Preventing and Minimising Gambling Harm

Consultation document

Draft three-year service plan for 2013/14 to 2015/16, levy calculation and proposed levy rates, and needs assessment
Preventing and Minimising Gambling Harm: Consultation document

Foreword

The Gambling Act 2003 (the Act) sets out the requirements for an integrated problem gambling strategy focused on public health. The Act states that the strategy must include:

• measures to promote public health by preventing and minimising harm from gambling
• services to treat and assist problem gamblers and their families and whānau
• 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
• evaluation.

The Ministry of Health (the Ministry) is responsible for developing and implementing the strategy. The Act requires that a new strategy be put in place at least every three years.

The Act anticipates that the Crown will recover the cost of developing and implementing the strategy, by way of a ‘problem gambling levy’ set by regulation at a different rate for each of the main gambling sectors. The Act also specifies consultation requirements for the development of the strategy and the levy rates.

Consistent with these requirements, the Ministry is now seeking comment, through a consultation process, on its draft three-year service plan (which is the proposed strategy for 1 July 2013 to 30 June 2016) and its proposed levy and levy rates for 1 July 2013 to 30 June 2016. The needs assessment undertaken by the Ministry is also attached, and some people might also wish to comment on this as part of the consultation process.

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

Ministers will consider the advice received from the Ministry, the Department of Internal Affairs and the Gambling Commission, and Cabinet will make decisions on the final shape of the service plan and the levy.
Submissions are now invited on the draft three-year service plan, the proposed problem gambling levy and levy rates, and the needs assessment. The Ministry encourages you to have your say to ensure we have an inclusive and comprehensive approach to preventing and minimising gambling harm for the period from 1 July 2013 to 30 June 2016.

Kevin Woods
**Director-General of Health**
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Introduction

This consultation document is divided into three sections. There is some minor duplication of content across the sections in order to provide appropriate context when any section is read in isolation.

**Draft three-year service plan for 2013/14 to 2015/16**

The draft service plan describes the Ministry’s proposed service priorities for public health and intervention services, workforce development (for both public health and intervention services), and research and evaluation, for the period from 1 July 2013 to 30 June 2016. This draft service plan, which is the proposed strategy for the three-year period, has been developed within the context of the Preventing and Minimising Gambling Harm Six-year strategic plan 2010/11–2015/16 (the strategic plan).

**Levy calculation and proposed levy rates**

This section, which will be published as part of the service plan, describes the process for calculating the problem gambling levy and the levy rates. It sets out four different levy calculations and their associated rates, and indicates which set of rates the Ministry recommends. The levy rates determine the portion of the levy that is payable by each of the four main gambling sectors (casinos, non-casino gaming machines, the New Zealand Racing Board and the New Zealand Lotteries Commission).

**Gambling Harm Needs Assessment 2012**

The needs assessment brings together a range of information to describe the impact of gambling harm in terms of population need.

The needs assessment in this consultation document is complete in itself. However, those wishing to have a more comprehensive understanding of the issues might wish to read it in conjunction with Informing the 2012 Gambling Harm Needs Assessment: Report for the Ministry of Health, which will be available on the Ministry’s website www.health.govt.nz

**How to have your say**

Your feedback is important because it will help shape the final draft service plan, proposed problem gambling levy and proposed rates, as submitted to Ministers and the Gambling Commission. Please take the time to make a submission.

The Ministry welcomes all feedback on the draft three-year service plan, the problem gambling levy and levy rates, and the needs assessment. It would be helpful if submitters tried to include or cite any evidence that supports their submissions.
The following questions may help you to focus your submissions:

1. Does the draft service plan adequately address the areas of public health and intervention services? If not, what issues or areas are not adequately covered?

2. Does the draft service plan adequately address workforce development for public health and intervention services? If not, what issues or areas are not adequately covered?

3. Does the draft service plan adequately address research and evaluation? If not, what issues or areas are not adequately covered?

4. Are there aspects of the funding proposals in the draft service plan, or any other aspects of the draft service plan, that you particularly agree with or disagree with, and if so, why?

5. Are there aspects of the proposed levy that you particularly agree with or disagree with, and if so, why?

6. The levy calculations canvass four different pairs of weightings: 5/95, 10/90, 20/80 and 30/70. Each weighting entails a different set of levy rates. The Ministry has indicated its preference for the 30/70 weighting. Are there other realistic pairs of weightings? Which pair of weightings, if any, do you support? Why?

7. Are there aspects of the needs assessment that you particularly agree with or disagree with, and if so, why?

There are two ways you can make a submission.

- Forward your comments, with the detachable submission form at the back of this document, to:
  
  Derek Thompson  
  Preventing and Minimising Gambling Harm Submissions  
  Ministry of Health  
  PO Box 5013  
  Wellington.

- Download the submission form available in the problem gambling section of the Ministry’s website, www.health.govt.nz, add your comments and email to:
  
  gamblingharm@moh.govt.nz
The Ministry will hold a series of public meetings for interested parties to discuss the document and ask questions to inform their written submissions. The dates, times and locations of these meetings can be downloaded from the problem gambling section of the Ministry’s website.

All submissions are due by **5 pm on Friday 7 September 2012**.

Your submission may be requested under the Official Information Act 1982. If this happens, the Ministry will release your submission to the person who requested it. A copy of all submissions received will be forwarded to the Gambling Commission to assist its independent consultation process.
1 Three-year Service Plan
2013/14 to 2015/16

1.1 Introduction

1.1.1 Background
The Ministry of Health (the Ministry) is responsible for developing and implementing the integrated problem gambling strategy focused on public health that is described in section 317 of the Gambling Act 2003 (the Act). The Act states 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 and 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.

In the Act, ‘harm’:

(a) means 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.

The Ministry appropriates funding to purchase services and activities through Vote Health. The Crown then recovers the cost of this appropriation through a levy, the ‘problem gambling levy’, on gambling operators.
1.1.2 Relationship of draft service plan to the 2010/11 to 2015/16 strategic plan

The draft service plan (this document) outlines the Ministry’s forecast budget and intentions for 2013/14 to 2015/16. The Ministry has developed this draft service plan in response to the needs assessment and within the context of its Preventing and Minimising Gambling Harm: Six-year strategic plan 2010/11−2015/16 (the strategic plan). However, note that it is the draft service plan that is the proposed integrated problem gambling strategy for 2013/14 to 2015/16.

1.1.3 Outline of the 2010/11 to 2015/16 strategic plan

As noted above, this draft service plan has been developed within the context of the strategic plan, which is available on the Ministry’s website. The Ministry is committed to a long-term approach, and that approach has not significantly changed from its first six-year strategic plan (published in 2005 and still available on the Ministry’s website). The overall goal is:

Government, gambling industry, communities and families/whānau working together to prevent the harm caused by gambling and problem gambling and to reduce health inequalities associated with gambling and problem gambling.

A number of key principles underpin the strategic plan and have guided the development of this draft service plan. The principles are to:

- maintain a comprehensive range of public health services based on the Ottawa Charter and New Zealand models of health (such as Te Pae Mahutonga and Whare Tapa Whā)
- fund services that target priority populations
- ensure culturally accessible and responsive services
- maintain a focus on improving Māori health gain
- address health inequalities
- strengthen communities
- ensure services are sustainable
- develop the workforce
- apply an intersectoral approach
- ensure links between public health and intervention services.

A key part of progressing the Ministry’s goal has been to set realistic and measurable objectives. These objectives form the foundation for the strategic plan and the Ministry’s outcomes framework. More detail on the objectives, their underlying principles and the relevant outcome indicators is set out in the strategic plan.
The strategic plan identifies the following 11 objectives.

- Objective 1: There is a reduction in health inequalities related to problem gambling.
- Objective 2: Māori families are supported to achieve their maximum health and wellbeing through minimising the negative impacts of gambling.
- Objective 3: People participate in decision-making about local activities that prevent and minimise gambling harm in their communities.
- Objective 4: Healthy policy at the national, regional and local level prevents and minimises gambling harm.
- Objective 5: Government, the gambling industry, communities, families/whānau and individuals understand and acknowledge the range of harms from gambling that affect individuals, families/whānau and communities.
- Objective 6: A skilled workforce is developed to deliver effective services to prevent and minimise gambling harm.
- Objective 7: People have the life skills and the resilience to make healthy choices that prevent and minimise gambling harm.
- Objective 8: Gambling environments are designed to prevent and minimise gambling harm.
- Objective 9: Problem gambling services\(^1\) effectively raise awareness about the range of harms from gambling that affect individuals, families/whānau and communities for people who are directly and indirectly affected.
- Objective 10: Accessible, responsive and effective interventions are developed and maintained.
- Objective 11: A programme of research and evaluation establishes an evidence base, which underpins all problem gambling activities.

This draft service plan outlines the services required to advance these 11 objectives over the 2013/14 to 2015/16 problem gambling levy period.

**Public health approach**

The Gambling Act 2003 recognises the importance of prevention, and requires the Ministry to adopt a public health focus in addressing gambling harm.

The Ministry uses a continuum of harm model. This approach recognises that people experiencing harm from gambling are at different stages of harm. People do not simply move along the continuum, but enter and exit at various points, and may re-enter at the same point or a different point after having previously exited. While it is necessary to address the needs of those who have already developed a serious problem and who need specialist help, taking an early preventive approach can avoid considerable loss and trauma.

\(^{1}\) The reference to problem gambling services for this objective includes health services that treat problem gamblers and excludes all primary health care services.
More detail on this public health approach, and the Korn and Shaffer model (Korn and Shaffer 1999) on which it is based, can be found in the strategic plan.

**Population health**

As part of its public health approach, the Ministry uses a population health framework to address gambling harm across different groups within the population. A population health framework addresses the differences in health status among, and within, populations. The goal is to maintain and improve the health status of the entire population and to reduce inequalities in health status between groups and/or subgroups.

**Health inequalities**

Health inequalities are differences in health status or in the distribution of health determinants between different population groups that are avoidable or unjust. A major health challenge for New Zealand is the inequalities in health between Māori and non-Māori, and between Pacific and non-Pacific peoples.

Inequalities in health are not random. Their causes are complex and multifaceted. A strong evidence base and a strategic approach from the health sector and other sectors are required to reduce health inequalities for those who are disadvantaged. Reducing health inequalities for disadvantaged sectors of the community is relevant to the prevention and minimisation of gambling harm because those who are disadvantaged are more likely to experience harm from gambling.

**Whānau Ora**

The Ministry recognises that the health system has not worked as well for Māori whānau as it could, with disparities across the board such as lower life expectancy, higher tobacco usage, higher rates of gambling harm and poor health outcomes.

Realising Māori potential to help improve health outcomes is the goal of Whānau Ora. Whānau Ora involves facilitating positive and adaptive relationships within whānau and recognising the interconnectedness of health, education, housing, justice, welfare and lifestyle as elements of whānau wellbeing.

The strategic plan complements a range of other Ministry strategic documents, including:

- *He Korowai Oranga: Māori Health Strategy*
- *Whakatātaka: Māori Health Action Plan*

The high-level aim of these approaches is for Māori families to be supported to achieve their maximum health and wellbeing. Whānau Ora provides an overarching principle for recovery and maintaining wellness.
The Whānau Ora outcomes within *Te Puāwaiwhero* represent high-level commitments from the Government that should inform and direct all analysis and consideration of progress in gambling harm outcomes.

To reflect how the activities and processes outlined within the Ministry’s strategic and service plans for preventing and minimising gambling harm, and problem gambling sector practices, are meeting the Government’s objectives for Māori health, the Ministry has mapped the gambling harm strategic activities and planning against the pathways and objectives in *He Korowai Oranga*. The alignment between these activities and the objectives in *He Korowai Oranga* is presented in the strategic plan.

### 1.1.4 The needs assessment

The needs assessment in this consultation document indicates that intervention services meet current demand and provide good geographical coverage across New Zealand. Although there are a few areas lacking access to face-to-face services, the Gambling Helpline ensures that all areas have a service available.

The needs assessment indicates that there have been reductions in expenditure, and possibly reductions in participation, in some forms of gambling. Even so, it confirms that Māori and Pacific people continue to be at higher risk of gambling harm. There might also be elevated risks among specific Asian sub-groups.

The needs assessment also concluded that gambling outlets are still concentrated in high deprivation areas, in which Māori and Pacific people are often over-represented. People living in these areas are still at greater risk of gambling harm.

Although the needs assessment in this consultation document is complete in itself, it draws on information from a range of other sources. Those who wish to gain a more comprehensive understanding of the issues can refer to these other sources, which are outlined below.

In 2008 the Ministry contracted out the gathering and analysis of relevant information to underpin the needs assessment for the 2010/11 to 2012/13 period. This included a literature review, updating the Ministry’s problem gambling geography, a review of Ministry-contracted research, and an analysis of prevalence data, presentation data and findings from the first stages of the Ministry’s service evaluation. The result was a document that is still available on the Ministry’s website: *Informing the 2009 Problem Gambling Needs Assessment: Report for the Ministry of Health*.

In 2011 the Ministry contracted out the preparation of an update report to underpin the needs assessment for the 2013/14 to 2015/16 period. The full report on this work, *Informing the 2012 Gambling Harm Needs Assessment: Report for the Ministry of Health*, will also be available on the Ministry’s website.
Key findings from the 2010 New Zealand Health and Lifestyles Survey (NZHLS) and preliminary findings from the 2011/12 New Zealand Health Survey (NZHS) are provided in the 2012 update. Fuller reports on the results of the 2010 NZHLS are available on the Health Promotion Agency/Health Sponsorship Council website www.hsc.org.nz. Fact sheets setting out findings from the 2011/12 NZHS will be made available on the Ministry of Health website as they are finalised.

1.1.5 The research agenda

In the course of preparing the strategic plan, the Ministry reviewed its research agenda for the 2010/11 to 2015/16 period. That review informed both the research programme for 2010/11 to 2012/13 (described in section 1.2.3) and the research and evaluation programme proposed in the draft three-year service plan (see section 1.6.3).

1.2 2010/11 to 2012/13 service period

1.2.1 Service changes

There were a number of highlights and notable service changes over the 2010/11 to 2012/13 period, including:

- the extraordinary efforts to ensure service delivery was maintained in the aftermath of the catastrophic Christchurch earthquake on 22 February 2011
- trialling alternative contracting arrangements to enhance Pacific and Māori capacity and capability in areas of need (eg, a transitional partnering arrangement between an established mainstream provider and a developing Māori service, and a partnering arrangement between an established Māori service and a newly contracted Pacific provider)
- the establishment of a new public health workforce development provider, Te Kakano (a partnership between two existing providers), to deliver on the Ministry’s commitment to this area as a key activity in 2010/11 to 2012/13
- revision of the intervention service practice requirements handbook to clarify points of practice and the Ministry’s intentions for the gambling harm intervention services
- implementation of a revised data monitoring collection, collation and reporting system to simplify the processes for intervention service providers while maintaining and improving data integrity
- the involvement of the gambling industry in several initiatives, including the multi-venue exclusion project, some research projects, and the implementation of the outcomes framework leading up to the baseline progress report
- the re-integration of the Gambling Helpline with Lifeline Aotearoa in April 2011 to reduce overheads and ensure better access to Lifeline Aotearoa’s integrated support and back-up services.
1.2.2 Efficiency of services and effectiveness of the strategy

The Ministry's evidence for the efficiency of services and the effectiveness of the integrated problem gambling strategy largely derives from two sources:

- its research and evaluation programme, including evaluations of awareness-raising campaigns, the national gambling study, a national effectiveness trial, gambling and non-gambling longitudinal studies, and a comprehensive outcomes monitoring and reporting project
- its standard contract management processes, including monthly data collection, six-monthly reporting, routine audits, and verification visits.

There is already some evidence from these sources that the strategy is effective. For example:

- face-to-face intervention service statistics typically report substantial improvements on measures of problem gambling, dollars lost and control over gambling, when clients are re-assessed after treatment
- preliminary results from a national effectiveness trial also indicate substantial post-intervention improvements on a range of problem gambling measures (as well as on measures of hazardous drinking, mental health, and quality of life)
- the 2010 New Zealand Health and Lifestyles Survey found that the proportion of people who recalled having seen television advertising about gambling harm and solutions had more than doubled since 2006/07
- the 2010 New Zealand Health and Lifestyles Survey found a reduction since 2006/07 in the proportion of people who reported someone in their wider family or household going without something they needed or bills not being paid because too much was spent on gambling
- preliminary results from the 2011/12 New Zealand Health Survey indicate that the percentage of adults at risk of problem gambling is lower than at the time of the 2006/07 New Zealand Health Survey, and that there is some reduction in inequalities attributable to problem gambling.

Relevant research and evaluation projects include the national gambling study, a national effectiveness trial, a comprehensive outcomes monitoring and reporting project, and longitudinal studies. The outcomes monitoring and reporting framework will provide systematic and comprehensive evidence on the effectiveness of the integrated problem gambling strategy. The baseline report is expected in late-2012. That report and subsequent reports on progress against the framework’s indicators will inform the Ministry’s approach to its public health and intervention services over the 2013/14 to 2015/16 period.”

In addition, in 2011 KPMG reported the results of its independent Value for Money review of problem gambling services (available on the Ministry’s website). It identified a range of strengths and some areas that would benefit from further development. It concluded that there had been a strong upward trend in value for money over the previous three years but that it was premature to assess overall value for money, as the Ministry’s outcomes framework was still being implemented.
1.2.3 Ongoing delivery

Service delivery during the 2010/11 to 2012/13 period as it relates to public health activity, intervention, accessibility for and responsiveness to Māori, and research is discussed below.

Public health

Central to the Ministry’s national public health activity has been the continuation of the Kiwi Lives awareness-raising campaign, co-ordinated by the Health Sponsorship Council until 1 July 2012 and by the Health Promotion Agency thereafter. Phase three of the campaign, ‘The coin toss’, was launched in June 2011. It is aimed at empowering and enabling people who are at higher risk of developing gambling problems and those in their lives who have the opportunity to intervene before gambling becomes harmful.

Public health service delivery continued to include a range of community-level activities undertaken across the country, including working with government agencies, church groups, educational institutions, marae and gambling venue operators.

Service providers continued to participate in the process for reviewing gambling venue policies, providing a community perspective to the consultation process undertaken at least three-yearly by territorial authorities. This process has seen a number of authorities introduce either gaming machine caps or sinking-lid policies in their regions.

Intervention

The 2011 year saw a levelling-off in the number of people accessing intervention services. This included a levelling-off in the number of brief interventions. The number of calls to the Gambling Helpline continued to decline, as it has in previous years.

Accessibility for and responsiveness to Māori

The number of Māori accessing intervention services remained relatively high throughout the three years from July 2008 to June 2011, and it appears to have remained at similar levels since. Coverage was extended during the 2010/11 to 2012/13 period, and there are now 14 dedicated Māori providers. Dedicated Māori public health and intervention services are a key strand of the Ministry’s commitment to improving Māori health outcomes.

Research

The research programme continued to be a focus for the Ministry over the 2010/11 to 2012/13 period. The work in this area involved:

- several projects that should be completed by 1 July 2013:
  - an analysis of the results of the gambling module in the 2009 iteration of the Pacific Island Families Study (mothers and children)
– a study on the effect of gambling venue characteristics on gambling and problem gambling
– a study on the effect of marketing, advertising and sponsorship on gambling and problem gambling
– a study on the impacts of gambling and problem gambling on Asian families and communities
– a national effectiveness trial for an internationally validated brief intervention

• commencement of several national projects, including:
  – a national study of gambling participation and problem gambling prevalence, and a 12-month incidence study
  – inclusion of a substantive gambling module in the Youth 2012 survey
  – an analysis of the results of the gambling module in the 2012 Pacific Island Families Study (mothers, fathers and children)
  – an investigation into Māori input into decision-making on gambling
  – implementation of facilitation services and pathways for co-existing disorders
  – inclusion of a three-year follow-up phase into the national effectiveness trial for an internationally validated brief intervention
  – an evaluation of both public health and intervention service delivery

• continuation of several projects:
  – a study on the impacts of gambling and problem gambling on Pacific families and communities
  – a study on community-level harm from gambling
  – a study on the impacts of gambling and problem gambling on Māori families and communities
  – a study on the delivery of problem gambling services to prisoners
  – a study on the effect of game characteristics, player information display systems and pop-ups on gambling and problem gambling
  – a study into the early identification of casino potential problem gamblers

• continuation of the scholarship programme to encourage research in gambling and problem gambling.

1.3 Factors for consideration, 2013/14 to 2015/16

Some of the factors outlined below suggest a changing environment and some potential volatility in service demand over the 2013/14 to 2015/16 period. Even so, the Ministry is confident that, overall, the proposed funding for both public health and intervention services will be adequate to meet demand and deliver a high-quality service consistent with the Gambling Act 2003 and the Ministry’s service standards and strategic requirements.
1.3.1 Drive for enhanced efficiency and effectiveness

These are uncertain times for the global economy and for the New Zealand economy. As a result, all government agencies and the non-government organisations (NGOs) they fund are expected to strive to enhance their efficiency and effectiveness. The Ministry expects this factor to be a key driver throughout the 2013/14 to 2015/16 period. Data from the baseline and subsequent reports on progress against indicators in the outcomes framework for gambling harm will inform and guide efforts in this area.

1.3.2 Review of mental health and addictions

The strategic direction for the mental health and addictions sector is currently being reviewed. Some of the outcomes of that review will probably have implications for the alignment between gambling harm services and the broader health sector. It is likely that those outcomes will need to be considered during the 2013/14 to 2015/16 levy period.

1.3.3 Difficulty predicting gambling behaviour

The uncertain economic times also make it more difficult to predict how gamblers will behave. The number of non-casino gaming machines has been dropping since late 2003, and spending on these machines tends to follow more general economic trends. Therefore, annual non-casino gaming machine expenditure is likely to remain well below its 2003/04 peak for the whole of the service plan period.

Conversely, spending on gambling products that offer the chance of a ‘life-changing’ prize for a small outlay tends to rise in difficult times. Given that changes to the rules for Powerball and Big Wednesday in 2007 and 2011 increased the probability of large jackpot prizes, annual expenditure on New Zealand Lotteries Commission products might continue at recent record levels throughout the period.

This suggests that the percentage of clients citing non-casino gaming machines as a primary problem gambling mode might continue to diminish. By contrast, the percentage citing Lotteries Commission products might continue at post-2008 levels.

1.3.4 The Gambling Helpline

The number of calls to the Gambling Helpline has been declining for some years. In 2011 the Helpline was re-integrated with Lifeline Aotearoa to reduce overheads and to ensure better access to support and back-up services.
The Helpline provides a free 24-hour, 7-day-a-week service and is a first contact point for people in crisis. It provides a back-up for other gambling harm services that are not 24/7. It also ensures coverage in rural areas where there are no face-to-face services.

A service of this nature is critical to the Ministry’s service delivery model. However, the recent Value for Money Review of the problem gambling services funded by the Ministry noted that the average cost per call to the Helpline is much higher than any available comparator. There is clearly a need to re-consider how the Helpline is contracted and managed within the framework of the other gambling harm services and within the framework of the other non-gambling helpline services funded or part-funded by the Ministry.

1.3.5 The outcomes reporting framework

The benchmark report on progress against the indicators in the outcomes framework for gambling harm is expected in late 2012. That report and subsequent progress reports will inform the Ministry’s approach to its services to prevent and minimise gambling harm, including public health services, throughout the 2013/14 to 2015/16 period.

1.3.6 The Health Promotion Agency

On 1 July 2012 the Health Promotion Agency assumed the functions of the Alcohol Advisory Council of New Zealand (ALAC) and the Health Sponsorship Council. The objective of this change is to improve co-ordination, reduce fragmentation and ensure more effective and efficient delivery of services.

The implications of this change for the Ministry’s 2013/14 to 2015/16 strategy to prevent and minimise gambling harm are unclear. A key foundation of the Ministry’s population-focused public health approach is the Kiwi Lives awareness-raising campaign, which was co-ordinated by the Health Sponsorship Council. The Ministry’s intention is that this campaign will continue.

1.3.7 Potential impact of additional gambling facilities in the Auckland casino

Although the details of any agreement are still to be finalised, it is possible that the Auckland casino will be granted the right to operate additional machines and/or tables in return for SkyCity building and operating the New Zealand International Convention Centre. This is likely to result in some additional gambling expenditure. At this stage it is unclear what the flow-on effect, if any, might be in terms of increased demand for gambling harm services.
1.3.8 Online gambling

A number of stakeholders have raised concerns about the potential for a dramatic increase in online gambling. Proposals to increase internet speed and capacity, patterns of online gambling in overseas jurisdictions and increasing use of online payment methods all combine to suggest that New Zealand might be approaching a tipping point. However, the research findings tend to be mixed. Most studies suggest that the vast majority of the limited number of online gamblers in New Zealand restrict themselves to New Zealand Lotteries Commission and New Zealand Racing Board products. The Ministry will continue to monitor developments in this area.

1.3.9 The Gambling (Gambling Harm Reduction) Amendment Bill

This Member's Bill, which seeks to address disparities in harm from non-casino gaming machines, is before the Commerce Committee. It is due to be reported back in November 2012. Once again, the potential implications for the Ministry’s 2013/14 to 2015/16 strategy to prevent and minimise gambling harm are unclear.

1.4 Three-year service plan, 2013/14 to 2015/16

This draft service plan is the proposed integrated problem gambling strategy (as described in section 317 of the Act) for 1 July 2013 to 30 June 2016. However, it is guided by the objectives outlined in the strategic plan. The draft service plan sets out the proposed funding in 2013/14 to 2015/16 for public health and intervention services, workforce development (for both public health and intervention services), research and evaluation.

The service plan maintains the emphasis on a more outcomes- and results-based approach to funding services to prevent and minimise gambling harm, with a focus on achieving value for money alongside optimal service coverage. There will be further refinements as findings become available from the outcomes framework for monitoring progress against the Ministry’s objectives.

The draft service plan takes into account information presented in the needs assessment and changes that have taken place in the gambling environment since the previous plan was developed. It will also incorporate feedback received during the consultation process.

The four core intervention components of the Ministry’s comprehensive approach are brief intervention, full intervention, facilitation, and follow-up services. The emphasis on improving the delivery, performance monitoring and evidence for these four core intervention components will continue. The Ministry will also continue to emphasise the need for innovative, targeted approaches to public health activity, with clear and comprehensive reporting on these activities.
Māori and Pacific people continue to be over-represented in statistics on gambling harm. Specific sub-groups of Asian people also appear to be more at risk of harm (notably international students and recent migrants). Services tailored to these population groups will continue to be a focus in the 2013/14 to 2015/16 period. Service providers are expected to contribute to improvements in whānau ora and to a reduction in health inequalities, recognising the cultural values and beliefs that influence the effectiveness of services for Māori and other at-risk groups.

1.5 Funding

This section sets out the services and funding the Ministry believes are required in the 2013/14 to 2015/16 period to achieve the outcomes set out in the strategic plan. Part of the funding requirements for each service period is a reconciliation of actual and forecast expenditure for the previous funding period. This reconciliation is discussed next, followed by an overview of forecast expenditure for 2013/14 to 2015/16.

1.5.1 Reconciliation of actual and forecast expenditure, 2010/11 to 2012/13

Table 1 shows the Ministry’s funding requirements as outlined in the 2010/11 to 2012/13 service plan. At the time of writing the Ministry anticipates that, over the 2010/11 to 2012/13 period, it will spend $75,000 (GST exclusive) less than the amount allocated in the service plan.

<table>
<thead>
<tr>
<th>Services</th>
<th>2010/11 ($)</th>
<th>2011/12 ($)</th>
<th>2012/13 ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public health services</td>
<td>6,757,795</td>
<td>7,090,551</td>
<td>6,965,362</td>
</tr>
<tr>
<td>Intervention services</td>
<td>8,413,180</td>
<td>8,549,343</td>
<td>8,563,730</td>
</tr>
<tr>
<td>Research contracts</td>
<td>2,499,073</td>
<td>2,224,073</td>
<td>1,423,000</td>
</tr>
<tr>
<td>Ministry of Health operating costs</td>
<td>957,044</td>
<td>978,617</td>
<td>1,000,839</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>18,627,092</strong></td>
<td><strong>18,842,584</strong></td>
<td><strong>17,952,931</strong></td>
</tr>
</tbody>
</table>

1.5.2 Services forecast for 2013/14 to 2015/16

The Ministry has calculated its budget requirements for 2013/14 to 2015/16 based on the needs assessment and the Ministry’s assessment of future service needs and requirements. The forecast budgets for the four main service lines are shown in Table 2. Each budget line is discussed in more detail in section 1.6.
### Table 2: Proposed Ministry of Health spend (GST exclusive), 2013/14 to 2015/16

<table>
<thead>
<tr>
<th>Services</th>
<th>2013/14 ($)</th>
<th>2014/15 ($)</th>
<th>2015/16 ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public health services</td>
<td>6,778,747</td>
<td>6,858,000</td>
<td>6,834,980</td>
</tr>
<tr>
<td>Intervention services</td>
<td>8,330,000</td>
<td>8,550,000</td>
<td>8,420,350</td>
</tr>
<tr>
<td>Research contracts</td>
<td>3,129,751</td>
<td>2,425,000</td>
<td>1,075,000</td>
</tr>
<tr>
<td>Ministry operating costs</td>
<td>957,044</td>
<td>978,617</td>
<td>1,000,839</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>19,195,542</strong></td>
<td><strong>18,811,617</strong></td>
<td><strong>17,331,169</strong></td>
</tr>
</tbody>
</table>

### 1.6 Existing and new services

The Ministry has grouped its services under four expenditure areas:
- public health services
- intervention services
- research contracts
- Ministry operating costs.

#### 1.6.1 Public health services

The public health component of the Ministry’s draft service plan includes:
- primary prevention services
- public health workforce development and training
- a minimising gambling harm awareness and education programme
- national coordination
- conference support
- audit.

The needs assessment found that people living in deprived areas were at greater risk of harm from gambling than those in less deprived areas, and that Māori and Pacific people were at greater risk than people of other ethnicities. It also found that most harm is associated with gaming machine gambling, and that gaming machines are disproportionately located in higher deprivation communities, where Māori and Pacific people are over-represented. Accordingly, it is appropriate to focus on these people and communities.

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

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Note that while the national coordination and conference support services represent overall sector capacity, the nature of the services aligns with public health principles and they have been budgeted to reflect this alignment.
Table 3: Proposed public health expenditure (GST exclusive), by service area, 2013/14 to 2015/16

<table>
<thead>
<tr>
<th>Service</th>
<th>2013/14 ($)</th>
<th>2014/15 ($)</th>
<th>2015/16 ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary prevention (public health action)</td>
<td>4,748,747</td>
<td>4,698,000</td>
<td>4,744,980</td>
</tr>
<tr>
<td>Workforce development</td>
<td>120,000</td>
<td>180,000</td>
<td>180,000</td>
</tr>
<tr>
<td>Awareness and education programme</td>
<td>1,680,000</td>
<td>1,680,000</td>
<td>1,680,000</td>
</tr>
<tr>
<td>National coordination services</td>
<td>130,000</td>
<td>130,000</td>
<td>130,000</td>
</tr>
<tr>
<td>Conference support</td>
<td>100,000</td>
<td>20,000</td>
<td>100,000</td>
</tr>
<tr>
<td>Audit activities</td>
<td>–</td>
<td>150,000</td>
<td>–</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>6,778,747</strong></td>
<td><strong>6,858,000</strong></td>
<td><strong>6,834,980</strong></td>
</tr>
</tbody>
</table>

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

**Primary prevention services**

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

In line with the Ministry’s strategic funding principles, the Ministry will continue to fund dedicated Māori, Pacific and Asian public health services to provide appropriate and relevant services in the respective communities.

There are five key service specifications that contribute to the public health approach to gambling harm:

- **policy development and implementation**: engagement with government agencies, social organisations, private industry and businesses to reduce gambling harm
- **safe gambling environments**: to ensure that environments that provide gambling opportunities are actively minimising harm and that individuals are supported to recognise and seek support to minimise gambling harm
- **supportive communities**: people live in communities that provide strong protective factors and that support individuals and family resilience
- **aware communities**: agencies, communities, families and individuals are aware of the range of harms arising from gambling
- **effective screening environments**: to identify individuals at risk of experiencing harm from gambling as early as possible and to ensure they are made aware of where to access appropriate minimising gambling harm intervention services.
The Ministry currently contracts 20 service providers to deliver primary prevention services for a combination of the public health service specifications (up to a maximum of all five). Based on current service delivery and the regular monitoring of service providers, the Ministry considers it realistic to broadly maintain its current arrangements with public health service providers for the time being. Minor amendments might be made where the needs assessment, modelling and achievement of service delivery targets suggest they are appropriate.

However, the market for public health service providers in the area of gambling harm has not been tested for some years. The Ministry considers it would be worth doing this to test the potential to enhance efficiency and effectiveness. The Ministry proposes to undertake this process.

**Public health workforce development and training**

One of the 11 objectives outlined in the strategic plan is the development of a skilled workforce to deliver effective services to prevent and minimise gambling harm. Public health workforce development and training was a key activity area in the 2010/11 to 2012/13 service plan, and the Ministry contracted Te Kakano as a public health workforce development provider during that period.

The Ministry supports providers to deliver training that is aligned with *Te Uru Kahikatea: The Public Health Workforce Development Plan 2007–2016*, which provides a national strategic approach to public health workforce development. Even so, there has not been a clear definition or explanation of competency-based requirements and expectations, or suitable public health qualifications. Accordingly, the Ministry proposes to provide more structure and clarity to support the professionalisation of the workforce.

The Ministry will look to raise competency-based training requirements and expectations, including adding specific reference to competency expectations in future contract service specifications. The Ministry intends to continue funding a dedicated workforce development and training coordination service. It also intends to provide dedicated workforce development funding within contracted full-time equivalent (FTE) public health service specifications to allow service providers scope to offer advanced and/or targeted public health workforce development and training.

**Gambling harm awareness and education programme**

A key part of the Ministry’s population-focused public health approach is the continuation of the Kiwi Lives awareness-raising campaign, coordinated by the Health Sponsorship Council until 1 July 2012 and by the Health Promotion Agency thereafter. This campaign, which was originally launched in April 2007, includes a national media component, the development of resources to support public health and intervention strategies, and a continued focus on evaluation. It prompts New Zealanders to think and talk about the broad impacts of problem gambling on individuals, communities and families, and to be aware of actions they can take to prevent and minimise gambling harm.
Phase three of the campaign (‘the coin toss’) was launched in June 2011. It is aimed at empowering and enabling people who are at higher risk and those in their lives who have the opportunity to intervene before gambling becomes harmful. Several results from the 2010 NZHLS indicate that the campaign is having some success. (For example, the proportion of people who were aware of any advertising about gambling harm and solutions was significantly higher in 2010 than in 2006/07.)

The draft service plan proposes an increase of $200,000 per year throughout the 2013/14 to 2015/16 period so that the campaign can be broadened to include a component focusing on gambling venues.

**National coordination and conference support**

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

**National coordination**

The national coordination service is a central point for disseminating key messages and ensuring providers across the range of services deliver those messages consistently. The service also facilitates the coordination of training and workforce development events for all services. For smaller providers, it facilitates networks and collegial support through hui, fono and other national events. Key outputs include the coordination, editing, printing and dissemination of a regular newsletter, and the coordination and management of provider workforce development forums.3

**Conference support**

Conference funding represents the Ministry’s contribution to a biennial international problem gambling conference held in New Zealand and an annual contribution to a national addiction and/or public health conference relevant to preventing and minimising gambling harm. The most recent biennial international conference was in 2012. As a result, in the 2013/14 to 2015/16 period the biennial conference will take place twice.

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

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3 Includes a national provider forum and forums to engage with Māori, Asian and Pacific providers.
National addiction sector or wider public health conferences enable problem gambling practitioners to meet and exchange ideas with practitioners from other related sectors, and enable a wider network for the exchange of knowledge. By contributing to and making use of existing workforce development opportunities, such as conferences, the Ministry is encouraging greater alignment across the broader mental health and addictions sector. This alignment is cost-effective and extends the skills of alcohol and other drug and problem gambling practitioners. This extension of skills will allow for greater service flexibility, particularly in smaller towns and remote areas.

The funding for national and international conference support is shown in Table 4.

<table>
<thead>
<tr>
<th>Conference</th>
<th>2013/14 ($)</th>
<th>2014/15 ($)</th>
<th>2015/16 ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>National addictions sector and/or public health conference support</td>
<td>20,000</td>
<td>20,000</td>
<td>20,000</td>
</tr>
<tr>
<td>New Zealand-based international problem gambling conference support</td>
<td>80,000</td>
<td></td>
<td>80,000</td>
</tr>
</tbody>
</table>

**Audit**

The Ministry audits gambling harm services every three years. The audits focus on governance and financial management, cultural responsiveness, data management and service quality and delivery.

1.6.2 Intervention services

The Ministry’s approach to preventing and minimising gambling harm includes the following intervention services:

- helplines and web-based services
- psychosocial intervention and support services
- the information system
- workforce development and training
- audit.
Table 5: Proposed intervention services expenditure (GST exclusive), by service area, 2013/14 to 2015/16

<table>
<thead>
<tr>
<th>Services</th>
<th>2013/14 ($)</th>
<th>2014/15 ($)</th>
<th>2015/16 ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Helpline services</td>
<td>1,100,000</td>
<td>1,100,000</td>
<td>1,100,000</td>
</tr>
<tr>
<td>Psychosocial interventions and support</td>
<td>7,035,000</td>
<td>7,035,000</td>
<td>7,105,350</td>
</tr>
<tr>
<td>Data collection and reporting</td>
<td>15,000</td>
<td>15,000</td>
<td>15,000</td>
</tr>
<tr>
<td>Workforce development</td>
<td>180,000</td>
<td>200,000</td>
<td>200,000</td>
</tr>
<tr>
<td>Audit</td>
<td>−</td>
<td>200,000</td>
<td>−</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>8,330,000</strong></td>
<td><strong>8,550,000</strong></td>
<td><strong>8,420,350</strong></td>
</tr>
</tbody>
</table>

Note: There is provision for dedicated Māori, Pacific and Asian services.

Helpline and web-based services

The Gambling Helpline provides a free 24-hour, 7-day-a-week service that represents a front-line first contact point for people in crisis as a result of their own or someone else’s gambling. It also includes dedicated Māori, Pasifika and Youth Gambling Helplines, and gambling debt and budget programmes. An Asian Gambling Hotline is provided by The Problem Gambling Foundation of New Zealand.

Helpline services are an integral component of a number of aspects of the Ministry’s service delivery model nationally, including:

- direct provision of information
- access by phone or other telecommunication/electronic means to intervention services for people unable to access face-to-face services
- referral to other gambling harm service providers
- web-based information on self-help, peer-to-peer support options and assessment guides.

The Ministry has ensured that the Gambling Helpline is at the forefront of the social marketing, education and awareness campaign. Current promotion, resources and materials under the ‘Choice Not Chance’ banner incorporate and align media messages for the public on the Gambling Helpline. The 2010 New Zealand Health and Lifestyles Survey estimated that 77% of adults were aware of the 0800 telephone gambling helpline, up from 68% in 2006/07.

Even so, the number of new Gambling Helpline clients declined each year from 2003 to 2011 (inclusive), except 2007 and 2010. There were 2122 new clients in 2011, down from 4569 in 2002. Most of this change occurred in only two years - 2005 and 2008 - coinciding with reductions in non-casino gaming machine expenditure following (respectively) a prohibition on smoking in gaming machine venues and the global financial crisis.
In 2011 the KPMG Value for Money Review concluded that the average cost per call to the Gambling Helpline is two to three times higher than the available comparators, although it also referred to research indicating that the helpline experiences very high call numbers relative to the country’s population.

In April 2011 the Gambling Helpline was re-integrated with Lifeline Aotearoa to reduce overheads and to ensure better access to Lifeline Aotearoa’s support and back-up services. It appears to meet current demand within its allocated funding.

The Ministry intends retaining helpline services as an integral component of its service delivery model. However, it also considers that the Gambling Helpline’s cost structures should be reviewed and the market tested to ensure that it delivers value for money. The Ministry expects to make savings, without compromising service to users, as a result.

**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). The four core intervention areas are brief intervention, full intervention, facilitation, and follow-up services.

Family and whānau members affected by someone else’s gambling can access the same range of services that is available to those experiencing gambling harm due to their own gambling.

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

All services are expected to be culturally safe and culturally competent. Dedicated Māori, Pacific and Asian services will continue to be provided to ensure appropriate access and services for these population groups.

The Ministry’s monitoring and reporting suggest there is adequate psychosocial intervention and support capacity within existing budgets and at current levels of demand. Once again, the Ministry considers there would be value in testing the market to establish the potential to enhance efficiency and effectiveness. The Ministry proposes to undertake this process.

**Data collection and reporting**

During the 2010/11 to 2012/13 service plan period the Ministry implemented a revised data monitoring collection, collation and reporting system. The revised system has simplified the processes for intervention service providers while maintaining data integrity.
In 2012 the data collection process was migrated to the Ministry from a small company that had provided all software, hardware and operational processes to report on the monitoring data. Most of the costs associated with the data collection process will be covered within the Ministry’s operating budget. The proposed small additional sum for data collection and reporting is to facilitate ongoing involvement by the previously contracted external company to address issues requiring institutional knowledge and to make any small technical adjustments that may be required.

**Intervention workforce development and training**

One of the 11 objectives outlined in the strategic plan is the development of a skilled workforce to deliver effective services to prevent and minimise gambling harm. As a result, training and workforce development will continue to be important service components to support psychosocial intervention services.

The Ministry would like to establish competency-based training requirements and expectations, and to provide greater clarity regarding appropriate and suitable qualifications, by the time the six-year strategic plan is revisited in 2015/16. This is supported by DAPAANZ’s recently developed Addiction Competencies Framework, which outlines competency pathways for key groups, including counsellors working to minimise gambling harm.

The Ministry considers that a combination of funding a dedicated workforce development and training coordination service, and dedicated workforce development funding allocated within contracted FTE service specifications, will provide the best outcomes.

A key focus for intervention workforce development over the 2010/11 to 2012/13 service period was to better align the gambling harm intervention workforce with other addiction services. There is a body of research to show that alcohol and other drug problems are often an issue for those experiencing harm from gambling.

**Audit**

The Ministry undertakes a routine three-yearly audit of gambling harm services. The audits focus on governance and financial management, data management, and service quality and delivery.

**1.6.3 Research and evaluation**

The Gambling Act 2003 states that the integrated problem gambling 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.

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It is clear that the Act supports a research agenda that is broader than specific health interests. In recognition of this, the Ministry, as the agency responsible for developing and implementing the integrated problem gambling strategy, has considered the information needs of the Department of Internal Affairs and the wider gambling and problem gambling sector interests.

Like all other areas of the service plan, the Ministry’s purchasing principles underpin the research agenda, including prioritisation of methodologies and approaches that ensure Māori involvement and participation in all research and that build Māori research capacity.

**The Ministry’s research priorities for 2013/14 to 2015/16**

To inform its research programme for 2013/14 to 2015/16, the Ministry reviewed its research agenda for the six-year 2010/11 to 2015/16 period. The agenda was informed by a range of sources, including:
- the priorities and rationale from the 2004–2010 Problem Gambling Strategy
- the findings of previously commissioned research
- the 2009 needs assessment
- the International Think Tank on Gambling Research, Policy and Practice
- the Ministry’s Gambling Research Reference Group feedback
- the Problem Gambling Stakeholder Reference group feedback
- a process of alignment with Gambling Research Australia projects recently completed, under way or scheduled for the 2010 to 2016 period.

The agenda identified a range of questions, the rationale for each category of investigation and links between categories, national and international evidence available to inform particular categories of investigation, and questions to be addressed by projects in 2010/11–2015/16.

**Research projects**

The specific projects the Ministry has identified for funding over the 2013/14 to 2015/16 period are those that it believes best address the Ministry’s research priorities and support the development of a whole-of-government approach for future planning. The priorities and projects identified by the Ministry for the 2013/14 to 2015/16 period are:

- continue to increase the evidence relating to risk and resilience factors by expanding the incidence component of the national gambling study to include re-contact at years two and three (this would be a cost-effective increase to a significant national project)
- extend the problem gambling sample in the existing national gambling study through venue-based intercept recruitment (like the increase in the incidence component, this would involve a modest budget increase for significant benefit)
• further develop the evidence for effective intervention services by commencing a national trial to assess the clinical outcomes of funded intervention services at one and two years after treatment (ideally this project would compare client outcomes in the different treatment arms of the national effectiveness trial)

• support the collection and analysis of longitudinal data to inform understanding of risk and resilience factors relating to problem gambling by funding a review, analysis and reporting on the gambling questions in the Growing up in New Zealand longitudinal study and continuation of funding for the Pacific Island Families longitudinal study

• continue to support and build gambling harm research capacity in New Zealand

• continue the outcomes monitoring and reporting project to improve the evidence base for the development of the Ministry’s 2016/17 to 2021/22 strategic plan, and to inform and support ongoing quality improvement in public health and intervention service delivery.

<table>
<thead>
<tr>
<th>Service area</th>
<th>2013/14 ($)</th>
<th>2014/15 ($)</th>
<th>2015/16 ($)</th>
<th>Project total ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013/14–2015/16 projects</td>
<td>2,629,751</td>
<td>2,050,000</td>
<td>800,000</td>
<td>5,479,751</td>
</tr>
<tr>
<td>Outcomes and evaluation</td>
<td>500,000</td>
<td>375,000</td>
<td>275,000</td>
<td>1,150,000</td>
</tr>
<tr>
<td>Research budget total</td>
<td>3,129,751</td>
<td>2,425,000</td>
<td>1,075,000</td>
<td>6,629,751</td>
</tr>
</tbody>
</table>

### 1.7 Ministry of Health operating costs

Ministry operating costs (departmental expenditure) include the contract management role, ongoing policy and service development work, management of the research, monitoring and evaluation programme, and management of the CLIC database within the Ministry. The 2011 KPMG Value for Money Review concluded that the Ministry’s operating costs are reasonable.

<table>
<thead>
<tr>
<th>Services</th>
<th>2013/14 ($)</th>
<th>2014/15 ($)</th>
<th>2015/16 ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating costs</td>
<td>957,044</td>
<td>978,617</td>
<td>1,000,839</td>
</tr>
<tr>
<td>Total</td>
<td>957,044</td>
<td>978,617</td>
<td>1,000,839</td>
</tr>
</tbody>
</table>
2 Levy calculation and proposed levy rates

2.1 Background

The Ministry is responsible for developing and implementing the integrated problem gambling strategy focused on public health that is described in section 317 of the Gambling Act 2003 (the Act). 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 and 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 Ministry appropriates funding through Vote Health. The Crown then recovers this sum through a levy, the ‘problem gambling levy’, on the profits of gambling operators. Section 319(2) of the Act states that the purpose of the levy is ‘to recover the cost of developing, managing, and delivering the integrated problem gambling strategy’.

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

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

However, the Act also anticipates that these sectors might change from time to time.

Section 320 of the Act sets out a formula to help calculate the levy rate for each sector. It uses weighted percentages of current player expenditure (losses) in each sector and ‘presentations’ to problem gambling services (numbers of people seeking help) that are attributable to each sector.

The levy rates are set by regulation every three years. The next levy period is from 1 July 2013 to 30 June 2016.
2.2 Process to develop the strategy and calculate the levy

The process for developing the strategy and calculating the levy is set out in section 318 of the Act. As part of this process, the Ministry of Health has undertaken a needs assessment, prepared a draft service plan for the period from 1 July 2013 to 30 June 2016 (the second three-year period of the Preventing and Minimising Gambling Harm: Six-year strategic plan 2010/11–2015/16), considered four alternative sets of levy rates, and indicated its support for one of those sets of rates.

The Ministry is now consulting on the draft service plan for 1 July 2013 to 30 June 2016 (which is the draft integrated problem gambling strategy for that period), the levy, the levy rates and the needs assessment,

Following consultation, the Ministry will submit proposals to the Ministers of Health and Internal Affairs, and to the Gambling Commission. The Gambling Commission may then commission its own advice, and will undertake its own consultation and make recommendations to the Ministers of Health and Internal Affairs. Cabinet will approve the service plan, determine the funding to be appropriated to the Ministry of Health and recommend to the Governor-General regulations setting out the sectors that will pay the levy and the relevant levy rates.

2.3 Levy formula and definitions

The formula for calculating the levy provides a mechanism for allocating among gambling operators, and collecting from them, the approximate cost of the integrated problem gambling strategy. The Act states that the calculation ‘must take into account the latest, most reliable, and most appropriate sources of information’. The figures in the four alternative levy calculation options below should be considered indicative. They will be updated following the consultation process to include the latest available data.

2.3.1 Sectors subject to the levy

The Gambling Commission has previously suggested that non-casino gaming machines should be split into two sectors: non-club (‘pub’) and club. The Ministry considers that the evidence supports this split, which would significantly reduce the levy rate for clubs, and slightly increase the rate for non-club operators. However, the Inland Revenue Department advises that, given its current work programme, it has no capacity over the next three years to implement such an initiative requiring significant changes to its IT systems. As a result, this consultation document does not propose splitting the NCGM sector into two sectors.

The following paragraphs outline the evidence on this issue available to the Ministry.
Information from problem gambling services indicates that fewer people seek help for problems associated with club machines, even after taking into account the lower number of club machines and their lower average per-machine-spend. Machines in clubs comprised just over 20% of all licensed NCGMs as at 30 June 2011, and spending on club machines was 13.3% of all NCGM expenditure in the quarter ended 30 June 2011. By contrast, fewer than 10% of people citing NCGMs as a primary problem gambling mode in 2010/11 named club machines.

There is also growing research evidence suggesting that club machines are less likely to be associated with harm. For example, the SHORE/Whariki (2008) study found that longer times spent playing machines in clubs was associated with far fewer negative impacts on 13 domains of life than longer times spent playing machines in bars. Similar findings emerged from the Opus study of gambling venue characteristics (In Press). It noted that ‘despite clubs being found to have longer playing durations, they were also shown to have significantly lower PGSI [Problem Gambling Severity Index] scores for those gamblers that took part in the intercept survey’.

Setting one levy rate for the whole NCGM sector adequately addresses differences that are attributable to differences in average per-machine-spend. This is because levy rates are set as percentages of expenditure. The lower the amount spent on any machine, the lower the amount payable in levy. However, setting one levy rate for the whole sector does not address any differences in gambling-related harm that are not attributable to differences in per-machine-spend.

The higher the weighting on ‘presentations’ (help-seeking), the more impact splitting the NCGM sector would have. For example, if the sector were split and the weighting were 5% on expenditure and 95% on presentations (5/95), the 311 clubs that operate machines in their own premises would pay a total of around $1.3 million (GST exclusive) less over the three-year period (and non-club gaming machine societies would pay around that much more). For the clubs, this amount would represent a reduction in their levy liability of almost 30%. For the 48 non-club gaming machine societies it would represent an increase of around 4%.

### 2.3.2 Current expenditure

Current player expenditure has been supplied by the Inland Revenue Department and is subject to tax confidentiality. Other data on gambling expenditure are available on the Department of Internal Affairs website, www.dia.govt.nz.

### 2.3.3 Presentations (people seeking help)

Figures on presentations were generated by the Ministry of Health from data collected by intervention service providers. Presentation figures relate to all clients who received a full facilitation or follow-up intervention session during 2010/11. Brief interventions are excluded, as are primary problem gambling modes in gambling sectors that are not subject to the levy.
2.3.4 Forecast expenditure

The current difficult economic climate has made forecasting expenditure for four years into the future more difficult than usual. Expenditure forecasts in this consultation document have taken into account the points discussed below.

Non-casino gaming machines (NCGMs)

The number of NCGMs is still declining. There were 20,302 NCGMs on 31 March 2007 and 18,001 on 31 March 2011. However, spending increased a little, to $856 million in 2010/11, after declining in each of the previous three years from a figure of $950 million in 2006/07. More recent electronic monitoring system data suggest that this small increase has been sustained, and it is anticipated that this low level of growth will continue throughout the 2013/14 to 2015/16 period.

Non-club expenditure has been between 86% and 87% of total NCGM expenditure every quarter since 30 June 2007, which was the first full quarter after the electronic monitoring system began operating. Club expenditure has always varied between 13% and 14%. The average is 86.4% non-club and 13.6% club. This trend is expected to continue throughout the 2013/14 to 2015/16 levy period.

Casinos

Over the six years up to and including 2010/11, casino spending fluctuated from around $430 million up to nearly $500 million; 2009/10 and 2010/11 were at the lower end of this range. Overall casino spending reduced a little in the latter part of the 2010/11 year because the Christchurch casino was closed for several months following the earthquake on 22 February 2011. Modest growth in casino gambling is forecast throughout the period of the proposed levy.

In New Zealand, spending in the Auckland casino dominates all casino spending. The Government is currently considering a proposal from SkyCity to allow additional machines and tables in that casino in return for SkyCity building and operating the New Zealand International Convention Centre. Details of the proposed arrangement have not yet been finalised.

New Zealand Racing Board

Spending on New Zealand Racing Board products has been relatively flat for some years. Low levels of growth are forecast for the whole of the 2013/14 to 2015/16 period.

New Zealand Lotteries Commission

Spending on New Zealand Lotteries Commission 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 that subsequently diminishes is forecast for the 2013/14 to 2015/16 period, reflecting an expectation that the market for New Zealand Lotteries Commission products will grow initially, then begin to mature.
2.3.5 Weighting

The weighting between current expenditure and presentations is central to determining the share of the levy payable by each gambling sector.

For the 2007/08 to 2009/10 and the 2010/11 to 2012/13 levy periods, the weighting was 10% on expenditure and 90% on presentations (10/90). The Ministry proposed a weighting of 30% on expenditure and 70% on presentations for the 2010/11 to 2012/13 period (30/70), and it again proposes this weighting for the 2013/14 to 2015/16 levy period.

The levy is intended to recover the cost of developing and implementing a strategy that addresses the risk of 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% on expenditure would be inappropriate, because it would unfairly penalise operators of relatively benign forms of gambling with high expenditure. A weighting of 30% or less on expenditure necessarily implies a weighting of 70% or more on presentations.

A ‘presentation’ refers to 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 primary gambling modes cited by the intervention service client. Therefore, the Ministry considers that presentations, as one indicator of harm, albeit harm at the acute end of the continuum, should be allocated a substantially heavier weighting than expenditure. This also tends to support a weighting of at least 70% on presentations and no more than 30% on expenditure.
However, presentations are not the only available indicator of harm. Other examples include estimates of problem gambling prevalence using screening instruments such as the PGSI, or survey questions that more directly assess the risk of harm associated with particular gambling products.

Some of these other indicators suggest a weighting on presentations that is not much higher than 70%. For example, the 2010 New Zealand Health and Lifestyles Survey (NZHLS) asked people whether, in the previous year, there had been an argument in their wider family or household, and/or people had gone without or bills had not been paid, because of gambling. Of those who said this was the case, 14% said that New Zealand Lotteries Commission products were the form of gambling most often involved. This figure rose to around 15% when considering only those gambling sectors that are subject to the levy. By contrast, Lotteries Commission products comprised only 5.7% of all presentations attributable to relevant gambling sectors in 2010/11.

Taken together, these two indicators of harm (presentations and the ‘household harm’ question in the NZHLS) suggest that the New Zealand Lotteries Commission should pay at least 5.7% of the total levy funding requirement, but no more than 15%. Table 14 on page 37 indicates that a 30/70 weighting would require the Lotteries Commission to pay $5.5 million of the $53.6 million to be raised by the levy. This is a share that is almost exactly in the middle of the 5.7% to 15% range.

This type of analysis suggests that (listing each sector’s 2010/11 presentation figure first followed by its ‘household harm’ figure):

- the NCGM share of the levy should be between 67.7% and 55%
- the New Zealand Racing Board share should be between 8.2% and 16%
- the New Zealand Lotteries Commission share should be between 5.7% and 15%.

The 30/70 weighting is the best fit on these three criteria.

The casino share should be between 18.4% and 14%. None of the weightings in Tables 11 to 14 achieves this. Only a 0/100 weighting would bring casinos within this range, and then only right at the top of the range. The proposed 30/70 weighting would require casinos to pay a 20% share. Arguably, this slightly higher share is reasonable given the uncertainty around the timing and any potential impact of the proposal for additional casino gambling facilities in Auckland.
There are other lines of reasoning that support a weighting on presentations that is higher than 50% but considerably lower than 100%.

The definition of harm in the Gambling Act 2003 is very broad. Presentations represent only a small subset of gambling harm, and that subset tends to be at the acute end of the continuum. Those who seek help are 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 levy is intended to recover the cost of developing and implementing the integrated problem gambling strategy focused on public health. 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 include gambling research (not just problem gambling research) and evaluation. A gambling sector’s share of presentations to intervention services is not necessarily an appropriate way of determining the share that sector should bear of public health, research and evaluation costs.

One critical problem with the weighting approach is that there may be no single weighting that would require each sector to pay its fairest share of the levy. In addition, a particular problem with a heavy weighting on presentations is that, as the Gambling Commission noted in its 2009 report, ‘diligent host responsibility in detecting problem gambling and encouraging the seeking of assistance is punished not rewarded’. Conversely, a particular problem with a heavy weighting on expenditure is that it unfairly penalises operators of relatively benign forms of gambling with high expenditure.

However, the Act requires the Ministry to use a weighting between expenditure and presentations to help determine each sector’s share. For all the reasons outlined above, the Ministry proposes a weighting of 30% on expenditure and 70% on presentations (30/70) for the 2013/14 to 2015/16 levy period.

Other options considered in this document are weightings of 5/95, 10/90 and 20/80, expenditure to presentations. Note that:

- the higher the weighting on expenditure, the higher the share of the levy to be paid by the New Zealand Lotteries Commission in particular (because that sector’s proportion of gambling expenditure is much higher than its proportion of presentations)
- the higher the weighting on presentations, the higher the share to be paid by the NCGM sector (because two-thirds of all presentations are attributed to that sector) and the lower the share to be paid by the New Zealand Lotteries Commission, in particular.

The share of the levy to be paid by casinos is not very sensitive to any weighting changes because that sector’s proportion of expenditure is relatively close to its proportion of presentations.
The Ministry is seeking feedback through this consultation document on which weighting option you prefer and why. It is important to note that the levy weighting options do not affect the total amount of the levy. The weighting chosen only affects the share of the levy to be paid by each gambling sector.

2.4 Levy calculations

The tables that follow set out:

- the Ministry of Health’s costings for the draft service plan described in this consultation document (ie, the costings for the draft strategy for the three-year period from 1 July 2013 to 30 June 2016)
- the effect of each of the four alternative weightings described above on the levy rates for the four current gambling sectors.

The formula for calculating the levy rate for each sector is:

\[
\text{Levy rate} = \frac{([A \times W1] + [B \times W2]) \times C}{D}
\]

where:

- \(A\) = 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, taking into account any under-recovery or over-recovery in the previous levy period
- \(D\) = forecast player expenditure in a sector for the period during which the levy is payable.

\(W1\) and \(W2\) are weights, the sum of which is 1.

A Gambling Amendment Bill has been before Parliament for several years. While this Bill proposes a change to the levy formula, this consultation document uses the formula that is currently set out in the Gambling Act 2003.

5 The Inland Revenue Department will provide information to the Department of Internal Affairs and Ministry of Health relating to the gaming duty paid by gambling operators. The Tax Administration Act 1994 requires both agencies to maintain the secrecy of the information received.
2.4.1 Net over-recovery in previous levy period

Section 320 of the Act states that any under-recovery or over-recovery of levy in the previous period (2010/11 to 2012/13) must be taken into account when calculating C, the funding requirement for the new period (2013/14 to 2015/16). Because the 2010/11 to 2012/13 levy period has not yet finished, forecasts are required.

The Department of Internal Affairs has used Inland Revenue Department data to forecast a levy over-collection of $1,667,100 (GST exclusive) in 2010/11 to 2012/13. This figure must be subtracted from the levy funding requirement for 2013/14 to 2015/16 (see Table 10 below).

There are two main reasons why an over-collection is forecast.

- NCGM spending is forecast to be higher than was anticipated (and much higher than the sector itself anticipated) when the 2010/11 to 2012/13 levy was being set.
- Rule changes that tend to generate more large jackpots are forecast to lead to higher spending on New Zealand Lotteries Commission products than was anticipated when the 2010/11 to 2012/13 levy was being set.

The funding requirement for 2013/14 to 2015/16 must also take into account any Ministry of Health under-spend in the previous levy period, because it leads to over-collection. The Ministry has forecast an under-spend of $75,000 (GST exclusive) for 2010/11 to 2012/13. This figure must also be subtracted from the levy funding requirement for 2013/14 to 2015/16 (Table 10).

Finally, the calculation must take account of any net over-strike or under-strike\(^6\) as a result of variations from the out-turn to 30 June 2010 that was forecast when the levy for 2010/11 to 2012/13 was being set. At that time, a net-over-strike of $69,506 was forecast for the period to 30 June 2010, and the amount to be collected in 2010/11 to 2012/13 was reduced by that amount. In fact, the Ministry’s Annual Report indicates that levies collected in the two levy periods to 30 June 2010 totalled $100.335 million and Ministry expenditure totalled $100.290 million, an over-strike of $45,000. The variation from forecast was therefore $24,506, and this amount is added to the levy funding requirement for the 2013/14 to 2015/16 levy period (Table 10).

---

\(^6\) An over-strike means that the amount to be recovered by the levy was over-estimated; an under-strike means that the amount was under-estimated.
### Table 10: Proposed levy funding requirement (GST exclusive), 2013/14 to 2015/16

<table>
<thead>
<tr>
<th>Funding requirement</th>
<th>$ (GST exclusive)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Draft service plan proposed Ministry of Health spend in 2013/14</td>
<td>$19,195,542</td>
</tr>
<tr>
<td>Draft service plan proposed Ministry of Health spend in 2014/15</td>
<td>$18,811,617</td>
</tr>
<tr>
<td>Draft service plan proposed Ministry of Health spend in 2015/16</td>
<td>$17,331,169</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td><strong>$55,338,328</strong></td>
</tr>
<tr>
<td>Minus forecast levy over-collect from 2010/11 to 2012/13</td>
<td>$(1,667,100)</td>
</tr>
<tr>
<td>Minus forecast Ministry of Health under-spend from 2010/11 to 2012/13</td>
<td>$(75,000)</td>
</tr>
<tr>
<td>Plus variation from forecast to 30 June 2010</td>
<td>$24,506</td>
</tr>
<tr>
<td><strong>Net levy funding requirement for 2013/14 to 2015/16</strong></td>
<td><strong>$53,620,734</strong></td>
</tr>
</tbody>
</table>

### Table 11: Proposed levy rates: 5/95 weighting

<table>
<thead>
<tr>
<th>Collection period starts 1 July 2013 (all GST exclusive)</th>
<th>NCGMs</th>
<th>Casinos</th>
<th>New Zealand Racing Board</th>
<th>New Zealand Lotteries Commission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sector levy rates (%)</td>
<td>1.33</td>
<td>0.67</td>
<td>0.54</td>
<td>0.25</td>
</tr>
<tr>
<td>Expected levy ($)</td>
<td>35,721,600</td>
<td>10,035,400</td>
<td>4,558,300</td>
<td>3,436,400</td>
</tr>
</tbody>
</table>

### Table 12: Proposed levy rates: 10/90 weighting

<table>
<thead>
<tr>
<th>Collection period starts 1 July 2013 (all GST exclusive)</th>
<th>NCGMs</th>
<th>Casinos</th>
<th>New Zealand Racing Board</th>
<th>New Zealand Lotteries Commission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sector levy rates (%)</td>
<td>1.30</td>
<td>0.68</td>
<td>0.55</td>
<td>0.28</td>
</tr>
<tr>
<td>Expected levy ($)</td>
<td>34,915,800</td>
<td>10,185,100</td>
<td>4,642,800</td>
<td>3,848,800</td>
</tr>
</tbody>
</table>

### Table 13: Proposed levy rates: 20/80 weighting

<table>
<thead>
<tr>
<th>Collection period starts 1 July 2013 (all GST exclusive)</th>
<th>NCGMs</th>
<th>Casinos</th>
<th>New Zealand Racing Board</th>
<th>New Zealand Lotteries Commission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sector levy rates (%)</td>
<td>1.25</td>
<td>0.69</td>
<td>0.59</td>
<td>0.34</td>
</tr>
<tr>
<td>Expected levy ($)</td>
<td>33,572,900</td>
<td>10,334,900</td>
<td>4,980,400</td>
<td>4,673,600</td>
</tr>
</tbody>
</table>
Table 14: Proposed levy rates: 30/70 weighting

<table>
<thead>
<tr>
<th>Collection period starts 1 July 2013 (all GST exclusive)</th>
<th>NCGMs</th>
<th>Casinos</th>
<th>New Zealand Racing Board</th>
<th>New Zealand Lotteries Commission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sector levy rates (%)</td>
<td>1.20</td>
<td>0.71</td>
<td>0.62</td>
<td>0.40</td>
</tr>
<tr>
<td>Expected levy ($)</td>
<td>32,230,000</td>
<td>10,634,500</td>
<td>5,233,700</td>
<td>5,498,300</td>
</tr>
</tbody>
</table>
3 Gambling Harm Needs Assessment 2012

3.1 Introduction

The Ministry of Health is responsible for developing and implementing an integrated problem gambling strategy focused on public health. This strategy is described in section 317 of the Gambling Act 2003. The Act requires that a new strategy be put in place at least every three years. As part of this three-yearly process the Act also requires the Ministry to undertake and consult on a needs assessment.

In the years immediately after the Act came into force the Ministry itself prepared the needs assessment. However, in 2008 it chose to contract out the gathering and analysis of relevant information to underpin the needs assessment for the 2010/11 to 2012/13 period. This included a literature review, updating the Ministry’s problem gambling geography, a review of Ministry-contracted research, and an analysis of prevalence data, presentation data and findings from the first stages of the Ministry’s evaluation of services to prevent and minimise gambling harm. The result was a document that is still available in the problem gambling section of the Ministry’s website: Informing the 2009 Problem Gambling Needs Assessment: Report for the Ministry of Health.

In 2011 the Ministry contracted out the preparation of a report to update the needs assessment for the 2013/14 to 2015/16 period. This report, Informing the 2012 Gambling Harm Needs Assessment: Report for the Ministry of Health (referred to as the 2012 needs assessment update report) will also be available on the Ministry’s website.

Key findings from the 2010 New Zealand Health and Lifestyles Survey (NZHLS) and preliminary findings from the 2011/12 New Zealand Health Survey (NZHS) are provided in the 2012 needs assessment update report. Fuller reports on the results of the 2010 NZHLS are available on the Health Sponsorship Council / Health Promotion Agency website. Fact sheets on the 2011/12 NZHS will be made available on the Ministry of Health website, as they are finalised.

The short needs assessment in this consultation document summarises key material from these reports. Those wishing to consider the issues in more detail may find it useful to refer to the source publications. Although not specific to New Zealand, the Ministry also considers that the report of the Australian Productivity Commission’s 2010 inquiry into gambling (Productivity Commission 2010) reflects a considered and robust assessment of many facets of gambling and gambling harm.

Many of these documents are large and some have not yet been finalised. For these reasons, they have not been published with this consultation document.
3.2 The gambling environment

3.2.1 Gambling participation

Numerous studies have examined gambling participation in New Zealand. From 1985 to 2005 the Department of Internal Affairs (DIA) ran a five-yearly survey of people’s participation in and attitudes towards gambling (Wither 1987; Christoffel 1992; Reid and Searle 1996; Amey 2001; Department of Internal Affairs 2008). In 1991 and 1999 DIA commissioned national surveys of gambling and problem gambling prevalence, the latter being only one component of the much larger New Zealand Gaming Survey (Abbott and Volberg 1991, 1992; Abbott and Volberg 2000; Abbott 2001).

In 2003, 2006/07 and 2011/12 the Ministry of Health included gambling components in the NZHS (Ministry of Health 2006, 2009, in press).

In 2006/07 the Gaming and Betting Activities Survey was run for the Health Sponsorship Council (Health Sponsorship Council and National Research Bureau 2007). The Health Sponsorship Council followed this in 2010 with the NZHLS, which included a substantial gambling component (Gray 2011; Health Sponsorship Council 2012).

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

Key findings from these surveys are set out below, with examples from the 2010 NZHLS.

- Most adults in New Zealand gamble at least occasionally. For example, the 2010 NZHLS estimated that 81% of people aged 15 or over had taken part at least once in at least one gambling activity in the previous 12 months.

- Only a minority of adults participate in any gambling activity other than New Zealand Lotteries Commission products or raffles. For example, the 2010 NZHLS estimated that nearly two in three adults (63%) had bought a New Zealand Lotteries Commission product at least once in the previous year. However, it also estimated that, in the previous year, only:
  - 16% had played a gaming machine in a pub or club at least once
  - 12% had bet on a horse or dog race at least once
  - 10% had played a gaming machine in one of the six casinos at least once
  - 4% had bet on a sports event at least once
  - 3% had played a table game at one of the six casinos at least once.
• Differences among gambling activities are even more pronounced when the frequency of participation is considered. For example, the 2010 NZHLS estimated that 29% of those who had bought a Lotto, Strike, Powerball or Big Wednesday ticket at least once in the previous year did so at least once a week. However, it estimated that only 7% of those who had played a gaming machine in a pub or club in the previous year did so at least once a week.

• Most of these surveys report findings relating to demographic differences in gambling participation, but they do not always agree on the details of these differences. Following are some of the findings from the 2010 NZHLS, which have also emerged from other surveys.
  – People aged 18 to 24 were more likely than people of other ages, and Māori were more likely than people of other ethnicities, to play gaming machines in pubs or clubs.
  – Māori were more likely than people of other ethnicities to play gaming machines in pubs or clubs frequently.
  – People living in areas of low deprivation were less likely than people living in areas of medium or high deprivation to play gaming machines in pubs or clubs frequently.
  – Older people were more likely than younger people to bet on horse or dog races, but less likely than younger people to bet on sports events.
  – Males were more likely than females to bet on races or sports, and to bet on races or sports frequently.
  – Asian people were more likely than people of other ethnicities to play either gaming machines or table games at casinos.
  – Asian and Pacific peoples were more likely not to have participated in any gambling activity.

• Other studies have found that:
  – relatively high percentages of the Asian people who play table games or machines in casinos gamble heavily
  – relatively high percentages of the Pacific people who play non-casino or casino gaming machines gamble heavily
  – non-casino and casino gaming machine gamblers are increasingly likely to be female.

Comparisons among surveys with similar methodologies carried out in different years suggest that participation rates for many gambling activities are either relatively static or have declined. For example, preliminary findings from the 2011/12 NZHS suggest that rates of participation in most gambling activities are lower than the rates found in the 2006/07 NZHS (and considerably lower than the rates found in the 2010 NZHLS).

It is worth noting that survey estimates depend not only on what is defined as an ‘adult’ and as a ‘gambling activity’, but also on the size of the sample and the response rate. Nevertheless, the findings set out above tend to emerge from many of the surveys cited.
3.2.2 Number and location of gambling outlets

Analyses in the *Informing the 2009 Problem Gambling Needs Assessment* report indicate that NCGM venues and Lotteries Commission and Racing Board retail outlets tend to be located in higher deprivation areas. Despite the ongoing reduction in the number of NCGM venues, analyses in the 2012 needs assessment update report suggest that this situation has not changed.

The number of licensed NCGM venues in New Zealand peaked at more than 2200 in the late 1990s and has been declining relatively steadily ever since. The quarterly total of licensed NCGMs peaked at 25,221 on 30 June 2003, the end of the last quarter before the passing of the Gambling Act 2003. The number of licensed machines dropped by around 2000 shortly after the Act was passed and has been falling relatively steadily since. As at 31 March 2012 there were 1403 venues and 18,001 machines.

There are currently six casinos in New Zealand: one each in Auckland, Hamilton, Christchurch and Dunedin, and two in Queenstown. This has not changed since the Hamilton casino opened in 2002. Changes to the law in 1997, when there were already two casinos and four further licence applications in train, imposed a moratorium on any further applications. Table 15 shows the number of machines and tables licensed for each casino.

<table>
<thead>
<tr>
<th>Casino</th>
<th>Gaming machines</th>
<th>Tables</th>
</tr>
</thead>
<tbody>
<tr>
<td>SkyCity Auckland</td>
<td>1647</td>
<td>110</td>
</tr>
<tr>
<td>SkyCity Hamilton</td>
<td>339</td>
<td>23</td>
</tr>
<tr>
<td>Christchurch Casino</td>
<td>500</td>
<td>36</td>
</tr>
<tr>
<td>Dunedin Casino</td>
<td>180</td>
<td>12</td>
</tr>
<tr>
<td>SkyCity Queenstown</td>
<td>86</td>
<td>12</td>
</tr>
<tr>
<td>Lasseters Wharf Casino (Queenstown)</td>
<td>74</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2826</strong></td>
<td><strong>199</strong></td>
</tr>
</tbody>
</table>


The numbers of casino gaming machines and table games have remained virtually unchanged since shortly after the Gambling Act was passed in 2003. The Act prohibited any new casinos and prohibited any increase in the opportunities for casino gambling in the existing casinos.
The casino sector is dominated by the Auckland casino, which generates around three-quarters of New Zealand’s casino gambling expenditure. SkyCity has proposed that it be permitted to operate additional machines and/or tables in the Auckland casino in return for it developing, building and operating the New Zealand International Convention Centre. Negotiations have been proceeding on a confidential basis, and no further details were available to the Ministry when this needs assessment was prepared.

The numbers of New Zealand Lotteries Commission and New Zealand Racing Board retail outlets have not increased significantly since 2008. As at 6 March 2012 there were just under 1100 Lotteries Commission and just under 700 Racing Board (TAB) retail outlets.

The only other venue-based gambling of any significance in New Zealand is housie. It is not discussed in this needs assessment because rates of participation and the amount spent by housie players are only a fraction of the next smallest form of gambling (New Zealand Racing Board products).

### 3.2.3 Online gambling

Estimates of the number of people in New Zealand who gamble online are the subject of debate. It is worth noting that research conducted online tends to produce higher estimates because, by definition, respondents are more likely to be people who are particularly active online.

The 2010 NZHLS estimated that 7.3% of adults had used the New Zealand Lotteries Commission’s MyLotto website to buy a lotteries ticket online, or had bet on a horse or dog race or sports event through the New Zealand Racing Board’s TAB website, at least once in the previous year. It also estimated that 2.1% of adults had gambled online on an overseas website at least once in that time. Preliminary results from the 2011/12 NZHS suggest a lower figure.

In any case, the number of people gambling online is likely to increase to at least some extent as internet speed and capacity increase, and as methods of transferring funds become more trusted. The impacts of such changes are difficult to determine.

### 3.2.4 Gambling expenditure

Total gambling expenditure (player losses) in the four main gambling sectors (NCGMs, casinos, New Zealand Lotteries Commission products, and the New Zealand Racing Board’s racing and sports betting products) increased almost every year from 1983/84 to a peak of $2.039 billion in 2003/04, before dropping slightly in 2004/05 to $2.027 billion. Between 2004/05 and 2010/11 annual expenditure in these four sectors ranged around the $2 billion mark, from as low as $1.913 billion (in 2009/10) to as high as $2.034 billion (in 2007/08).
Much of the growth over these two-and-a-half decades was attributable to spending on NCGMs, which were first licensed in 1988. Spending on NCGMs rose every year, from $107 million in 1990/91 to a high of $1.035 billion in 2003/04, when it accounted for more than half the annual total for these four sectors.

Between 2004/05 and 2010/11 spending in the NCGM sector ranged from as low as $849 million (in 2009/10) to a high of $1.027 billion (in 2004/05). The three most recent years, 2008/09 to 2010/11, were the lowest annual figures since 2001/02.

Spending dropped after changes to smoke-free legislation came into force on 10 December 2004, and dropped again in early 2008 after the global financial crisis struck. The reduction in machine numbers since September 2003 might also have led to an underlying trend of declining spending. However, it is worth noting that since 2003/04 annual spending exceeded the previous year’s figure twice, and that NCGM spending in Canterbury increased dramatically after the earthquake in February 2011 despite the number of functioning machines and venues dropping substantially.

Since March 2007 all NCGMs in New Zealand have been connected to an electronic monitoring system operated for DIA. DIA statistics show that in every quarter between the start of April 2007 and the end of March 2012, around 86% of NCGM spending was attributable to machines in commercial venues (‘pubs’), and 14% to machines in clubs. By contrast, as at 31 March 2012, machines in clubs made up just over 20% of all NCGMs and clubs made up 87% of the 359 NCGM operators.

Some of the growth in spending between 1984 and 2004 was attributable to New Zealand’s six casinos, the first of which opened in 1994 and the last in 2002. Casino spending has gradually declined since 2006. It is worth noting that the Christchurch casino was closed for some months after the earthquake in February 2011.

An increase in the number of Powerball balls from October 2007 (making large jackpots more likely) and the availability of some Lotteries Commission products online since May 2008 both seem to have resulted in increased spending on Lotteries Commission products. This is evident in Table 16 below. An increase in the number of Big Wednesday balls from September 2011 (again making large jackpots more likely) will probably ensure that the higher level of spending is at least sustained for some time.

Table 16 shows gambling expenditure statistics for 2005/06 to 2010/11 in actual dollars (not inflation-adjusted) for the four main gambling sectors. It shows that over this period expenditure was highest for NCGMs, followed by casinos, then New Zealand Lotteries Commission products, and finally the New Zealand Racing Board’s racing and sports betting products. (Note that totals in Table 16 may differ slightly from the sum of column entries because of rounding.) In each of the six years covered by Table 16, NCGMs and casinos together made up between 65% and 71% of total expenditure in these four main gambling sectors.
Most casino gambling expenditure also derives from gaming machines. For example, in its Full Year Result Presentation for the year ended 30 June 2011, SkyCity Entertainment Group indicated that spending on gaming machines in its Auckland and Hamilton casinos totalled almost $236 million. In other words, spending on gaming machines in these two casinos alone made up more than half the total amount spent on all casino gambling activities in all six New Zealand casinos in that year ($434 million).

The earlier participation section of this needs assessment reported estimates from the 2010 NZHLS indicating that 16% of adults had played an NCGM at least once in the previous year and 10% had played a casino machine. It also reported indications from the 2011/12 NZHS that the figures are now substantially lower than the 2010 NZHLS would suggest.

Comparing the expenditure information presented here with the gambling participation information presented earlier is enlightening. This comparison indicates that most of the money spent on gambling in New Zealand comes from a relatively limited number of people who play gaming machines in pubs or casinos. DIA’s gambling expenditure statistics and the findings from its Participation and Attitude Surveys suggest that this has been the case for more than a decade.

<table>
<thead>
<tr>
<th>Gambling sector</th>
<th>2006 ($M)</th>
<th>2007 ($M)</th>
<th>2008 ($M)</th>
<th>2009 ($M)</th>
<th>2010 ($M)</th>
<th>2011 ($M)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCGMs</td>
<td>906</td>
<td>950</td>
<td>938</td>
<td>889</td>
<td>849</td>
<td>856</td>
</tr>
<tr>
<td>Casinos</td>
<td>493</td>
<td>469</td>
<td>477</td>
<td>465</td>
<td>438</td>
<td>434</td>
</tr>
<tr>
<td>NZ Lotteries Commission</td>
<td>321</td>
<td>331</td>
<td>346</td>
<td>404</td>
<td>347</td>
<td>404</td>
</tr>
<tr>
<td>TAB racing and sports betting</td>
<td>258</td>
<td>269</td>
<td>272</td>
<td>269</td>
<td>278</td>
<td>273</td>
</tr>
<tr>
<td>Total</td>
<td>1,977</td>
<td>2,020</td>
<td>2,034</td>
<td>2,028</td>
<td>1,913</td>
<td>1,967</td>
</tr>
</tbody>
</table>

Source: Gambling Expenditure Statistics, Department of Internal Affairs (2012).

### 3.3 Harm and the risk of harm from gambling

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

Harm from gambling can include, among other things, relationship breakdown, depression, suicide, reduced work productivity, job loss, bankruptcy, and various types of gambling-related crime (including family violence, crime committed to finance gambling, and using gambling to launder the proceeds of crime).
At-risk gambling is associated with higher levels of smoking, depression, hazardous alcohol consumption and poorer self-rated health. For example, the 2006/07 NZHS found that:

- problem gambling was significantly associated with current smoking and hazardous drinking
- problem and moderate-risk gamblers were more likely to have a high or very high risk of an anxiety or depressive disorder
- problem gamblers were more likely to have worse self-rated health
- nine out of ten (91.6%) problem gamblers had visited a general practitioner in the previous year
- one in six problem gamblers (17.0%) had visited a psychologist, counsellor or social worker in the previous year.

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

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

This section discusses gambling behaviour that would be categorised as ‘problem’ gambling, ‘moderate-risk’ gambling ‘or ‘low-risk’ gambling on the basis of answers to questions in standard problem gambling screens. While reading this section it is worth noting that:

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

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

This problem should be mitigated to some extent by the end of 2013, when results from both the 2011/12 NZHS and the 2012 National Gambling Survey should be available. The 2011/12 NZHS essentially replicates the 2006/07 NZHS. The 2012 National Gambling Survey links both to those two New Zealand Health Surveys and to studies carried out in 1991 and 1999.

Nevertheless, using the PGSI the 2006/07 NZHS estimated that:

- 0.4% of people aged 15 or over (approximately 13,000 people) were problem gamblers
- 1.3% (41,000 people) were moderate-risk gamblers
- 3.5% (109,000 people) were low-risk gamblers.

The 2010 NZHLS also used the PGSI. Before making adjustments using meta-analysis to combine the timeliness of the 2010 NZHLS with the precision of the larger sample in the 2006/07 NZHS, the 2010 NZHLS estimated that:

- 0.7% of people aged 15 or over (approximately 24,000 people) were problem gamblers
- 2.3% (78,000 people) were moderate-risk gamblers
- 5.9% (200,000 people) were low-risk gamblers.
Responses to individual PGSI items are also informative. For example, the 2006/07 NZHS estimated that gambling had caused health problems, including stress or anxiety, for 0.8% of adults at least sometimes in the year before the Survey. The estimate in 2010 was 1.3%.

All these results suggest that the prevalence of at-risk gambling increased between 2006 and 2010. However, the 2011/12 NZHS is a better comparator than the 2010 NZHLS for the results from the 2006/07 NZHS (because the two New Zealand Health Surveys have similar methodologies and sample sizes). Preliminary results from the 2011/12 NZHS indicate that the prevalence of at-risk gambling is lower than suggested by the 2010 NZHLS.

Both the 2006/07 NZHS and the 2010 NZHLS concluded that the prevalence of at-risk gambling is associated with the number and nature of the gambling activities in which people participate. The 2010 NZHLS also found strong associations with the frequency of participation (the 2006/07 and 2011/12 NZHS did not ask about frequency of participation). Here are some examples.

- The 2010 NZHLS estimated that almost 10% of adults who had participated in four or more gambling activities at least once in the previous year were either problem gamblers or moderate-risk gamblers, and a further 12% were low-risk gamblers.
- The 2010 NZHLS estimated that 3.2% of adults who gambled frequently on ‘non-continuous’ forms (eg, lotteries) were problem gamblers or moderate-risk gamblers and a further 8.9% were low-risk gamblers, whereas 30.0% of ‘frequent continuous’ gamblers were problem or moderate-risk gamblers and a further 26.5% were low-risk gamblers.
- The 2010 NZHLS estimated that 85% of adults who bought a Lotto, Strike, Powerball or Big Wednesday ticket at least fortnightly were non-problem gamblers (that is, they scored 0 on the PGSI), compared with only 31% of adults who played an NCGM at least fortnightly.

### 3.3.2 Numbers experiencing harm from gambling

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

All the studies include a variety of indicators of gambling-related harm other than responses to problem gambling screening instruments.

For example, the 2006/07 NZHS estimated that 2.8% of adults (around 87,000 people) had experienced problems due to someone’s gambling in the year before the survey. Three-quarters of these people were either non-gamblers or non-problem gamblers, suggesting that they were unlikely to have experienced problems as a result of their own gambling. The 87,000 figure did not include children who had experienced problems due to someone’s gambling.
Over half (53%) of the adults who had experienced problems due to someone’s gambling reported that NCGMs were at least one of the forms of gambling involved, and 33% named casino machines. The next-highest figure was 16% for betting on horse or dog races, followed by Lotto at 14%.

The 2010 NZHLS included questions intended to produce estimates of the number of adults who ‘overdid’ their gambling (ie, who spent more time or money gambling than they meant to); the number who experienced arguments in their wider family or household about time, or money spent on gambling; and the number who reported someone in their wider family or household going without something they needed or bills not being paid because too much was spent on gambling. Here are some of the findings.

- Six percent of the adult population had ‘overdone’ their own gambling at least once in the year before the survey, and 1 in 10 of these had ‘overdone it’ 11 times or more during the year.

- The percentage of those aged 18 or over who had ‘overdone’ their own gambling in the year before the Survey was significantly lower than the estimate in the similar 2006/07 Gaming and Betting Activities Survey (Health Sponsorship Council and National Research Bureau 2007).

- Reports of ‘overdoing it’
  - were much more common among ‘frequent continuous’ gamblers than among those who gambled less frequently or only on non-continuous activities
  - were much more common among low-risk, moderate-risk or problem gamblers than among non-problem gamblers
  - were more common among those who participated in four or more gambling activities than among those who participated in fewer gambling activities.

- Almost 22% of adults said someone close to them had ‘overdone it’ in the previous year.

- NCGMs were by far the most common gambling form on which people reported themselves or someone else ‘overdoing it’. Other forms that figured prominently were casino gaming machines, Lotteries Commission products, betting on horse or dog races, and casino table games.

- Five percent of adults reported that there had been some argument about time or money spent gambling in their wider family or household in the previous year. This percentage had not changed from the estimate in the similar 2008 NZHLS (and the percentage reporting that there had ‘ever’ been some argument about time or money spent gambling had not changed from the estimate in the similar 2006/07 Gaming and Betting Activities Survey).

- Reports of some argument were much more common among ‘frequent continuous’ gamblers and among moderate-risk or problem gamblers, and, to a lesser extent, among those who participated in four or more gambling activities.

- Five percent of adults reported someone in their wider family or household going without something they needed or bills not being paid in the previous year because too much was spent on gambling.
• Reports of ‘going without’ were much more common among ‘frequent continuous’
gamblers and among moderate-risk or problem gamblers, and, to a lesser extent,
among those who participated in four or more gambling activities.

• In 2010 the estimated percentage who reported ever ‘going without’ was
significantly lower than the estimate in the similar 2006/07 Gaming and Betting
Activities Survey.

• NCGMs were the form of gambling most often associated with some argument or
‘going without’ (52% of cases). The next-highest were Lotteries Commission
products (14%), followed by casino gaming machines (10%) and betting on horse or
dog races (9%).

3.3.3 Ethnicity and harm from gambling

There continues to be clear evidence that people in some ethnic groups are more likely
to suffer gambling-related harm, and are more likely to be at risk of future harm, than
people in other ethnic groups. The 2006/07 NZHS made the following findings.

• After adjusting for age, Māori and Pacific males and females were approximately
four times more likely to be problem gamblers (as assessed by the PGSI) than males
and females in the total population. (Māori also had significantly higher gambling
participation rates, but the Pacific results were in spite of Pacific people having
significantly lower gambling participation rates.)

• Approximately 1 in 16 Māori and Pacific males and 1 in 24 Māori and Pacific females
were either problem or moderate-risk gamblers.

• When examining combined problem and moderate-risk gambling, Māori and Pacific
females were over 3.5 times more likely to be problem or moderate-risk gamblers
than females in the total population, after adjusting for age.

• Māori and Pacific males were significantly more likely to be problem or moderate-
risk gamblers than males in the total population, after adjusting for age.

• After adjusting for age, Māori males were two times more likely and Pacific males
almost three times more likely to have experienced problems due to someone’s
gambling in the previous year than males in the total population.

• After adjusting for age, Māori and Pacific females were 2.5 times more likely to have
experienced problems due to someone’s gambling in the previous year than females
in the total population.

• Many of these problems seemed to be attributable to someone else’s gambling. For
example, almost 1 in 20 Pacific non-gamblers had experienced problems due to
someone’s gambling in the previous year.

• After adjusting for age, people living in areas of high deprivation – areas in which
Māori and Pacific peoples are over-represented – were more likely to be problem or
moderate-risk gamblers, and were more likely to have experienced problems due to
someone’s gambling in the previous year, than people living in lower deprivation
areas.
Supporting many of these findings, the 2010 NZHLS made the following findings.

- Rates of at-risk gambling (as assessed by the PGSI) were higher among Māori and Pacific people than among European/Others.
- Rates of at-risk gambling increased as level of deprivation increased.
- Māori were significantly more likely than people of other ethnicities to say they had ‘overdone it’ in the previous year.
- Māori and Pacific people were more likely to say that someone close to them had ‘overdone it’ in the previous year.
- People living in high-deprivation areas were more likely to say that someone close to them had ‘overdone it’ in the previous year.
- Māori and Pacific people were more likely to say that there had been some argument about time or money spent gambling in their wider family or household in the previous year.
- People living in high-deprivation areas were more likely to say that there had been some argument about time or money spent gambling in the previous year.
- Māori and Pacific people were more likely to report someone in their wider family or household going without something they needed or bills not being paid in the previous year because too much was spent on gambling.
- People living in high deprivation areas were more likely to report ‘going without’ in the previous year because too much was spent on gambling.

A few measures in the 2010 NZHLS also suggested higher risks of gambling-related harm among Asian people. By contrast the 2006/07 NZHS found that European/Other and Asian people were less likely than Māori or Pacific people to be at-risk gamblers. It also found that European/Other and Asian people were much less likely than Māori and Pacific people to have experienced problems due to someone’s gambling in the year before the survey.

The SHORE/Whariki (2008) study used a different method but reported similar findings to the NZHS. It found that Chinese/Korean people were the least likely of four ethnic groups to have gambled at all in the previous year, and were the least likely to have participated in 8 of the 11 forms of gambling considered (the exceptions being casino tables, casino gaming machines and poker).

Māori and Pacific people were more likely than either Pākehā or Chinese/Korean people to have participated heavily in gambling other than lottery products (defined as participating for more than three hours a week in such gambling or losing more than 5% of their personal income) in the previous year. For Pākehā and Chinese/Korean people, the associations between various forms of gambling and the 13 domains of life examined in the study were mixed, but sometimes positive. For Māori and Pacific people, by contrast, higher levels of gambling, and particularly gambling on gaming machines in bars and casinos, were overwhelmingly associated with negative impacts and on many domains of life.
Research recently commissioned by the Ministry of Health suggests that the 2010 NZHLS findings might reflect the situation for specific Asian sub-groups rather than for Asian people in general, and that gambling-related harm might be a particular issue among recent migrants and international students (Sobrun-Maharaj et al in press). These findings suggest quite specific risks. New Zealand’s Asian population is growing, international education is an important sector, and both migrants and international students may not have ready access to family or community networks that help mitigate the risk of gambling harm.

### 3.3.4 Gender and harm from gambling

Several decades ago, researchers often considered that problem gambling was largely restricted to males. However, the available evidence suggests that there are now fewer significant differences between males and females in gambling participation, the prevalence of problem gambling, gambling harm, the risk of gambling harm or help-seeking. However, females still make up most of those who seek help for problems associated with someone else’s gambling, and it is likely that there are still some differences by gender within particular ethnic groups.

Here are some relevant findings from the Gambling Helpline and the face-to-face intervention services.

- In each of the 12 calendar years from 2000 to 2011 (inclusive), females made up between 46.8% and 51.0% of the Helpline’s gambler clients.
- In those same years, females made up between 71.1% and 77.8% of the Helpline’s ‘significant other’ clients.
- From 2004/05 to 2010/11, females made up between 49.0% and 54.5% of all face-to-face interventions.

Here are some relevant findings from the 2006/07 NZHS.

- There were no significant differences by gender in the age-standardised prevalence of problem gambling (as assessed by the PGSI). However, after adjusting for age, males were significantly more likely to be moderate-risk gamblers (2%) than females (0.8%), and males had a significantly higher prevalence in the combined problem and moderate-risk group (2.5%) than females (1.2%).
- By contrast, after adjusting for age, females were more likely to report having experienced problems due to someone’s gambling in the previous year (3.3%) than males (2.6%), although the difference was not significant.

The 2010 NZHLS found that:

- rates of at-risk gambling (as assessed by the PGSI) were not significantly different for males and females (although the estimate was higher for males in each at-risk category)
- males and females were equally likely to say they had ‘overdone’ their gambling at least once in the previous year
• males and females were equally likely to say that someone close to them had ‘overdone’ their gambling at least once in the previous year (although the estimate was slightly higher for females)
• females were more likely than males to say that there had been some argument about time or money spent gambling in their wider family or household in the previous year
• females were more likely than males to report someone in their wider family or household going without something they needed or bills not being paid in the previous year because too much was spent on gambling.

3.3.5 Age and harm from gambling

Some studies in the past have found that younger people were more likely to be at-risk gamblers. However, in recent studies the results have been more mixed.

The 2006/07 NZHS found the following.
• People aged 35 to 44 were at least three times more likely than any other age group to be problem gamblers (as assessed by the PGSI), with a prevalence of 1.2%.
• When looking at combined problem and moderate-risk gamblers, males had significantly higher rates than females in all age groups from 18 to 54; the rate for males was highest among those aged 18 to 24, followed by those aged 35 to 44.
• Rates of at-risk gambling decreased among people aged 55 or older.
• The proportion of adults reporting having experienced problems due to someone’s gambling in the previous year was similar for the age groups 15 to 44 for males and 15 to 54 for females; the proportion decreased in older age groups.

By comparison, the 2010 NZHLS found the following.
• People aged 35 and over were more likely than those aged 15 to 24 to be low-risk gamblers, but there were no significant differences by age among moderate-risk or problem gamblers.
• People aged 65 and over were less likely to say that someone close to them had ‘overdone’ their gambling at least once in the previous year.
• Those aged 45 to 54 were most likely to say that there had ‘ever’ been some argument about time or money spent gambling in their wider family or household, but those aged 15 to 24 or 35 to 44 were most likely to say it had happened in the previous year.
• Those aged 15 to 24 or 35 to 44 were most likely to report someone in their wider family or household going without something they needed or bills not being paid in the previous year because too much was spent on gambling.

Early exposure to gambling increases the risk of developing gambling problems (Abbott and Volberg 2000). Young people’s gambling is a focus of several of the research projects funded by the Ministry.
3.3.6 Geography and harm from gambling

As noted in the results reported above, people living in more deprived areas are disproportionately affected by, or at risk of, gambling-related harm. This is consistent with the geographical analyses discussed in Informing the 2009 Problem Gambling Needs Assessment. These analyses showed that people living in more deprived areas are at greater risk of developing problems with gambling. Fifty-six percent of all NCGM expenditure occurred in census area units with a deprivation decile rating of 8 or above, and Māori and Pacific peoples are over-represented in these deciles, suggesting that they are more likely to be affected. Although there were fewer NCGMs overall (19,856, a decrease of 9% from 2005), they were still concentrated in more deprived areas.

The 2012 needs assessment update report confirms that this is still the case. Like NCGM venues, New Zealand Racing Board and New Zealand Lotteries Commission outlets are also concentrated in high deprivation areas.

The Gambling Act 2003 required each territorial authority to develop gambling venue policies for non-casino gaming machine and New Zealand Racing Board venues. The policies were to be developed (and must be reviewed at least every three years) following a specified consultation process.

The policy for Racing Board venues must specify whether new TABs may be established in the territorial authority district, and if so, where they may be located.

The non-casino gaming machine venue policy must specify whether new gaming machine venues may be established in the territorial authority district, and if so, where they may be located. It may also specify restrictions (within statutory limits) on the number of machines that may be operated at a venue. Once a territorial authority has granted consent, it cannot withdraw it. As a result, territorial authorities can stop any new venue licences being granted, can restrict the number of machines in new venues, can limit or prohibit any increase in the number of machines that may be operated in existing venues, and can stop the re-licensing of a venue that has been without a licence for six months or more. However, a territorial authority cannot reduce the number of machines that may be operated in an existing venue, nor can it require that an existing venue stop operating machines. This limits any potential for territorial authorities to reduce the numbers of venues and machines in more deprived areas.

Fringe lenders also tend to focus on people in more deprived areas. Research by Auckland Uni Services for the Ministry of Consumer Affairs indicates that some Pacific people in South Auckland have borrowed money from these lenders in order to gamble (Auckland UniServices Limited 2007).
3.4 Helpline and intervention service demand

Intervention service capacity to meet demand is a key priority for the Ministry’s funding of services to prevent and minimise gambling harm. Current intervention service provision is meeting demand for services. Indeed, there appears to be capacity to meet increased demand. Presentation information indicates a general trend towards reduced help-seeking from formal intervention services. This was particularly apparent in the number of new clients seeking help from the Gambling Helpline.

Gaming machines continued to be the form of gambling most often cited by help-seekers.

3.4.1 Response

The Ministry has updated its modelling for intervention services based on the latest participation and presentation figures. The model also includes the numbers and locations of NCGMs. This ensures that forecast demand and requirements for services address the trends described in this section.

Although presentation statistics typically represent only a small sample of the people adversely affected by gambling, the Ministry considers this data relevant for considering changes and trends in service utilisation and in modelling demand.

3.4.2 Gambling Helpline and intervention service data

The Ministry uses two primary sources for intervention service information: presentation data from the Gambling Helpline and presentation data from face-to-face intervention services.

Gambling Helpline data indicate that the Helpline’s number of new clients declined by over 13% in the 2011 calendar year. Apart from small percentage increases in 2007 and 2010, the number of new clients has declined each year since the end of 2002. The decline in 2005 (the first calendar year after changes to the smoke-free legislation came into force on 10 December 2004) was particularly pronounced. The number of repeat clients has declined each year since the end of 2004.

An 8.5% reduction in 2011 followed reductions of between 16.8% and 18.6% in each of the previous three years. There were 2122 new clients and 1478 repeat clients in the 2011 calendar year.

Face-to-face intervention service data indicate a levelling off or decline in 2010/11.

- There were 2381 new gambler clients, excluding brief interventions (down from 2582 in 2009/10 and 2595 in 2008/09).
- There were 4608 gambler clients, excluding brief interventions (down from 4705 in 2009/10 but up from 4237 in 2008/09).
- Including brief interventions, there were 9111 new clients (down from 10,498 in 2009/10 but up from 7552 in 2008/09).
• Including brief interventions, there were 12,090 clients (down from 13,244 in 2009/10 but up from 9743 in 2008/09).

• With the exception of new gambler clients, and excluding brief interventions, all figures were higher in 2010/11 than in each year from 2007/08 back to 2004/05.

The ethnic breakdown of face-to-face intervention service clients reflects the disproportionate risk of gambling-related harm among Māori. In 2010/11 Māori comprised 30% of clients, excluding brief interventions. Since 2004/05 this figure has ranged from 26.9% to 30.0%.

Including brief interventions, the figure in 2010/11 was 29.7%. Since 2004/05 this figure has ranged from 26.9% to 38.6%. The Helpline figures in 2011 were 17.9% of gamblers and significant others and 21.0% of new gambler clients. The high level of service use by Māori is encouraging from a service uptake perspective.

The uptake of face-to-face intervention services by Pacific people is also relatively encouraging, and has improved recently. In 2010/11 Pacific people comprised 13.4% of clients, excluding brief interventions. This was the highest figure in the period extending back to 2004/05, followed by the 2009/10 figure. Including brief interventions, the figure in 2010/11 was 14.5%, and once again the last two years were the highest.

However, Pacific uptake of the Helpline services is less encouraging. The Helpline figures in 2011 were 6.2% of gamblers and significant others and 6.8% of new gambler clients. The figures tend to range around the level of Pacific representation in the general population.

Asian presentation rates to the face-to-face intervention services remain comparatively low, at 6.0% in 2010/11. Including brief interventions increases that figure to 8.3%, a drop from 8.7% in 2008/09. Asian people also made up over 8% of the Helpline's new gambler clients in both 2011 and 2010, and over 7% of gamblers and significant others. In addition, the Asian Hotline run by the Problem Gambling Foundation received around 900 calls in the calendar year to December 2011.

NCGMs continued to be the primary mode of problem gambling cited by new gambler clients: over 69% for the Helpline and over 62% for the face-to-face intervention services. However, both these percentages have dropped in recent years.

By contrast, there has been an increase in the percentage of new clients citing New Zealand Lotteries Commission products: 7.3% of new gambler clients of the face-to-face intervention services in 2010/11, up from 6.5% in 2009/10 and 4.7% in 2008/09.
In addition, clients citing Lotteries Commission products as a primary problem gambling mode were over 12% of all clients of the face-to-face intervention services (including brief interventions) in 2010/11, up from 11.5% in 2009/10 and 8.8% in 2008/09. These increases are probably related to the increased frequency of large jackpot prizes and the enhanced appeal of large jackpots in difficult economic times, and perhaps also to the availability since May 2008 of some Lotteries Commission products online.

The Lotteries Commission figures cited above tend to support the Ministry’s recommendation in the ‘Weighting’ section of this consultation document (section 2.3.5 on pages 30 to 32). The figures above can be contrasted with the 5.7% figure in that section for the Lotteries Commission’s share of ‘presentations’.

### 3.5 Conclusions

The needs assessment provides a range of information and research that indicates that gambling-related harm continues to be a social and health issue in New Zealand. Both the 2006/07 NZHS and the 2011/12 NZHS indicate that the number of adults exhibiting at-risk gambling behaviour is relatively small compared, for example, to the estimated number of adults with hazardous drinking behaviour (551,300) or who are current smokers (619,900). However, there is still a substantial burden of gambling-related harm in New Zealand communities.

Services currently achieve both geographic coverage and 24-hour, 7-day-a-week availability, either through face-to-face or telephone coverage. Key ongoing issues include:

- the disproportionate levels of harm experienced by Māori and Pacific people
- the effects of higher levels of exposure to gambling products – and how to mitigate them – for people living in more deprived areas
- high rates of co-morbidities among problem gamblers, and correspondingly high usage of health and allied health services, along with the opportunities for screening and intervention that this high usage presents
- the possibility of an increase in online gambling
- the possibility of an increase in problems associated with New Zealand Lotteries Commission products, linked to an increase in the number of large jackpots
- the involvement of younger people in gambling.
References


Ministry of Health. *Gambling Results from the 2011/12 New Zealand Health Survey*. Wellington: Ministry of Health, in press.


Making a submission

Submissions close on Friday 7 September 2012 at 5 pm.

Please note: any submissions received after this time will not be included in the analysis of submissions.

Please detach and return.

Please include the following detachable pages with your written submission or email your response to gamblingharm@moh.govt.nz

The following questions may help you to focus your submission:

1. Does the draft service plan adequately address the areas of public health and intervention services? If not, what issues or areas are not adequately covered?

2. Does the draft service plan adequately address workforce development for public health and intervention services? If not, what issues or areas are not adequately covered?

3. Does the draft service plan adequately address research and evaluation? If not, what issues or areas are not adequately covered?

4. Are there aspects of the funding proposals in the draft service plan, or any other aspects of the draft service plan, that you particularly agree with or disagree with, and if so, why?

5. Are there aspects of the proposed levy that you particularly agree with or disagree with, and if so, why?

6. The levy calculations canvass four different pairs of weightings: 5/95, 10/90, 20/80 and 30/70. Each weighting entails a different set of levy rates. The Ministry has indicated its preference for the 30/70 weighting. Are there other realistic pairs of weightings? Which pair of weightings, if any, do you support? Why?

7. Are there aspects of the needs assessment that you particularly agree with or disagree with, and if so, why?
You do not have to answer all the questions or provide personal information if you do not want to.

This submission was completed by: (name)

Address: (street/box number)

(town/city)

Email: 

Organisation (if applicable): 

Position (if applicable):

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

☐ An individual (not on behalf of an organisation)

☐ On behalf of a group or organisation(s)

☐ Other (please specify): ....................................................................................

Please indicate which sector(s) your submission represents
(You may tick as many boxes as apply)

☐ Consumer ❑ Family/whānau

☐ Academic/research ☐ Māori

☐ Pacific ☐ District health board

☐ Education/training ☐ Local government

☐ Provider ☐ Funder

☐ Non-government organisation ☐ Prevention/promotion

☐ Professional association ☐ Other (please specify):

........................................................

Please return only one copy of your submission no later than 5 pm Friday 7 September 2012 to:

Derek Thompson
Preventing and Minimising Gambling Harm Submissions
Ministry of Health
PO Box 5013
WELLINGTON
Email: gamblingharm@moh.govt.nz
All submissions will be acknowledged by the Ministry of Health and a summary of submissions will be sent to all those who request a copy. The summary will include the names of all those who made a submission, unless individuals request that their names not be published. A copy of all submissions received will be forwarded to the Gambling Commission to assist its independent consultation process.

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

☐ Yes

☐ No

Your submission may be requested under the Official Information Act 1982. If this happens, the Ministry of Health will release your submission to the person who requested it. However, if you are an individual as opposed to an organisation, the Ministry will remove your personal details from the submission if you check the following box:

☐ I do not give permission for my personal details to be released under the Official Information Act 1982.

☐ I do not give permission for my name to be listed in the published summary of submissions.