to the gambling research field, and provides an alternative measure of harm compared with the limited and more clinically orientated measure in the PGSI scale)
- Commissioning research from the Pacific Island Families Study, to study exposure to gambling among Pacific Island youth aged under 17 years.

Other significant evaluations that have commenced in the last 12 months include:

- AUT and the Problem Gambling Foundation of New Zealand (PGF)'s evaluation of the Partners for Change Outcome Management System
- Malatest International's evaluation of the Sorted Whānau financial literacy intervention with Māori and Pacific at-risk population groups
- Malatest International's evaluation of the efficacy of the Hawke's Bay MVE process for Māori and Pacific 'excludes' and their affected others.

4.1.3 Factors considered for 2019/20 to 2021/22

This section discusses a number of factors that the Ministry considered when developing the draft service plan for 2019/20 to 2021/22. Some of these factors suggest a changing environment and some uncertainty 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 Act and the Ministry's service standards and strategic requirements.

The New Zealand Health Strategy

The Ministry led the development of the New Zealand Health Strategy: Future Direction, which sets out a vision of the future for the health sector in the 10 years from 2016 to 2026 and five strategic themes for the changes that will take the health system towards this future. These five strategic themes have been explicitly linked to each of the 11 strategic objectives and priority actions described in Section 3.3.

Ongoing gambling-harm-related inequities

The number of people presenting for gambling support and treatment is consistently lower than the numbers predicted from gambling surveys that identify the population likely to be experiencing moderate to severe harm. Moreover, this number has not increased in line with population growth. Services appear to be reaching fewer people in need. This discrepancy suggests a need to reconsider the accessibility and effectiveness of current activities.

There is 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 other ethnic groups. The HLS 2016 shows that inequities remain. Ethnic and other disparities in the burden of harm have persisted since the first gambling survey was conducted in 1991. Reducing these health inequities will continue to be a focus in the 2019/20–2021/22 period.

Submissions to the draft strategy featured strong calls from health and service providers, particularly those identifying with Māori, Pacific and Asian communities:

- to address health inequalities and linguistic and cultural barriers to accessing information and support
- to support youth and young adults

- to better address the needs of vulnerable groups
- for greater input into the design and delivery of public health activities.

The Ministry has outlined a series of actions in the proposed service plan, including actions to address inequalities; develop pilots and evaluate new service models; and make greater use of technology, consumer networks and co-design to address culture and language barriers and improve service uptake. In addition, the Ministry proposes to reorient its strategic reporting to develop more timely and accessible data for the next strategy period, to better inform the prevalence of gambling activities and harm in New Zealand, as well as obtain better information as a result of the actions set out in the draft strategy.

Alignment with other health and social services

Rates of harmful drinking, tobacco use, other drug use and psychological distress tend to be much higher among people experiencing problem gambling (a high risk of gambling harm), and, to a lesser extent, among moderate- and low-risk gamblers, than they are among the general population. Those living in areas with a higher social deprivation score are also more likely to experience gambling harm.

The service plan will continue to promote actions that better align services that prevent and minimise gambling harm with other health and social services in the 2019/20–2021/22 period. Where gamblers experience significant comorbidities, we will also explore options for developing more holistic packages of care.

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 implemented outcomes-focused agreements incorporating these principles for its preventing and minimising gambling harm contracts in January 2018, and expects to refine these based on learning from audit, evaluation and research in the 2019/20–2021/22 period.

Changes in gambling participation and expenditure

While the overall gambling participation rates as a percentage of the population have been static over the past five years or so, the total numbers of 'at-risk' gamblers in the population have increased in line with population growth.

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, although the causes of harmful gambling behaviour are complex.

The overall amount gamblers spent on the four main form of gambling in New Zealand has increased each year since 2010/11, most recently from \$2.209 billion in the 2015/16 financial year to \$2.334 billion in 2016/17. Adjusting for the effects of inflation and changes to the New Zealand population (aged 18 years and over), this was an overall increase of 1.1 percent over the six-year time period.

Section 5.4 outlines changes in expenditure on each of the main forms of gambling.

Online gambling and gaming convergence

Health provider and service provider submissions on the draft strategy observed that there appears to be an increased prevalence of and risks associated with online gambling and gaming convergence, particularly for youth and young adults. This has implications for public health.

During the 2019/20–2021/22 period, the Ministry will research current online gambling behaviour and convergence risks and the implications for child wellbeing, for example this may result in specific public health support based on this research. It will also assess the need for further controls, with the DIA as the regulatory authority.

Technology-based and other innovative interventions

There was broad support in submissions to increase funding for technology to manage gambling harm. In previous years, the Ministry commissioned a feasibility study on a smartphone application to prevent and minimise gambling harm. In 2016/17–2018/19 it conducted a clinical trial of the app (the SPAGeTTI Trial). The Ministry has also funded a national MVE administration service, part of the remit of which is to manage a secure database for all MVEs.

During the 2019/20–2021/22 period, the Ministry will develop a technology innovation fund to pilot technology-based interventions and implement them, where pilot projects show that such interventions are cost-effective. Industry support has grown for facial recognition software to be incorporated into MVE processes within NCGM venues. The Ministry will continue its planned 2018/19 trial of a MVE database to evaluate its effectiveness.

Legislative changes

There have been no recent amendments to the Act, and none are confirmed for the 2019/20–2021/22 period.

Operating costs

Service provider submissions on the draft service plan noted that there was no allowance for general increases in operating costs or the impact of pay equity decisions, and that there has been no adjustment to contracts or Ministry expenses for several levy periods.

The Ministry does not propose to provide a cost adjustment, because there will be opportunities to look at the costs of delivering specific services as the Ministry runs its request-for-proposals (RFP) processes for new contracts (including pilots).

The Ministry's focus is on funding outcomes and results. The proposed increase in evaluations will enable most services to be reviewed, and together with the new pilot trials will give a better indication of where the Ministry should target resources to address gambling harm.

4.2 Proposed service plan and funding for 2019/20 to 2021/22

Change in focus

The 2018 Gambling Harm Reduction Needs Assessment, submissions on the 2018 strategy consultation document, insights from the HLS 2016, the NGS 2018 and the 2018 Gambling Outcomes Monitoring Report (in publication) have all informed the development of the proposed service plan set out below.

The main changes in the service plan are to:

- expand the service mix to more closely match those available in the wider addiction and mental health sector (eg, peer support, residential care, consumer networks)
- foster co-design and establish a consumer (lived-in experience) network to inform services
- make greater use of pilot, evaluation and action research to inform service development.

The Ministry intends to use pilots to develop or trial new service models, particularly to address:

- gaps in current service provision – public health, psychosocial and intervention services
- areas of systemic, persistent gambling harm, health inequities and gambling relapse
- technology to manage and mitigate gambling harm
- recovery services that enhance the mana of service users and build their resilience.

In addition, the Ministry proposes to refocus the mix of services for 2018/19–2021/22 to:

- increase awareness and engagement by those at risk (eg, by introducing a greater focus on health literacy, service responsiveness and gambling host responsibility)
- explore new intervention initiatives, based on learning about what works from the evaluation and research

- include an emphasis on addressing long-standing inequities for Māori and other ethnicities, through both culturally specific services and 'mainstream' services
- maintain the emphasis on an outcomes- and results-based approach to services, with a focus on achieving value for money alongside optimal service coverage.

The Ministry will continue to:

- prioritise reducing gambling harm-related health inequalities and equities for vulnerable, at-risk populations; particularly Māori, Pacific and Asian communities
- encourage further workforce development with public health training (in core competencies and minimum qualifications) and intervention training (for DAPAANZ registration or equivalent)
- fund the gambling helpline service, through the integrated national telehealth service
- explore enhancing telephone support to Pacific and Asian communities with extended hours and interpreting support.

Enhanced process to develop service details

In response to significant interest from a range of stakeholders, the Ministry intends to follow an open process to develop, pilot, evaluate and implement the proposals in the strategy. This will begin with Ministry-led workshops to discuss the approach, scope and priorities for pilots, followed by an invitation for specific detailed proposals through a procurement process. Pilots may include both public health and intervention components, and the Ministry will evaluate them to inform future service provision.

Budget for 2019/20 to 2021/22

The draft service plan outlines the services that the Ministry considers it will require for the 2019/20–2021/22 period to make further progress towards the objectives in the strategy. It also sets out indicative budgets for preventing and minimising gambling harm, covering the four nominal budget areas, plus a line item for new services and innovation pilots:

- public health services
- intervention services
- research and evaluation
- new services and innovation pilots
- Ministry operating costs.

Table 15 shows the proposed budget for 2019/20–2021/22 (Table 26 in Section 5 shows overall funding requirements). The remaining sections discuss each of the line items in Table 15 in more detail.

The strategy proposes that the Ministry increase the total level of spending in the next three-year levy period to a total of \$60.339 million, comprising a \$55.339 million appropriation and \$5 million transferred from the current appropriation (being forecast underspent funding to 30 June 2019). The increase in total funding is proposed because:

- funding levels and appropriations have remained largely unchanged since 2008/09, but the number of people affected has steadily increased in line with population growth
- for the next levy period, the Ministry proposes to change the service focus and mix to address the matters and priorities noted above and also pilot new activities
- the pilots will enable innovative solutions to address areas of systemic, persistent gambling harm and vulnerable communities and to target the priority areas and vulnerable groups described above
- the funding will be used for the purposes for which it was appropriated
- the increase will enable the Ministry to maintain baseline services while piloting new interventions and service models and undertaking further evaluations to assess where to best direct current resources in the long term.

The Ministry will consider whether this increase in budget should be maintained in full or part in future years based on what it learns over the course of implementation. Should a number of pilots be evaluated as successful, the Ministry is likely to seek an increase in the level of its funding appropriation accordingly for the 2022/23–2025/26 levy period.

Table 15: Indicative budget to prevent and minimise gambling harm (GST exclusive), 2019/20–2021/22

Service area	2019/20 (\$m)	2020/21 (\$m)	2021/22 (\$m)	Total (\$m)
Public health services (harm prevention and minimisation)	6.870	6.790	6.870	20.530
Intervention services (to treat and help problem gamblers and their families/whānau)	8.433	8.405	8.405	25.243
Research and evaluation	2.060	2.219	2.350	6.629
New service and technology pilots	1.335	1.695	1.970	5.000
Ministry operating costs	0.957	0.99	0.99	2.937
Total (\$m)	19.655	20.099	20.585	60.339

4.3 Public health services

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

The overall budget proposed for public health services for the 2019/20–2021/22 period is largely unchanged from the previous funding period (see Table 16). However, the Ministry intends to explore the potential for different ways of delivering public health services (eg, using a community mobilisation approach) and funding contracts (the budget currently assumes the use of full-time equivalent employees (FTEs)). Section 4.6 describes additional funding for new pilots.

Indicative priority areas for 2019/20 to 2021/22 are as follows:

- reviewing and applying knowledge from successful local models of public health service delivery, including methods such as community mobilisation, and the wealth of health services research available, to provide smarter services that deliver improved health outcomes
- increasing screening as a key tool to promote awareness of the harm caused by gambling and to identify earlier harmful addictive behaviour patterns and appropriate forms of treatment
- future proofing our approaches; for example, assessing whether new screening tools are more appropriate for New Zealand's public health needs. This may include the short gambling harms scale, which has been suggested as a better way of measuring the harm caused by gambling than the PGSI (which would be maintained for monitoring purposes)
- improving the infrastructure that connects the gambling sector, to increase cohesion and collaboration; share best practices; boost coordination; increase transparency; support the whole gambling sector workforce, including venue staff; and share learning and data across the wider health sector – such as mental health and other addictions
- extending public health services to accommodate impacts on young people. This addresses the strong feedback within submissions that online gambling and gaming convergence, in particular, is having a harmful impact on young people. The Ministry will explore this impact with the Ministry of Youth Development and Oranga Tamariki, and related strategies such the Child and Youth Wellbeing Strategy will inform service delivery.

Table 16: Indicative public health budget (GST exclusive), by service area, 2019/20–2021/22

Service area	2019/20 (\$m)	2020/21 (\$m)	2021/22 (\$m)	Total (\$m)
Primary prevention (public health action)	4.700	4.700	4.700	14.100
Workforce development (public health)	0.180	0.180	0.180	0.540
Awareness and education programme	1.680	1.680	1.680	5.040
National coordination service	0.130	0.130	0.130	0.390
Consumer networks	0.100	0.100	0.100	0.300
Conference support	0.080	0.0	0.080	0.160
Total (\$m)	6.870	6.790	6.870	20.530

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

Primary prevention (public health action)

Primary prevention services cover 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 public health awareness and education programmes at a local and regional level.

The Ministry will continue to fund dedicated Māori, Pacific and Asian providers to offer primary prevention services and explore further ways to reach those most at risk of gambling harm.

The Ministry intends that service providers work across the five general domains listed below. However, it is clear that some behaviour change and innovation is required. The Ministry will undertake further advice and design work before it purchases services through a procurement process.

1. **Policy development and implementation:** The Ministry and service providers¹⁷ engage with other government agencies, social organisations and private industries and businesses to reduce gambling harm.
2. **Safe gambling environments:** Environments that provide gambling opportunities are encouraged to actively minimise harm, and individuals are supported to recognise and seek support to minimise gambling harm.
3. **Supportive communities:** People live in communities that provide strong protective factors and that support individuals' and family resilience.
4. **Aware and motivated communities:** Agencies, communities, families and individuals are aware of the signs and range of harmful gambling arising from gambling and how/where to seek support.
5. **Effective screening environments:** Individuals at risk of experiencing harm from gambling are identified as early as possible, and are made aware of where to access appropriate minimising gambling harm intervention services.

¹⁷ This engagement is a key expectation in the Ministry's contracts with service providers.

Based on its current experience and the needs assessment, the Ministry intends to maintain funding for existing services at broadly the same level as in the previous funding period. However, it intends to explore the potential for innovation within that overall budget, particularly taking a community mobilisation approach, and drawing on successful models across the wider health system.

Workforce development (public health)

In the 2013/14–2015/16 period, the Ministry's gambling harm public health workforce development provider identified the core competencies (including the cultural competencies) required for that workforce. In the most recent period, public health core competency assessment tools were developed to enable the public health workforce to assess their competency levels and associated training and development needs.

The focus in the 2019/20–2021/22 period will be increasing uptake of a training programme to help the workforce identify and achieve appropriate formal qualifications.

Submissions identified that there needs to be greater emphasis on understanding different worldviews in cultural competence training, including training for health support people working with Māori, Pacific and Asian communities.

Awareness and behaviour change programme

The Ministry expects that health promotion programmes will continue to raise awareness and educate about the signs and risks of harmful gambling, and how people can respond and seek help, by:

- promoting risk awareness and positive action messages that encourage positive behaviour change
- encouraging the development and promotion of self-help digital tools to improve access to relevant information, help and online support
- improving the reach of services to Māori, Pacific, Asian and other vulnerable groups, and the associated uptake of treatment and support.

The HPA will continue to actively promote the Gambling Helpline, Choice Not Chance (www.choicenotchance.org.nz) and face-to-face services, with a renewed focus on Māori, Pacific and Asian audiences and other vulnerable groups, for the 2019/20–2021/22 period. The HPA will also develop and promote self-help digital tools to increase accessibility to help and provide online support information. It will also continue to work in partnership with the DIA and the Ministry to promote safer gambling environments and host responsibility, including embedding work with class 4 venues and expanding these activities to address other modes of gambling.

National and regional service providers will continue to provide a variety of health promotion activities to minimise gambling related harm in the community. These activities include advocating for healthy policies with other agencies, working with gambling venues, increasing community action and raising community awareness of gambling harm at a local and regional level. In line with the strategy's objectives, the Ministry will support service providers including dedicated Māori, Pacific and Asian public health service providers to provide appropriate services within their communities.

The Ministry will encourage service providers, and the gambling sector generally, to participate in reviews of national and local council gambling venue policies, providing a community perspective to the three-yearly consultation process undertaken by territorial authorities. Previously, this process has resulted in a number of authorities introducing either gaming machine caps or sinking-lid policies in their regions.

National coordination, consumer networks and conference support

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

National coordination service

The national coordination service is a key support for preventing and minimising gambling harm services. It informs all service providers of significant developments, facilitates training opportunities, provides regular updates and administers the National Preventing and Minimising Gambling Harm Advisory Group.

Consumer network

The Ministry will provide funding and support to establish a national consumer network ('experts-by-experience') during this levy period. The network will inform service design and evaluation, particularly when the Ministry is piloting innovative services, and will assist with laying the foundations for introducing peer support into intervention services over time. The intention is to provide a systematic means for consumers to inform service design and evaluation/research.

Consumer networks are common in other health service areas. Internationally, advice from consumers is considered essential to the development, delivery and evaluation of mental health and addiction services. A key consideration is ensuring that such a network can provide free and frank advice to the Ministry. The indicative costs (see Table 16) cover travel, meeting and coordinator costs. This proposal aligns with the Ministry's Mental Health and Addiction Directorate goal to have consumer networks covering all of its work.

Conference support

The Ministry contributes part of the funding for a biennial international gambling conference held in New Zealand and an associated international think tank. The conference will take place twice in the 2019/20–2021/22 period, in February 2020 and 2022. The Ministry is budgeting for an \$80,000 contribution towards the costs of each conference and think tank.

Holding international conferences on gambling harm in New Zealand promotes the country as a world leader in preventing and minimising gambling harm. It also enables practitioners, researchers, industry representatives and government officials from around the world to meet and exchange ideas specific to gambling harm.

4.4 Intervention services

The Ministry has increased the indicative budget for the 2019/20–2021/22 period from the previous period to accommodate an increased focus on service development to address persistent gambling harm (see Table 17). Section 4.6 describes additional funding for piloting new intervention services.

Within this budget, the Ministry intends to explore the potential for more innovative intervention services. In particular, it will seek to fund or develop services that are client-centred and enhance the mana of consumers. The Ministry will base new approaches on successful regional or local models, where they exist, and will co-design them with stakeholders, and particularly with consumers.

Indicative priority areas for 2019/20 to 2021/22 are to:

- explore innovative ways to treat the whole person through joined-up gambling, drug, alcohol and mental health services
- pilot and evaluate new service models to address gaps in current service provision. The pilots will focus on delivering both public health and intervention services across regions (particularly rural regions) and responsiveness to Māori
- lay the foundations to pilot and introduce residential care and peer support into the intervention service mix in the medium term
- develop the range of online self-help available
- deliver services that are responsive to the needs of different population groups; in particular, those groups where there is strong evidence of inequality and inequity in gambling harm.

Table 17: Indicative intervention budget (GST exclusive), by service area, 2019/20–2021/22

Service area	2019/20 (\$m)	2020/21 (\$m)	2021/22 (\$m)	Total (\$m)
Helpline and web-based services	1.168	1.140	1.140	3.448
Psychosocial interventions and support	7.100	7.100	7.100	21.300
Data collection and reporting	0.015	0.015	0.015	0.045
Workforce development (intervention)	0.150	0.150	0.150	0.450
Total (\$m)	8.433	8.405	8.405	25.243

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.

Currently the Ministry funds two forms of telephone-based support, as follows.

- The Gambling Helpline provides a free 24/7 service, and is a first contact point for people in crisis as a result of harmful gambling. It also provides a back-up for other services that are not available 24/7, and ensures coverage in rural areas, where there are no face-to-face services. This is critical to the Ministry's service delivery model.
- The Asian Gambling Helpline is a limited service for the Asian community, provided by the PGF, and is funded out of psychosocial interventions and support services.

Submissions from health and service providers, particularly those serving Pacific and Asian communities, called for more language-appropriate support. Suggestions included translating key information into common languages online, and extending the hours and range of interpreter languages available. The Ministry will explore ways to extend the reach of these front-line services with Asian and Pacific providers and the consumer network.

It will also explore ways to increase the general helpline referral rate: currently only 0.8 percent of calls are referred to a treatment provider.

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 refers to brief screening for problems, typically in a non-clinical environment. This should not be confused with brief clinical interventions; for example, via telephone.

During this period, the Ministry intends to add residential care and peer support to the service mix with pilot services (see Section 4.6).

The Ministry is committed to improving access to services for all people adversely affected by gambling. Services and activities designed to identify people who are experiencing harm are crucial in providing early prevention and intervention treatment. This approach enables the Ministry to work actively to minimise the impact harmful gambling has on individuals and their families/whānau and others.

Many people of all ethnicities will access 'mainstream' services rather than culturally-specific services. Given the long-standing inequities Māori have experienced, and the Crown's responsibilities under Te Tiriti o Waitangi, the Ministry will consider how it can ensure that 'mainstream' services go beyond cultural competence, and actively imbed te ao Māori concepts into their clinical interventions.

In addition, the Ministry notes that submissions called for more culturally accessible services. The Ministry intends to continue to work with dedicated Māori, Pacific and Asian service providers and consumer networks to explore ways to provide culturally appropriate interventions and support for those population groups. The Ministry expects all services to be clinically safe and effective.

The Ministry considers it appropriate to pilot psychosocial interventions and support to address areas highlighted by the needs assessment and to test new service models: for example, to develop pilot services in areas that currently have limited access and explore innovation within those services.

Data collection and reporting

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

As of 2018, intervention service providers are required to record and report clients National Health Index (NHI) numbers to the Ministry. These identifiers allow individual patients to be positively and uniquely identified for the purposes of treatment and care and for maintaining medical records. This will also help provide better data about services provided, treatment efficacy and outcomes.

Workforce development (intervention)

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

The Ministry will continue to support intervention practitioners to:

- register as health practitioners permitted to practise within a relevant scope of practice under the Health Practitioners Competence Assurance Act 2003, or
- register with or be endorsed by DAPAANZ as having demonstrated the relevant specific competencies, or
- be equivalently registered with another relevant health professional body and hold at least six months' post-qualification experience as an addiction practitioner.

A key focus is to align the gambling harm intervention workforce with the wider addiction workforce. Research shows that alcohol and other drug problems are often an issue for those experiencing harm from gambling. Adopting workforce standards with comparable standards across the broader addiction workforce will provide greater career mobility and pathways and help build a more resilient and sustainable workforce.

As noted in the discussion of public health, Māori, Pacific and Asian stakeholders and service provider submissions noted the need for more effective workforce training, including training in cultural competence and the importance of understanding the different worldviews of potential clients.

The Ministry will also explore appropriate level of training for kaiāwhina and peer support workers (but not at DAPAANZ level).

4.5 Research and evaluation

Section 317 of the Act 2003 specifies 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. As well as addressing these requirements, the research and evaluation proposals that appear in this document were also informed by a review of the Ministry's research agenda, submissions feedback on priorities in the draft strategy consultation document and changes in the operating environment. There is a consensus among stakeholders that we need more action-oriented research and evaluations and less 'more of the same' prevalence-focused research.

Over the 2019/20–2021/22 period, the Ministry will review and fund specific projects that it believes best address the objectives of the strategy. Proposed priority areas for 2019/20–21/22 are:

- researching gambling-related health inequities experienced by vulnerable at-risk populations, particularly Māori, Pacific peoples, Asian and youth/children

- introducing programme evaluation more widely into all activities funded by the Ministry
- researching the convergence of gaming and gambling; in particular, how this may impact in the next two to three years as opportunities to gamble online from traditional and overseas providers increase (eg, Lotto's online instant win and online offerings).

Table 18: Indicative research and evaluation budget (GST exclusive), 2019/20–2021/22

Service area	2019/20 (\$m)	2020/21 (\$m)	2021/22 (\$m)	Total (\$m)
Research	1.485	1.499	1.5	4.484
Evaluation (including outcomes reporting)	0.575	0.72	0.85	2.145
Total (\$m)	2.06	2.219	2.35	6.629

The research and evaluation work programme

The Ministry will base its work programme to inform the research and evaluation priorities noted above around the following key themes:

- the prevalence and incidence of problem gambling and gambling-related harms and risk factors: while the Ministry may scale this back, it will maintain sufficient research to monitor prevalence as a key indicator of harm
- inequality and inequity: what drives the differences among and between population groups and how these differences are changing
- identification of what works best and why, based on learning from evaluations, including evaluation of past activities, to improve and innovate services, interventions and future research
- relapse prevention (this research is intended to cover gambling addiction specifically in the first instance; however, further work could be commissioned to address co-morbidity effects)
- emerging issues such as the convergence of gambling and gaming, and the use of the internet or other digital distribution platforms to provide access to gambling opportunities
- the impact of local territorial authority policies and venue licence conditions on gambling harm minimisation, with particular reference to high social deprivation areas
- econometric drivers of gambling expenditure and related patterns of NCHM venue, location and functioning.

Audits

The Ministry's audit team will undertake audits of contracted services in line with the Ministry's audit policy.

The Ministry has increased the evaluation budget to accommodate an increased evaluation programme. This may also include periodic audits from time to time where the audit requires clinical independence.

Where appropriate, the Ministry will apply lessons learned from audits or evaluations to future contracts. For example, a governance and financial audit of intervention and public health service providers undertaken during the 2017/2018 financial year provides a baseline for assessing progress to strengthen the governance of funding agreements.

4.6 New service and innovation pilots

The Ministry intends to develop new service models to address areas of persistent harm and improve service effectiveness. As a priority, it will pilot and assess:

- new ways of providing public health and intervention services in geographical areas or communities that are currently under-served, to address inequities
- innovative uses of technology to manage or mitigate gambling harm
- peer-support services and a small amount of residential care for gambling harm.

Table 19: Indicative budget for new service and innovation pilots (GST exclusive), 2019/20–2021/22

Service area	2019/20 (\$m)	2020/21 (\$m)	2021/22 (\$m)	Total (\$m)
Pilots to address inequity (public health and intervention services)	0.700	0.800	0.800	2.300
Technology-related innovation covering MVE, online support and machine-related controls/monitoring (harm prevention)	0.500	0.500	0.500	1.500
Peer support pilot	0.035	0.235	0.430	0.700
Residential care pilot	0.100	0.160	0.240	0.500
Total (\$m)	1.335	1.695	1.970	5.000

Pilots

The Ministry proposes to fund a range of new pilot service models that address inequity related public health and intervention services. Examples include cultural models/services, language support, online services, public health messaging and access for isolated communities.

Pilot costs are based on current full time equivalent (FTE) personnel costs at about \$100,000 per annum. The Ministry plans between three and five pilots of various sizes

each year in the second and third years, but a smaller number in the first year (2019/20), to allow for phasing. The Ministry does not currently know the exact size or number of these pilots; therefore, a more precise costing is not practical.

The Ministry will meet the pilot evaluation costs from the research evaluation allocation.

Technology

The Ministry proposes to allocate a fund to support technology-related innovation. There is a strong consensus from both industry and service providers that the strategy should provide for greater use of technology to mitigate and manage gambling harm. The Ministry could use this fund to build on an established activity such as potentially funding a database with facial recognition capabilities, trialling venue management modules, or to develop online support tools or pilot tools to monitor and manage or limit player exposure to gambling harm. The Ministry will evaluate all trials.

Peer support

Peer support is a model that has been proven overseas and in New Zealand for other forms of addiction ('peer' in this context means a person who has had a similar kind of relevant experience to other people that has had a significant impact on their lives). The formal evidence for peer support in mental health and addiction is growing, and shows high satisfaction from consumers of services. Outcomes from peer services are as good as if not better than conventional services, yet there currently are no funded peer support positions within gambling harm services.

The Ministry proposes to encourage training for and trial the introduction of peer services during this levy period. Costs are based on providing support for workforce development/training in each year, plus funding additional peer support positions in years two and three. The Ministry has taken into account a range of factors, including current FTE costs and average peer support workers' salaries and training costs.

There are a few ways in which the Ministry could support this aim; however, its preference is for a limited number of workforce development scholarships. The Ministry has not yet determined the workforce development component costs for this, as more investigation into potential demand and timing is necessary.

Residential care

Overseas experience indicates that residential care is a beneficial form of treatment for a small number of people with severe addiction behaviours, and therefore would be an option for the limited number of people in New Zealand experiencing high levels of gambling harm.

The Ministry currently funds some gambling harm support to people in alcohol and other drug residential treatment; however, demand does exist to provide residential treatment that provides gambling support first and foremost. The Ministry will work with providers to develop and pilot a clinically robust model of care, based on intensive treatment for people experiencing severe gambling harm, but likely allowing for support for co-existing issues in addition. It will then adopt a 'package-of-care' approach to funding, similar to the way in which it funds alcohol and drug treatment residential care.

The Ministry proposes to fund a small number of packages each year in the last year of the levy, with each package supporting about five people per year, depending on complexity of need. The Ministry expects to phase in this support with an established treatment provider, and has yet to decide whether to purchase on a capacity or demand basis, via a fee for service as required.

4.7 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 2019/20–2021/22, the Ministry has phased the budget accordingly.

Table 20: Indicative budget for Ministry operating costs (GST exclusive), 2019/20–2021/22

	2019/20 (\$m)	2020/21 (\$m)	2021/22 (\$m)	Total (\$m)
Total operating costs (\$m)	0.957	0.990	0.990	2.937

Implementation

Two aspects of the strategy implementation are worth noting: the extensive use of pilots to test new service and design models, and a joint work programme with the DIA to address areas of mutual interest related to gambling harm.

Extensive use of pilots

The Ministry intends to follow an open process to develop, pilot, evaluate and implement the proposals in the strategy.

In response to significant interest from stakeholders, the Ministry will hold a series of workshops to determine the size, location and characteristics of the pilots, before inviting specific proposals through a procurement process. Requests for proposals would set out more detailed funding proposals. Historically, the Ministry has offered this form of funding through a competitive tender, such as those for the research innovation rounds held under previous strategies. However, the Ministry wishes to test the opportunity for greater collaboration on some pilots, to make more effective use of resources. Pilots may include both public health and intervention components, and the Ministry will evaluate all pilots to inform future service provision.

Joint work programme with the Department of Internal Affairs

The proposed strategy involves areas in which the DIA and the Ministry of Health have mutual responsibilities or interests: for example, areas in which the policy or regulatory settings are outside the direct control of the Ministry of Health, or where the Ministry's work requires input from the DIA, which administers the Act and the broader regulatory and policy framework.

One example is work that looks at the potential to trial and evaluate an enhanced MVE database that supports facial recognition and other administration service improvement for excluded and affected others. The Ministry would work through the details of such a project with the DIA and industry, and potentially other affected stakeholders, to ensure the design was robust and likely to be effective.

To provide visibility for this type of work, the two departments are establishing a joint work programme covering the priority areas. They expect the programme to include the following topics:

- MVE and host responsibility
- use of technology
- research into areas of mutual interest – such as effectiveness of class 4 policies, prevalence of online gambling or socioeconometric drivers of gambling expenditure
- NCGM locations policy
- potential changes to the levy formula.

Some elements of this work programme will be led by the DIA (eg, changes to the levy formula, which is set in legislation), and others will be led by the Ministry.

5 Draft levy rates for 2019/20–2021/22

5.1 Background

Section 319(2) of the Act states that the purpose of the problem gambling 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 2019 to 30 June 2022, matching the period of the next strategy.

5.2 The levy-paying sectors

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

- NCGM operators
- casinos
- the NZRB
- the NZLC.

The Ministry notes the submission from Clubs New Zealand proposing a separate sector for NCGMs operated by clubs. This proposal has been raised in previous consultations on the strategy and levy, and has also been the subject of court action, the result of which was no change to the status quo composition of the NCGM sector.

The consultation document indicated that the Ministry of Health would consider the question of changes to the levy formula after its decisions about the next levy period, which it would make using the current policy settings. While it is possible that there could be changes to the number, size or composition of each gambling sector used to calculate the levy, the Ministry is not aware of any new research indicating an urgent need to do this. The Ministry also notes that there have been no proposals to adjust the levy-paying sectors made during the current levy period.

Accordingly, the Ministry does not propose any changes to the four gambling sectors from which the levy is collected. The DIA and the Ministry will consider the submission of Clubs New Zealand when they review comments from all the submissions about potential changes to the levy formula. They will inform stakeholders of the outcome of this review in due course.

5.3 Process for setting the levy rates

The Act sets out the process for developing and setting the levy rates needed to recover the cost of the strategy (refer to sections 318–320 of the Act).

As part of this process, the Ministry consulted on its estimated annual funding requirements, totalling \$60.339million, and four alternative sets of estimated levy rates for 1 July 2019–30 June 2022. Total spending was to be funded by an appropriation of \$55.339 million plus a transfer of \$5 million from the current Vote appropriation for problem gambling.¹⁸ Section 4.2 sets out the reasons for the additional funding in the next levy period.

Submissions on the draft strategy that commented on these amounts were divided. On one hand, NCGM operators opposed the \$5 million net increase, with many suggesting that total funding should be reduced to between \$40 and 52 million. Most other submissions – notably service providers and health sector and consumers – either supported the additional spending or indicated it should be further increased to offset providers’ increased operating costs. The Ministry notes that the expense transfer and the additional funding proposed is appropriate. Table 26 shows how these funds and levy overpayments have impacted on the total amount to be raised by the levy in the next levy period.

This section sets out the proposed levy rates, which the Associate Minister of Health will refer to the Gambling Commission. The Gambling Commission may then obtain its own advice on the proposed rates, and will convene a consultation meeting. It will subsequently make recommendations to the responsible Ministers. Cabinet will approve the strategy, determine the level of funding to recommend to Parliament as the Ministry’s appropriation and endorse responsible Ministers’ recommendations to the Governor-General on regulations setting out the sectors that will pay the levy and the relevant levy rates.

¹⁸ 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.

5.4 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:

$$\text{Levy rate for each sector} = \frac{([A \times W1] + [B \times W2]) \times C}{D} \text{ plus or minus } R$$

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 for which the levy is payable

R = the estimated under-recovery or over-recovery of levy from a sector in the previous levy periods¹⁹

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 (forecast player expenditure in the sector) determines the levy rate that is necessary for a sector to pay its required contribution.

The Act states that the levy rate calculations 'must take into account the latest, most reliable and most appropriate sources of information' from the Ministry, Inland Revenue Department (IRD) or the DIA, as the case may be. The levy proposed below is calculated using actual data to 30 June 2018 for presentations and NCGM expenditure, and DIA expenditure data to 30 June 2017 for casinos, the NZRB and the NZLC. It also used levy payments as returned to the IRD up to 30 June 2018. All other figures used are estimates or forecasts as advised by the DIA. Accordingly, the Ministry may update the levy calculations before it prepares the papers for Cabinet for it to make final decisions about the levy and Ministry's appropriation, if such updated information becomes available.

¹⁹ **R** was added to the formula by section 107 of the Gambling Amendment Act 2015, which came into effect on 3 March 2015.

Estimated current player expenditure (A)

The DIA has estimated current player expenditure using a variety of sources of information, including its NCGM electronic monitoring system (EMS), gambling operators' annual and half-yearly reports and information from the IRD.²⁰ Other data on gambling expenditure is available on the DIA's website (www.dia.govt.nz).

Table 21 and Figure 7 show player expenditure by the four main gambling sectors for the eight years up to 2016/17.

Table 21: Gambling expenditure and proportions from the four main sectors, 2009/10–2016/17

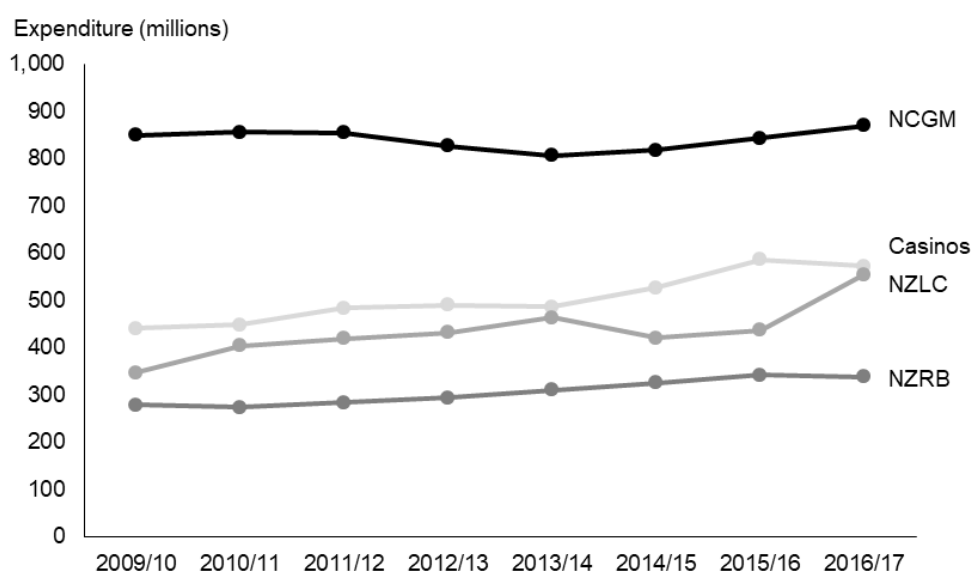
Year	NCGMs		Casinos		NZRB		NZLC		Total \$m
	\$m	%	\$m	%	\$m	%	\$m	%	
2009/10	849	44.4	440	23.0	278	14.5	347	18.1	1,914
2010/11	856	43.2	448	22.6	273	13.8	404	20.4	1,982
2011/12	854	41.9	483	23.7	283	13.9	419	20.5	2,038
2012/13	827	40.5	490	24.0	294	14.4	432	21.1	2,042
2013/14	806	39.0	486	23.5	310	15.0	463	22.4	2,065
2014/15	818	39.1	527	25.2	325	15.5	420	20.1	2,091
2015/16	843	38.2	586	26.5	342	15.5	437	19.8	2,209
2016/17	870	37.3	572	24.5	338	14.5	555	23.8	2,334

Source: www.dia.govt.nz/diawebsite.nsf/wpg_URL/Resource-material-Information-We-Provide-Gambling-Expenditure-Statistics (accessed 10 June 2018).

Notes: All values are actual (not inflation adjusted), in New Zealand dollars, GST-inclusive and rounded to the nearest million. The sum of the rows may differ from the total shown in the 'Total' column due to rounding.

²⁰ The IRD provides gaming duty and problem gambling levy data to the DIA. The Tax Administration Act 1994 requires the IRD 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.

Figure 7: Gambling expenditure by year from the four main sectors, 2009/10–2016/17



Although the total money spent gambling increased in all four sectors between 2009/10 and 2016/17:

- the proportion of total expenditure on NCGMs declined from 44 to 37 percent
- the proportion of total expenditure on NZLC products increased from 18 to 24 percent
- the proportion of total expenditure remained relatively constant for casinos (23–25%) and the NZRB (14–16%).

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 client presentations to problem gambling sources.

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 for each year from 1 July 2009 to 30 June 2018. The figures exclude brief screening interventions, and primary problem gambling modes (PPGMs) in gambling sectors that are not subject to the levy are excluded (for reasons that have been canvassed in detail in documentation of previous levy-setting processes).

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

The Ministry has made no changes to the way in which it has recorded or weighted PPGMs since the last levy period. As previous consultation documents have discussed the meaning of PPGMs at length, the Ministry does not intend to repeat that detail in this document, but can provide an in-depth description if required.

Table 22 and Figure 8 show the presentations attributed to each of the four levy-paying sectors each year from 2009/10 to 30 June 2018.

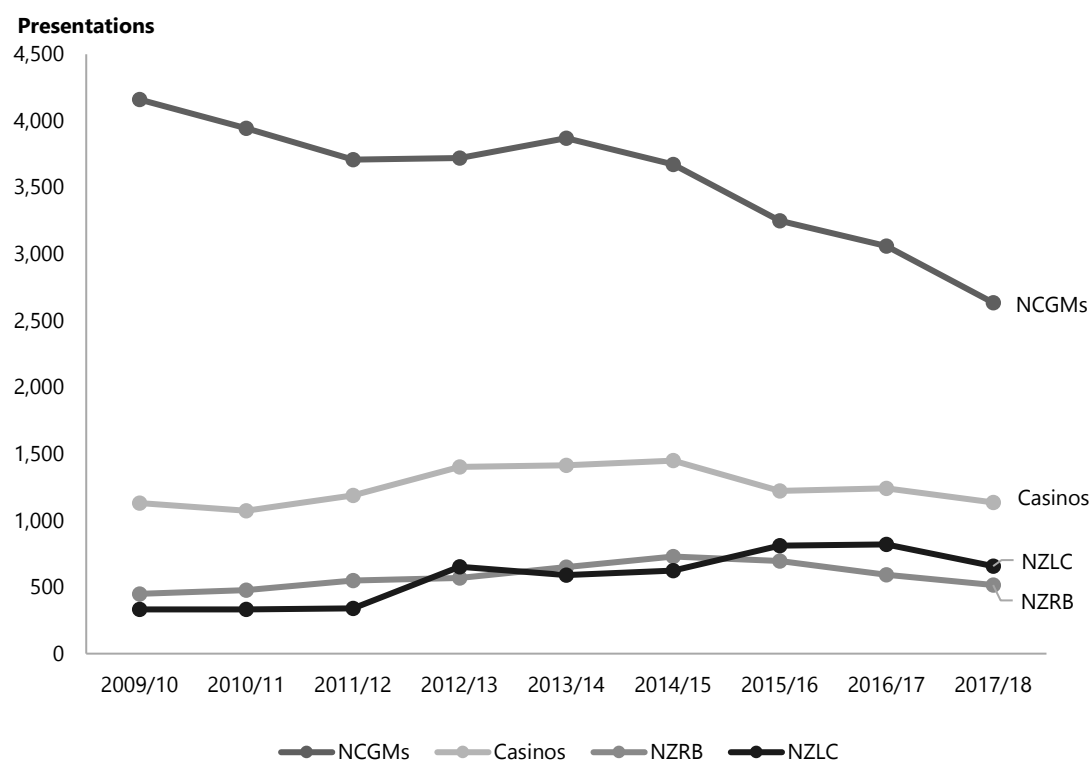
Table 22: Presentations and proportions attributed to the four main sectors, 2009/10–2017/18

	NCGMs		Casinos		NZRB		NZLC		Total
	n	%	n	%	n	%	n	%	n
2009/10	4,160	69	1,131	19	449	7	332	5	6,072
2010/11	3,945	68	1,073	18	476	8	332	6	5,825
2011/12	3,708	64	1,188	21	548	9	339	6	5,783
2012/13	3,721	59	1,403	22	568	9	652	10	6,344
2013/14	3,871	59	1,413	22	651	10	590	9	6,525
2014/15	3,674	57	1,449	22	729	11	624	10	6,476
2015/16	3,251	54	1,221	20	696	12	812	14	5,980
2016/17	3,060	54	1,240	22	593	10	820	14	5,713
2017/18	2,635	53	1,135	23	515	10	657	13	4,941

Source: Service user data, Ministry of Health and 2017/18 CLIC data. URL: www.health.govt.nz/our-work/mental-health-and-addictions/problem-gambling/service-user-data/intervention-client-data (accessed 1 November 2018).

Note: The sum of the rows may differ from the total shown in the 'Total' column due to rounding.

Figure 8: Presentations by year attributed to the four main sectors, 2010/11–2017/18



When considering the data presented in Table 22 and Figure 8, note that from 1 October 2011, the Ministry required 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). Accordingly, the Ministry considers that its presentation figures from 2012/13 onwards are more reliable and appropriate than its earlier figures.

Other points to note from these table are as follows.

- The *number* of NCGM presentations peaked in 2009/10, but the *share* of NCGM presentations peaked in 2004/05. Both figures have been declining unevenly since those respective dates. These patterns probably largely reflect the trend for reductions in both the number of NCGMs and NCGM venues and in the total NCGM sector expenditure as a proportion of the total gambling expenditure.
- The *number* of casino presentations has increased each year since 2004/05 until peaking in 2014/15, and have declined slightly since. However, the overall *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 until peaking in 2016/17. The *share* of NZRB presentations has tended to increase slightly as a result but has fluctuated a little.
- The *number* of NZLC presentations has continued to increase since 2013/14, and the *share* of presentations has steadily increased over time. These patterns coincide with the increase in expenditure over this time. The number and share of NZLC presentations are now at their highest levels for this sector since the levy was introduced.

It is also worth noting that the changes the Ministry made to its systems in 2008 and 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). The Ministry considers that these changes are likely to have resulted in more accurate presentation data.

The funding requirement (C)

The funding requirement represented by **C** in the formula is the amount that the Ministry considers it requires by way of an appropriation to implement the strategy. For 2019/20–2021/22, the Ministry is proposing an appropriation of \$55.339 million.

Section 4 sets out details about the total funding required and the component sum to be appropriated.

Forecast player expenditure (D)

The amounts represented by **D** in the formula are sector-by-sector forecasts of the amounts that the DIA expects gamblers to spend on the gambling products of the four levy-paying gambling sectors in the period 2019/20–2021/22. 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 DIA forecast for each sector is set out below.

There may be changes in gambling expenditure as a result of future changes to the Act or regulations. It is not possible to forecast the likely impact of any changes until the nature of any legislative or policy changes are clearer.

Non-casino gaming machines

The number of NCGMs has declined from 25,221 in 2003 to 15,420 as of 30 June 2018²¹ (there are 1140 active venues).

Expenditure also declined for a number of years, but has seen yearly increases since 2013/14. For example, from a historical low of \$806 million in 2013/14, expenditure increased to \$818 million in 2014/15, \$843 million in 2015/16, \$870 million in 2016/17 and \$895 million in 2017/18.²²

The DIA forecasts expenditure to continue with small annual increases in the next three years.

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

In the NCGM sector, club expenditure continues to decrease, while non-club expenditure has increased. Non-club expenditure has historically been around 86–87 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. However, since 2016/17, non-club expenditure has increased to around 89 percent of total expenditure; club expenditure sits at around 11 percent of the total.

²¹ URL: www.dia.govt.nz/diawebsite.nsf/wpg_URL/Resource-material-Information-We-Provide-Summary-of-Venues-and-Numbers-by-Territorial-AuthorityDistrict (accessed 6 November 2018).

²² URL: www.dia.govt.nz/diawebsite.nsf/wpg_URL/Resource-material-Information-We-Provide-Gambling-Expenditure-Statistics (accessed 6 November 2018).

Casinos

Over the last three years, spending on casino gambling has fluctuated. Figures from the DIA show expenditure of \$527 million in 2014/15, \$586 million in 2015/16 and \$572 million in 2016/17. Casino expenditure is impacted by variations in international tourist numbers, including 'VIP' gamblers.

The DIA anticipates some growth in expenditure for 2018/19–2020/21, but its forecast is relatively 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 \$342 million in 2015/16, with a slight decline to \$338 million in 2016/17.

The DIA anticipates modest expenditure growth in the next three-year period. Potential increases in expenditure brought about by technical innovation and product development may be impacted by competition in the racing and sports betting market from offshore betting agencies.

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; the DIA reports expenditure of \$420 million in 2014/15, \$437 million in 2015/16 and \$555 million in 2016/17.

The DIA indicates that the increase in 2016/17 is due to changes to Lotto games, which delivered more winners and bigger Powerball prizes (DIA 2018). Lotto is also working to diversify its portfolio by introducing new games to help mitigate fluctuations in spending on its lottery products.

The DIA forecast has been revised based on the NZLC Statement of Intent for 2019–2022, and is for flatter expenditure growth for 2018/19–2020/21 than earlier forecast. It forecasts more steady expenditure growth for the period across the other three sectors, as Table 23 shows.

Table 23: Forecast expenditure by sector (GST-inclusive), 2019/20–2021/22

Forecast expenditure	NCGMs	Casinos	NZRB	NZLC
2019/20 (\$m)	951.143	645.345	383.428	593.9
2020/21 (\$m)	981.184	667.463	395.794	606.8
2021/22 (\$m)	1,012.173	689.581	408.161	638.0

Note: These forecasts are for the next levy period, based on the best estimates available at the time of writing. The further out we forecast, the less reliable that forecast can be. The Ministry advises that, while these 'out years' follow a general trend, they are not as reliable as a yearly forecast for the next year ahead. These forecast figures will be updated with actual data as is available when calculating the levies for the next levy period.

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 underpayment or overpayment from that sector in previous levy periods. This legislative change ended the previous system, deemed unfair, whereby all four gambling sectors were required to meet any net underpayment or overpayment of the levy amount across all sectors from the previous levy period.

Expected and actual levy payments to IRD are tracked separately from the Ministry's planned versus actual spending of its appropriation. The Ministry's funding for preventing and minimising gambling harm is appropriated by Parliament and this revenue is ring-fenced separately in Vote Health. To ensure that the Ministry's spending matches the appropriated revenue, the Ministry's spending from year to year is drawn and recorded against this account. The Ministry is forecast to spend about \$5million less than the amount appropriated before the start of this levy period.²³

Some NCGM submissions on the consultation document considered the Ministry's approach to apply the forecast underspend was incorrect and stated it should be applied in calculating R (rather than C).

The Ministry's initial approach (Option 1) was to apply an operational perspective in calculating C, so that the expense transfer was taken into account in determining the funding the Ministry would require in the new levy period. The alternative (Option 2) would be to amend the Ministry's estimated projected actual spending in the current period to June 2019 by deducting the underspend amount from the Ministry's expenditure forecast that was set when the current levy and appropriations were approved. This would increase the value of R by the unspent amount.

²³ This has largely accumulated as a result of a legal challenge to the procurement process early in the levy period and resulting delays in being able to let service provider contracts in the Waikato and other areas.

The Ministry has considered these submissions and reviewed the reports on previous levy proposals, including the Gambling Commission's 2015 report, and concluded that there are arguments for and against either interpretation. Importantly, the Ministry notes that there is very little difference between either interpretation in terms of the proposed new levy rates and amounts payable by each levy paying sector. Any differences are due to slight differences in each sector's share of presentations and share of expenditure that apply in each levy period.

The 'R' calculation involves the following:

- The Ministry's projected total available spending for the period 2004 to 2019 was calculated by:
 - updating the 2015 estimates with the actual spending from its annual reports for 2015/16 (the last year of the previous period that used estimates) and 2016/17
 - using estimated expenditure for 2017/18 and 2018/19
 - adding these sums to the actual spending recorded for previous years' levy periods between 2004 to 2015.
- This total is the target recovery amount from the four levy-paying gambling sectors. For Option 1 the total is \$266.922 million and Option 2 is \$261.922 million.
- The Ministry estimates the levy payments received by IRD will total \$273.880 million by 30 June 2019. This was calculated by totalling actual payments from each sector made to IRD up to 30 June 2018, together with the estimates of sector payments up to 30 June 2019.

The values obtained using Option 1 and Option 2 are summarised in Table 24a.

Table 24a: Levy calculations key figures

Key figure	Option 1 \$m (GST exclusive)	Option 2 \$m (GST exclusive)
Ministry projected spending (2004/05–2018/19)	266.922	261.922
R (2004/05–2018/19)	6.958	11.958
C (2019/20–2021/22)	55.339	60.339
Levy amount adjusted (C–R)	48.381	48.381

The Ministry then calculated the amount of levy each sector was expected to pay by:

- referring to the relevant Cabinet approved strategy before the start of each levy period. It used that information to identify each sector's expected share of the levy requirement for each three-year period
- using those shares to calculate the amount each sector was expected to pay as their contribution to the Ministry's spending in each levy period
- totalling these amounts across all levy periods to arrive at the amount each sector was expected to pay up to 30 June 2019.

Table 24b shows the values obtained for each sector.

Table 24b: Sector shares and levy amounts based on Ministry's total spend

Sector	Option 1		Option 2	
	Percent	\$m (GST exclusive)	Percent	\$m (GST exclusive)
NCGM share	65.52%	174.884 m	65.72%	172.133 m
Casinos' share	19.54%	52.149 m	19.48%	51.014 m
NZRB share	8.74%	23.331 m	8.68%	22.745 m
NZLC share	6.20%	16.558 m	6.12%	16.029 m
Total required levy amount for calculating R		266.922m		261.922m

The Ministry then compared the amounts obtained from the above calculations based on Ministry spending with the amounts of levy each sector is expected to have paid to IRD. The differences for each sector are shown in Table 24c.

Table 24c: Estimated underpayment or overpayment of problem gambling levy, 2004/05–2018/19, by sector

Sector	Option 1	Option 2
	\$m (GST exclusive)	\$m (GST exclusive)
NCGMs	-3.462	-6.213
Casinos	-1.710	-2.845
NZRB	-0.354	-0.940
NZLC	-1.432	-1.961
Nett difference (total)	-6.958	-11.958

Note: A negative figure indicates an expected overpayment for the levy period to 30 June 2019.

The levy formula value 'R' accounts for under- or over-recovery in the previous period when calculating the levy rate for the next period. Overpayment amounts are deducted from the amounts required from each sector, while any underpayments are added.

For each sector, the previous forecasts underestimated the actual gambling expenditure subject to the levy (for 2016/17–2018/19) resulting in levy payments exceeding the amount required. The amount of expected overpayment for each for a sector is shown in Table 24c. This amount is deducted from each sector's allocated share of the levy payments for 2019/20–2021/22.

Expenditure on NCGMs for 2016/17 was about 6 percent greater than the \$812 million forecast in 2015/16. If this continues for the remainder of the levy period, it will result in the overpayment as shown above. This amount will be used to offset NCGM levy payments for the next levy period.

Casino expenditure for 2016/17 was greater than forecast; if this continues for the remainder of the levy period, this will lead to the sector paying more levy than was anticipated when the levy was set.

Expenditure on NZRB products is tracking at slightly above that forecast for 2016/17 in the current strategy. If this continues for the remainder of the levy period, it will result in a slight overpayment compared with the amount expected when the levy was set.

Expenditure on NZLC products remains 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. Changes to lottery products and draws have also contributed to the uncertainty of forecasts.

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.

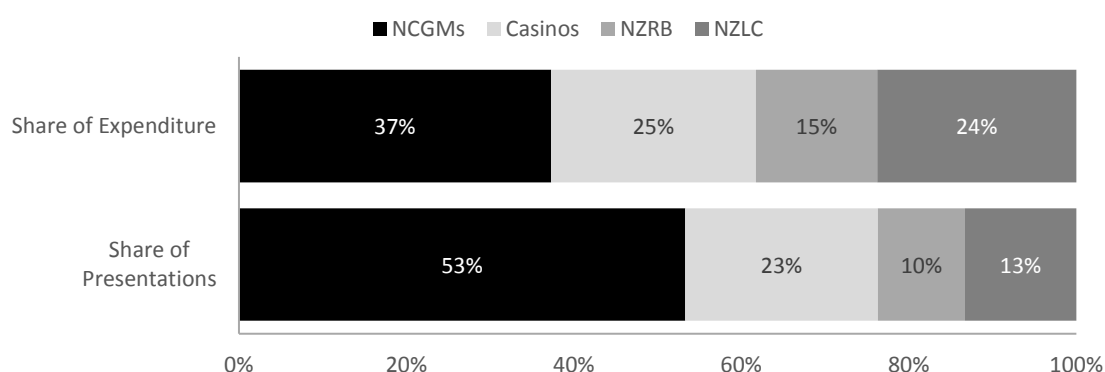
Table 25 and Figure 9 show the proportion of presentations attributed to each levy-paying sector for the 12-month period from 1 January to 31 December 2017 and each levy-paying sector's proportion of expenditure for the 2016/17 financial year (to be updated when 2017/18 data become available).

Table 25: Share of presentations and expenditure by sector, 2017/18

NCGMs		Casinos		NZRB		NZLC	
Presentations	Expenditure	Presentations	Expenditure	Presentations	Expenditure	Presentations	Expenditure
0.533	0.373	0.230	0.245	0.104	0.145	0.133	0.238

Notes: Presentations are for 2017/18; expenditure is for 2016/17. These are the most recent years comparative data is available for all four sectors.

Figure 9: Share of presentations and expenditure by sector, 2017/18



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 respectively), the weighting between expenditure and presentations is critical to determine how much each sector will be required to pay. Tables 27–30 set out the levy rates and forecast payment by sector for each weighting option.

The weighting approach is limited in that there may be no single weighting that could be applied to determine each sector's fairest share of the levy. However, the Act specifies that these weightings must be used to determine the levy for each sector.

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 expenditure may 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 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 a report on the proposed problem gambling levy, 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' (Gambling Commission New Zealand 2009).

Presentations and expenditure are not the only potential indicators of harm. The consultation document called for suggestions about how the levy formula could be changed in future to better reflect harm. The Ministry notes other means to estimate problem gambling prevalence, such as screening instruments like the PGSI, or survey questions that directly address the risk of harm (eg, 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 presentation figures for the more recent levy periods, in which the NZRB and NZLC shares of presentations are somewhat higher, are likely to be more reliable and appropriate.

The Ministry recognises there is a case for a harder look at how the levy formula is configured, and will consider submissions on this topic as part of its joint work programme with the DIA. Stakeholders will have an opportunity to comment on any specific proposals to change the levy during the next levy period.

Four weighting options are set out below. The Ministry notes that, in all five levy periods to date, the option chosen by Ministers has been the 10/90 weighting; that is, 0.1 (10%) on expenditure and 0.9 (90%) on presentations.

The Ministry notes there is now a stronger evidence-based case to increase the weighting on expenditure from 10% to 30%. A broad range of submissions on the draft strategy called for a greater weighting on expenditure, arguing it is a more current indicator of exposure to harm than presentations, which tend to reflect harm that has manifested as a crisis.

Accordingly, the Ministry's preference is for the 30/70 option, although it considers that any weighting from 30/70 to 5/95 would be reasonable.

5.5 Levy calculations

Table 26 below shows the net levy funding requirement given the proposal to increase spending to \$60.339 million for the next three-year levy period, accounting for forecast unspent funding and levy overpayments for the period to 30 June 2019.

As discussed above for variable 'R', it is possible to calculate the levy rate two ways, depending on which period is used to account for the \$5 million forecast underspend. Option 1 accounts for it in the new levy period, by adjusting C to \$55.339 million as the cost of funding required taking into account the expense transfer. Option 2 accounts for the underspend by reducing the total projected Ministry spending to 30 June 2019, which results in R being \$5 million more than in Option 1. Under Option 2, C is not adjusted and remains at \$60.339 million.

Importantly, while each option results in different values of C and R depending on which period is used to adjust for the unspent funds, there is very little difference them in terms of each sector's levy rate or the amount of each sector's estimated payment. These differences are the result of minor changes to each sector's shares between levy periods and rounding.

These options result in the following levy rates and payment allocations for the next levy period. In Tables 27–30 the red figures show where amounts calculated under Option 2 differ from those calculated using Option 1.

Table 26: Nett funding requirement for 2019/20–2021/22

Proposed levy funding requirement 2019/20 to 2021/22 (GST exclusive)	\$ million
Draft strategy proposed Ministry of Health spend: public health	20.530
Draft strategy proposed Ministry of Health spend: intervention services	25.243
Draft strategy proposed Ministry of Health spend: research and evaluation	6.629
Draft strategy proposed Ministry of Health operating costs	2.937
Draft strategy proposed Ministry of Health spend: new service pilots and technology fund	5.000
Subtotal	60.339
Minus forecast levy over-collection from 2016/17–2018/19	-6.958
Minus forecast Ministry of Health transfer of under-spent 2016/17–18/19 appropriation (Option 1 used to calculate C, Option 2 used to calculate R)	-5.000
Net levy funding requirement for 2019/20–2021/22	48.381

Levy weighting combinations

Tables 27–30 set out the implications for each of the four alternative levy weightings 5/95, 10/90, 20/80 and 30/70 respectively.

Each table shows the levy rate per sector and the expected amount of levy payment per sector over the next three-year period, under either option. The levy rate and payment amounts under Option 2 are the same as under Option 1 except:

- under each weighting combination, the NZLC levy rate increases one percentage point and the expected amount of NZLC levy payments increases by 180,000 over three years
- for the 5/95 weighting combination the NZRB levy rate decreases one percentage point and the expected amount of NZRB levy payments decreases by about 120,000 over three years
- for the 30/70 weighting combination, the NCGM levy rate decreases one percentage point and the expected total amount of NCGM levy payments decrease by about 300,000 over three years.

As described previously, the red figures in the following tables highlight those amounts calculated under Option 2 that differ from the corresponding amount calculated using Option 1.

Table 27: Estimated levy rates and payments (\$m) per sector: 5/95 weighting

Collection period starts 1 July 2019 (all GST exclusive)	Option 1				Option 2			
	NCGMs	Casinos	NZRB	NZLC	NCGMs	Casinos	NZRB	NZLC
Sector levy rates (%)	0.87	0.55	0.47	0.34	0.87	0.55	0.46	0.35
Expected levy payment (\$m)	25.617	11.013	5.581	6.252	25.617	11.013	5.462	6.435

Table 28: Estimated levy rates and payments (\$m) per sector: 10/90 weighting

Collection period starts 1 July 2019 (all GST exclusive)	Option 1				Option 2			
	NCGMs	Casinos	NZRB	NZLC	NCGMs	Casinos	NZRB	NZLC
Sector levy rates (%)	0.85	0.55	0.47	0.35	0.85	0.55	0.47	0.36
Expected levy payment (\$m)	25.028	11.013	5.581	6.435	25.028	11.013	5.581	6.619

Table 29: Estimated levy rates and payments (\$m) per sector: 20/80 weighting

Collection period starts 1 July 2019 (all GST exclusive)	Option 1				Option 2			
	NCGMs	Casinos	NZRB	NZLC	NCGMs	Casinos	NZRB	NZLC
Sector levy rates (%)	0.82	0.56	0.49	0.39	0.82	0.56	0.49	0.40
Expected levy payment (\$m)	24.145	11.213	5.818	7.171	24.145	11.213	5.818	7.355

Table 30: Estimated levy rates and payments (\$m) per sector: 30/70 weighting

Collection period starts 1 July 2019 (all GST exclusive)	Option 1				Option 2			
	NCGMs	Casinos	NZRB	NZLC	NCGMs	Casinos	NZRB	NZLC
Sector levy rates (%)	0.79	0.56	0.51	0.42	0.78	0.56	0.51	0.43
Expected levy payment (\$m)	23.262	11.213	6.056	7.723	22.967	11.213	6.056	7.906

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Glossary

AUT	Auckland University of Technology
CLIC	Client Information Collection
DAPAANZ	Addiction Practitioners' Association Aotearoa New Zealand
DIA	Department of Internal Affairs
EGM	Electronic gaming machine
EMS	Electronic monitoring system
FTE	Full-time equivalent
HLS	Health and Lifestyles Survey
HPA	Health Promotion Agency
IRD	Inland Revenue Department
Ministry	Ministry of Health
MVE	Multi-venue exclusion
NCGM	Non-casino gaming machine
NGO	Non-governmental organisation
NGS	National Gambling Study
NZLC	New Zealand Lotteries Commission
NZRB	New Zealand Racing Board
PGF	Problem Gambling Foundation of New Zealand
PGSI	Problem gambling severity index
PPGM	Primary problem gambling mode
WHO	World Health Organization