

Strategy to Prevent and Minimise Gambling Harm

2016/17 to 2018/19

Proposals document

Citation: Ministry of Health. 2015. *Strategy to Prevent and Minimise Gambling Harm 2016/17 to 2018/19: Proposals document*. Wellington: Ministry of Health.

Published in October 2015
by the Ministry of Health
PO Box 5013, Wellington 6145, New Zealand

ISBN 978-0-947491-15-4 (online)
HP 6281

This document is available at www.health.govt.nz



MANATŪ HAUORA



This work is licensed under the Creative Commons Attribution 4.0 International licence. In essence, you are free to: share ie, copy and redistribute the material in any medium or format; adapt ie, remix, transform and build upon the material. You must give appropriate credit, provide a link to the licence and indicate if changes were made.

Contents

Introduction	1
Structure of this document	1
Next steps	1
1 Proposed nine-year Strategic Plan 2016/17 to 2024/25	2
1.1 Background	2
1.2 Overall goal of the strategy	11
1.3 Key principles underpinning the strategy	11
1.4 A public health approach	11
1.5 A population health framework	12
1.6 Equity	13
1.7 Health literacy	13
1.8 Outcomes framework for the strategy	14
1.9 Alignment of the strategy with <i>He Korowai Oranga: Māori Health Strategy</i>	26
1.10 Alignment of the strategy with <i>'Ala Mo'ui: Pathways to Pacific Health and Wellbeing</i>	29
2 Proposed three-year Service Plan 2016/17 to 2018/19	32
2.1 Background	32
2.2 Service Plan for 2016/17 to 2018/19	38
3 Proposed levy rates for 2016/17 to 2018/19	45
3.1 Background	45
3.2 Proposals to change the levy-paying sectors	45
3.3 Process for setting the levy rates	47
3.4 The levy formula	48
3.5 Levy calculations	57
References	58

List of tables

Table 1:	Priorities for action – Objective 1	15
Table 2:	Priorities for action – Objective 2	16
Table 3:	Priorities for action – Objective 3	17
Table 4:	Priorities for action – Objective 4	18
Table 5:	Priorities for action – Objective 5	19
Table 6:	Priorities for action – Objective 6	20
Table 7:	Priorities for action – Objective 7	21
Table 8:	Priorities for action – Objective 8	22
Table 9:	Priorities for action – Objective 9	23
Table 10:	Priorities for action – Objective 10	24
Table 11:	Priorities for action – Objective 11	25
Table 12:	Alignment of the Strategy with <i>He Korowai Oranga</i>	27
Table 13:	Alignment of the strategy with <i>'Ala Mo'ui</i>	30
Table 14:	Indicative budget to prevent and minimise gambling harm (GST exclusive), 2016/17 to 2018/19	38
Table 15:	Indicative public health budget (GST exclusive), by service area, 2016/17 to 2018/19	39
Table 16:	Indicative intervention budget (GST exclusive), by service area, 2016/17 to 2018/19	41
Table 17:	Indicative research and evaluation budget (GST exclusive), 2016/17 to 2018/19	43
Table 18:	Indicative budget for Ministry operating costs (GST exclusive), 2016/17 to 2018/19	44
Table 19:	Club share of all presentations attributed to NCGMs, 2007/08 to 2014/15	46
Table 20:	Presentations attributed to the four levy-paying sectors, 2004/05 to 2014/15	50
Table 21:	Share of expenditure and presentations by levy-paying sector, 2014/15	51
Table 22:	Under-recovery or over-recovery of levy, 2004/05 to 2015/16, by sector	54
Table 23:	Forecast expenditure by sector (GST inclusive), 2016/17 to 2018/19	57
Table 24:	Estimated levy rates: 5/95 weighting	57
Table 25:	Estimated levy rates: 10/90 weighting	57
Table 26:	Estimated levy rates: 20/80 weighting	57
Table 27:	Estimated levy rates: 30/70 weighting	57

List of figures

Figure 1:	Gambling-related harm: the continuum of need and intervention	12
Figure 2:	<i>He Korowai Oranga</i> : 'the cloak of wellness'	26
Figure 3:	The components of <i>'Ala Mo'ui</i>	29

Introduction

Structure of this document

The Ministry of Health considered the submissions on its *Strategy to Prevent and Minimise Gambling Harm 2016/17 to 2018/19: Consultation Document* and made revisions when it thought they were warranted. This proposals document is the result.

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

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

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

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

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

Proposed levy rates for 2016/17 to 2018/19

This section sets out proposed levy rates for the three-year period corresponding to the term of the proposed Service Plan, and describes the process by which they were calculated and the Ministry's reasoning for the levy rates it proposes.

Next steps

The Ministry has submitted this document to Ministers and to the Gambling Commission, as required by section 318(2) of the Gambling Act 2003.

The Gambling Commission undertakes its own analysis and will convene a meeting in November 2015 to consult invited stakeholders on the Strategy and the levy rates. It will subsequently provide advice to the responsible Ministers.

After considering the Gambling Commission's advice, the responsible Ministers take a paper to Cabinet seeking its endorsement of Ministers' decisions on the shape of the Strategy and the levy. While that is likely to happen in March 2016, the new Strategy and problem gambling levy regulations will not be made public until around late-May 2016, when the 2016 Budget has been tabled in Parliament.

The new Strategy and the associated problem gambling levy regulations should take effect on 1 July 2016.

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

1.1 Background

1.1.1 The gambling environment

Participation in gambling

Most adults in New Zealand gamble at least occasionally. However, only a minority participate in any gambling activity other than buying New Zealand Lotteries Commission (NZLC) products or raffle tickets. For example, the 2012 National Gambling Study (NGS)¹ (Abbott et al 2014c) found that 62 percent of adults bought a Lotto ticket at least once in the previous year, but only:

- 14 percent played a non-casino gaming machine (NCGM) at least once
- 12 percent bet on a horse or dog race at least once
- 8 percent played a casino gaming machine in New Zealand at least once
- 5 percent bet on a sports event at least once
- 4 percent played a casino table game in New Zealand at least once.

Differences among gambling activities are more pronounced when frequency of participation is considered. For example, the 2012 NGS estimated that 17 percent of adults bought a Lotto ticket at least once a week, but it also estimated that only 1.5 percent played an NCGM this frequently.

Gambling participation has fallen, and frequent participation in riskier forms of gambling has fallen markedly, since the 1990s. For example, the 1991 national survey (Abbott and Volberg 1991) estimated that 18 percent of adults participated at least once a week in continuous forms of gambling,² while the equivalent 2012 NGS estimate was 6 percent. As another example, the Department of Internal Affairs (DIA) 1990 participation and attitudes survey estimated that 5 percent of adults played an NCGM at least once a week, while the equivalent figure in the last such survey in 2005 was 3 percent (both surveys discussed in DIA 2008), and the 2012 NGS estimate was 1.5 percent. However, results from recent iterations of the New Zealand Health and Lifestyles Survey (HLS) suggest that these downward trends might have slowed or levelled off (Tu and Puthipiroj, in press).

The 2012 NGS also indicated that the percentage of adults participating in more than three different gambling activities at least once during the previous year (another risky gambling behaviour) has fallen since the 1990s. Once again, however, recent iterations of the HLS suggest that this downward trend might have slowed or levelled off.

¹ A national study of gambling participation, gambling harm, problem gambling and attitudes towards gambling, with one-year and two-year follow-up components focusing on the incidence of problems related to gambling.

² Continuous forms of gambling offer the opportunity for rapidly repeated cycles of risking money, the result being determined, collecting winnings and again risking money. Examples of continuous forms of gambling include NCGMs, casino table games and betting on horse or dog races.

Number and location of gambling outlets

The number of NCGM venues in New Zealand peaked at more than 2200 in the late 1990s, and has been declining relatively steadily since. The quarterly total of licensed NCGMs peaked at 25,221 on 30 June 2003, fell by around 2000 shortly after the Act was passed, and has been falling relatively steadily since. As at 30 June 2015 there were 1266 venues and 16,579 machines.

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

There are six casinos in New Zealand: one each in Auckland, Hamilton, Christchurch and Dunedin, and two in Queenstown. They operate a total of just over 2800 gaming machines and just under 200 table games. The Christchurch Casino was the first to open, in 1994. The Hamilton casino was the last, in 2002. The Act prohibits any more casinos.

The Auckland casino generates around three-quarters of New Zealand's casino gambling expenditure. As a result of the New Zealand International Convention Centre Act 2013, that casino will soon add as many as 230 single-terminal gaming machines and 40 tables.

Since 2005 several analyses (most recently: Allen and Clarke 2015) have shown an association between numbers of NCGM venues, numbers of NCGMs and NCGM expenditure on the one hand and higher deprivation on the other. Some of these analyses also suggest that NZLC and NZRB retail outlets tend to be located in higher deprivation areas.

Online gambling

The number of people in New Zealand who purchase NZLC products online and the share of NZRB betting that is derived from online channels have both been growing. However, there is considerable debate about the number of people in New Zealand who gamble online with *overseas-based* gambling operators.

The 2012, 2013 and 2014 waves of the NGS found that the percentage of adults gambling online with an overseas-based gambling operator did not increase over those three years (Bellringer et al, in press). An Offshore Racing and Sports Betting Working Group convened by the Minister for Racing, Hon Nathan Guy, will report this year.

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

Gambling expenditure

According to DIA,³ total gambling expenditure (player losses) in the four main gambling sectors increased almost every year from 1983/84 to a peak of \$2.039 billion in 2003/04, before dropping slightly in 2004/05 to \$2.027 billion. Between 2003/04 and 2013/14, annual expenditure in these four sectors ranged around \$2 billion, from \$1.928 billion (in 2009/10) to \$2.091 billion (in 2013/14). However, in inflation-adjusted terms the 2013/14 figure of \$2.091 billion was around half a billion dollars *below* the \$2.039 billion figure for 2003/04.

³ The expenditure figures in this section are sourced from the DIA website: www.dia.govt.nz/diawebsite.nsf/wpg_URL/Resource-material-Information-We-Provide-Gambling-Expenditure-Statistics (accessed 17 June 2015).

Much of the growth over the past 25 years was attributable to spending on NCGMs, which were first licensed in 1988. From 1990/91 (the first year for which figures are reported) until 2003/04 NCGM spending rose every year, from \$107 million in 1990/91 to a high of \$1.035 billion in 2003/04, when it accounted for more than half the annual total for the four main gambling sectors.

Over the 10 years from 2004/05 to 2013/14, spending in the NCGM sector fell from \$1.027 billion to \$806 million, even without adjusting for inflation.

While NCGM spending has declined over the last decade, there has been a substantial increase in spending on NZLC products. There have also been smaller, less consistent, increases in spending on casino gambling and NZRB products.

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

1.1.2 Gambling harm and the risk of gambling harm

The nature of gambling harm

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 and crime committed to finance gambling). There are 'ripple effects'; that is, harms can and often do extend beyond gamblers to encompass family members, whānau, friends, employers, colleagues and whole communities.

The measurement of gambling harm

There are different ways to measure gambling harm. The Australian Productivity Commission (Productivity Commission 2010) has cautioned against a narrow focus on 'problem gamblers' (in the sense of people scoring above a certain threshold on a screening instrument), because:

- there is substantial existing harm and risks of future harm among 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
- it largely ignores the harmful effects associated with *other people's* gambling.

Using a screening instrument called the Problem Gambling Severity Index screen (PGSI), the 2012 NGS estimated that:

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

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

As another measure of harm, the 2012 NGS also asked respondents whether, in their wider family or household, someone had ever had to go without something they needed, or some bills weren't paid, because too much was spent on gambling by another person. It estimated that someone else's gambling had these harmful effects *at some time* in the wider families or households of around 430,000 adults. In about a third of these cases, someone else's gambling had these effects *in the previous year*.

Similarly, the 2011/12 New Zealand Health Survey (NZHS) asked respondents whether, in the past twelve months, they had problems because of someone else's gambling. It estimated that 2.5 percent of adults (around 89,000 adults) had such problems (Rossen 2014).

Forms of gambling associated with gambling harm

As noted earlier, most of the money spent on gambling in New Zealand comes from the relatively limited number of people who play non-casino or casino gaming machines, or both. There is also compelling evidence from both New Zealand and international research that gambling harm is far more likely to be associated with gaming machine gambling (whether gambling on NCGMs or on machines in a casino) than with any other form of gambling.

In New Zealand betting on horse or dog races, betting on sports events and gambling on casino table games are other forms of gambling that are more likely to be associated with harm, but none of these forms approaches the levels of harm associated with gaming machines.

Like gambling participation, the forms of gambling most likely to be associated with harm vary by ethnicity, gender, age, etc. For example, the SHORE/Whāriki (2008) study found that the Chinese and Korean group had the lowest rates of participation in all forms of gambling except poker (in which their participation rate was the second-highest after Māori) and casino table games (in which their participation rate was the highest). Similarly, a submission to the Ministry's 2015 consultation document from Asian Family Services in Auckland stated that 'a very high proportion of our clients are SkyCity casino table game gamblers'.

Ethnicity and gambling harm

There continues to be compelling evidence that Māori and Pacific peoples are more likely to suffer gambling harm (whether as a result of their own or someone else's gambling), and more likely to be at risk of future harm, than people in other ethnic groups. Some specific Asian populations and subgroups also seem to be more likely to suffer gambling harm.

For example, analyses in the 2006/07 and 2011/12 iterations of the NZHS and multivariate analyses in the 2012 NGS concluded that even after taking into account key demographic and socioeconomic variables, Māori and Pacific peoples were significantly more likely to experience gambling harm (Rossen 2014; Abbott et al 2014b). In addition, estimates from the 2012 NGS suggested that close to 50 percent of problem gamblers and close to 40 percent of moderate risk gamblers are Māori or Pacific.

The 2012 NGS concluded that 'ethnic and other disparities in the burden of harm have persisted since the time the first gambling survey was conducted in 1991' (Abbott et al 2014b, p 18).

The 'Pacific' and 'Asian' categories each encompass a variety of different population groups. Within each of these categories, some population groups have low rates of participation in gambling. For example, it is likely that these rates are lower among the Indian population in New Zealand than among the East Asian and Southeast Asian populations. As a result, high level analyses tend to mask inequities among or within populations.

Even at a high level, however, some inequities among populations are readily apparent. For example, the 2012 NGS found that, overall, Asian and Pacific adults are less likely to participate in gambling than European/Other and Māori adults (the figures were 61 percent, 75 percent, 82 percent and 85 percent respectively). Taken together with prevalence rates for at-risk gambling, this means that Pacific, Māori and Asian adults *who do gamble* are at much higher risk than the European/Other gambler group. The NGS estimated that almost a fifth (17 percent) of Pacific gamblers are in the combined moderate risk and problem gambler group. The figures for Māori and Asian gamblers were 16 percent and 14 percent respectively. The equivalent figure for European/Other gamblers was eight percent (Abbott et al 2014b, p48).

The 2012 NGS also suggested that the prevalence of at-risk gambling varies significantly by gender both among and within some of these overall population categories. After adjusting for age, the NGS found that Asian and European/Other females were *less likely* to be moderate-risk or problem gamblers than Māori or Pacific females. By contrast, it found that Asian males (like Māori and Pacific males) were *more likely* to be in the combined group than European/Other males, and more likely to be in the combined group than Asian females. It also found that Pacific males were *more likely* to be in the combined group than Pacific females and *more likely* to be in the combined group than both males and females in each of the other three population categories (Abbott et al 2014b, pp 46 and 47).

Other research commissioned by the Ministry suggests that specific Asian subgroups (for example, recent migrants and international students) might be particularly vulnerable to gambling harm (Sobrun-Maharaj et al 2012). New Zealand's Asian population is growing, particularly in Auckland. As a result, it is important to address the vulnerability of specific segments of the Asian population to gambling harm.

Māori and Pacific populations are generally younger, and their proportion of the total population is also predicted to grow in future. As a result, it is important that the issue of Māori and Pacific vulnerability to gambling harm be given priority. In this context, recent research examining the impact of gambling on Pacific families and communities (Bellringer et al 2013) and the gambling reports from the Pacific Island Families longitudinal study (to date, Bellringer et al 2008 and 2012) are likely to become increasingly important and useful.

Gender and gambling harm

Several decades ago, researchers tended to consider that problem gambling was largely restricted to males. Females are still more likely to report, and seek help for, problems associated with someone else's gambling. However, 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. The evidence also suggests that many of the remaining differences are diminishing or even reversing. For example, in 2014/15 more Māori females than either males or females of any other ethnicity attributed their help-seeking to problems associated with non-casino gaming machines.

There are still likely to be some significant differences by gender within ethnic groups (for example, the differences noted earlier between Asian males and Asian females and between Pacific males and Pacific females).

Age and gambling harm

Several submissions to the Ministry's 2015 consultation document referred to the harm to children that is associated with the gambling problems of a parent, caregiver or other adult.

New Zealand and international studies (for example: Kalischuk et al 2006; Productivity Commission 1999; Watson and Watson 2004) have concluded that the impacts on children can include obvious gambling-related neglect (such as being left in cars outside casinos); the impacts of poverty; the impacts of arguments, anger and violence; impacts on social integration and education; and a higher risk of withdrawal, depression, anger and suicidality. One Australian study concluded that children living with a parent or caregiver who has a serious gambling problem experience 'pervasive loss', encompassing both physical and existential aspects of the child's life (Darbyshire et al 2001).

It is worth noting that the impacts of gambling on children often do not feature prominently in problem gambling prevalence studies. However, the Ministry is currently investing in the Family Violence Study and in large-sample child-focused longitudinal studies (the Growing Up in New Zealand Study and the Pacific Islands Families Study), all of which focus on these impacts.

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

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

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

Among other things, students with signs of unhealthy gambling were more likely to have a family member who had done something because of gambling that could have got them in serious trouble; to have gambled on NCGMs, casino gaming machines or tables, or with the TAB, in the previous year; and to have attempted suicide in the previous year.

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

DIA's participation and attitude surveys (discussed in DIA 2008), the last two iterations of the NZHS (discussed in Rossen 2014) and the 2014 HLS (Tu and Puthipiroj, in press) all agree that rates of gambling participation among youth (variously defined as those aged 15 to 19 or those aged 15 to 17) are relatively low. For example, the 2012 NZHS estimated that around 95 percent of 15–17-year-olds had not gambled at all in the year before being surveyed.

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

Some overseas studies have found a growing issue with at-risk gambling among older adults, possibly related to the marketing of gambling venues as a forum for social interaction. However, there has been little or no evidence of this issue in New Zealand to date. For example, the 2012 NGS found that the percentage of adults in the combined moderate risk and problem gambler group decreased in each successive age group from those aged 18 to 24 to those aged 65 and over. Even so, the aging of the New Zealand population suggests a need to monitor and be responsive to the needs of this population segment.

Geography and harm from gambling

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

The Gambling Act 2003 requires each territorial authority to develop gambling venue policies for NCGM and NZRB venues. Territorial authorities may decline an application for consent on the basis of their venue policies, and may limit or prohibit any increase in the number of machines that may be operated in existing venues. A territorial authority cannot reduce the number of machines that may be operated in an existing venue; nor can it require that an existing venue stop operating machines. This limits any potential for territorial authorities to reduce the numbers of venues and machines in more deprived areas.

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

Co-morbidities

There is compelling evidence from New Zealand and international research that at-risk gambling is associated with higher levels of smoking, hazardous alcohol consumption, other drug use and depression, and with poorer self-rated health. For example, the 2011/12 NZHS reported that low-risk gamblers were twice as likely and adults in the combined moderate risk and problem gambler group were almost six times as likely to have an anxiety or depressive disorder. Further, adults in the combined group were almost three times more likely to have been diagnosed with a common mental disorder than those with no gambling problems, and were three times more likely to have been diagnosed with depression specifically.

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

Intervention service data

Intervention service data for clients who received a full, facilitation or follow-up session in 2014/15 show that the total number of clients was the highest since the Ministry assumed responsibility for problem gambling services on 1 July 2004, as were the total numbers of new clients and gambler clients. The total number of existing clients was higher only in 2012/13 and 2013/14, and the total number of family/affected other clients was higher only in 2013/14.

Excluding numbers for brief interventions, Māori made up 30.0 percent of clients, Pacific peoples 22.1 percent and East Asian 6.6 percent. Since 2004/05, the figure for Māori has ranged between 26.9 percent and 36.0 percent. By contrast, the 2012/13, 2013/14 and 2014/15 figures for Pacific peoples, which were all over 22 percent, were the highest since the Ministry assumed responsibility for these services. Until 2012/13, the highest previous figure had been 13.7 percent, in 2011/12. The high level of service use by Māori has always been encouraging; the recent substantial increase in uptake of services by Pacific peoples is also encouraging.

At more than 51 percent, NCGMs continued to be the primary mode of problem gambling most often cited by new gambler clients in 2014/15. However, this figure was over 70 percent in 2004/05, and until 2011/12 was always over 60 percent. Other forms of gambling that featured prominently among the primary modes of problem gambling for new gambler clients were casino gaming machines (11.2 percent); casino table games (10.3 percent); betting on horse or dog races (6.2 percent); lotto (5.8 percent); and sports betting (3.8 percent).

Conclusions

Key ongoing issues include:

- the disproportionate levels of harm experienced by Māori and Pacific people, and by some segments of the Asian population
- the higher levels of exposure to gambling products and the disproportionate levels of harm experienced by people living in more deprived areas
- high rates of co-morbidities among at-risk gamblers
- the harm experienced by children, and the involvement of younger people in gambling
- the possibility of an increase in online gambling
- the implications of an aging population.

1.1.3 Functions of the Strategic Plan and Service Plan

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

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

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

1.1.4 The strategy and the role of the Ministry of Health

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

The Act says that the strategy must include:

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

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

- (a) harm or distress of any kind arising from, or caused or exacerbated by, a person’s gambling; and
- (b) including personal, social, or economic harm suffered –
 - (i) by the person; or
 - (ii) by the person’s spouse, civil union partner, de facto partner, family, whānau, or wider community; or
 - (iii) in the workplace; or
 - (iv) by society at large.

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

1.1.5 The role of the Department of Internal Affairs

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

1.1.6 Alignment with other strategic documents

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

- *The New Zealand Health Strategy* (which is being refreshed in 2015)
- *He Korowai Oranga: Māori Health Strategy* (refreshed in 2014)
- *’Ala Mo’ui: Pathways to Pacific Health and Wellbeing 2014–2018*
- *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017*
- *Te Puāwaiwhero: The Second Māori Mental Health and Addiction National Strategic Framework 2008–2015.*

1.2 Overall goal of the strategy

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

Government, the gambling sector,⁴ communities and families/whānau working together to prevent and minimise gambling harm, and to reduce related health inequities.

1.3 Key principles underpinning the strategy

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

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

1.4 A public health approach

Gambling harm can be reduced by reducing both incidence ('new cases') and the duration of problems, including relapse. While effective treatment reduces suffering and problem duration, it has limited impact on prevalence and much less on incidence. This is why prevention (reducing the development of problems in the first place, through a focus on their social and other determinants) is so important. The Act recognises the importance of prevention, and requires the Ministry to adopt a public health focus in addressing gambling harm.

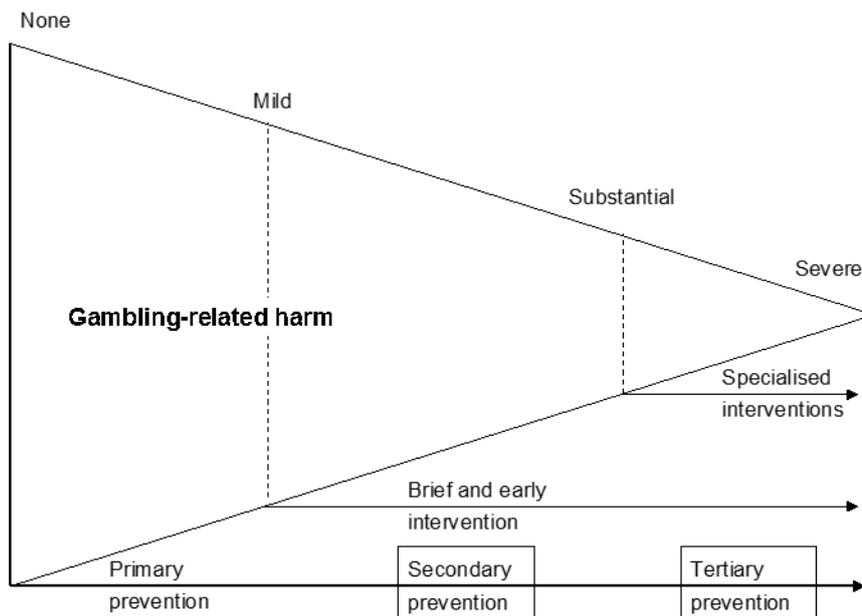
The Ministry uses a continuum-of-harm approach to interventions based on the Korn and Shaffer model. Figure 1 summarises this approach. This approach recognises that people experience varying levels of harm from gambling. It also recognises that at any given time most people are experiencing no gambling harm or only mild gambling harm. This is one reason why effective public health strategies to prevent and minimise gambling harm, focusing on the determinants of gambling harm, are likely to be the most successful 'intervention'.

⁴ In this context 'the gambling sector' includes commercial and non-commercial gambling operators (including the NZRB and the NZLC), member associations such as Clubs New Zealand and Hospitality New Zealand, operators of gambling venues (including publicans and operators of retail outlets), providers of services to prevent and minimise gambling harm, and gambling researchers.

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

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

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



Source: Adapted from Korn and Shaffer 1999

1.5 A population health framework

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

Improved health and equity for all populations is one of the Health Quality and Safety Commission's Triple Aim objectives.⁵ As noted in the Ministry's *Statement of Intent 2015 to 2019*, the Ministry has a programme of work aimed at further strengthening quality and safety in the health and disability system.⁶ One of the Ministry's initiatives in this area is working more closely with the Health Quality and Safety Commission.

⁵ www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/health-quality-and-safety-indicators/ (accessed 17 June 2015).

⁶ www.health.govt.nz/system/files/documents/publications/ministry-of-health-statement-of-intent_2015-to-2019.pdf (accessed 1 July 2015).

1.6 Equity

The World Health Organization says that equity ‘refers to fair opportunity for everyone to attain their full health potential regardless of demographic, social, economic or geographic strata’. This definition relates both to health status and to the social determinants of health. Inequities are inequalities that are judged to be unfair, that is, both unacceptable and avoidable.⁷

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

Inequities between Māori and non-Māori and between Pacific peoples and non-Pacific peoples are a particular challenge for New Zealand. The Ministry is working to enhance its long-standing focus on equity, through strategies and frameworks like *He Korowai Oranga: Māori Health Strategy*; *Equity of Health Care for Māori: A framework*; *’Ala Mo’ui: Pathways to Pacific Health and Wellbeing 2014–2018* and *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017*.

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

As noted in section 1.1.2, people living in areas of higher deprivation and some segments of the Asian population also seem to be more likely to suffer gambling harm.

It is worth noting that many of the populations and population segments that are more likely to experience gambling harm make up a growing proportion of the overall population, particularly in Auckland. This is another reason why it is important to reduce gambling-harm-related inequities.

1.7 Health literacy

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

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

⁷ www.who.int/gender-equity-rights/understanding/equity-definition/en/ (accessed 17 June 2015).

1.8 Outcomes framework for the strategy

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

In July 2013 the Ministry published the *Outcomes Framework for Preventing and Minimising Gambling Harm – Baseline Report*, developed by a broad sector advisory group, the Ministry and KPMG. It reported on all 11 objectives, and measured 56 of the 65 outcome indicators. The Ministry intends to continue working with the Advisory Group to complete update reports for the period to 30 June 2016.

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

The 11 objectives, which remain substantially unchanged, are as follows.

Objective 1: There is a reduction in gambling-harm-related inequities (particularly in the inequities experienced by Māori and Pacific peoples and some segments of the Asian population, as the groups that are most vulnerable to gambling harm).

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

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

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

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

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

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

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

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

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

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

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

Objective 1:

There is a reduction in gambling-harm-related inequities

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

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

Table 1: Priorities for action – Objective 1

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

Underlying principles: Diversity

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

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

Objective 2:

Māori have healthier futures, through the prevention and minimisation of gambling harm

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

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

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

Table 2: Priorities for action – Objective 2

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

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

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

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

Table 3: Priorities for action – Objective 3

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

Underlying principles: Participation

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

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

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

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

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

Table 4: Priorities for action – Objective 4

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

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

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

The Ministry will again focus on increased buy-in from the wider government sector at a central level, to better address the wider issues associated with gambling harm. The Ministry will continue to work closely with other government agencies, as promoted in approaches such as Better Public Services.⁸ There is still considerable scope for wider screening of individuals and populations at risk of gambling harm, through work with other agencies.

Table 5: Priorities for action – Objective 5

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

⁸ www.ssc.govt.nz/better-public-services (accessed 17 June 2015).

Objective 6:

A skilled workforce is developed to deliver effective services to prevent and minimise gambling harm

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

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

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

Table 6: Priorities for action – Objective 6

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

Objective 7:

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

The Ministry recognises that for most people gambling is a recreational activity that is enjoyed safely and in moderation. However, for a significant minority gambling causes harm for themselves and others. Certain groups, including Māori, Pacific peoples, some segments of the Asian population, and people living in higher deprivation areas are particularly vulnerable to gambling harm, for a variety of reasons.

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

Table 7: Priorities for action – Objective 7

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

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

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

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

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

Table 8: Priorities for action – Objective 8

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

Objective 9:

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

Families /whānau of problem gamblers are often the worst affected by problem gambling. Children living with adults who have gambling problems are particularly likely to experience a range of harms. The Ministry therefore places great importance on helping families to recognise the problem, address the issues and seek help if necessary, and funds the HPA to undertake certain activities to this end.

(It is worth noting that in September 2015, the Ministry published *Supporting Parents Healthy Children*,⁹ a guideline covering the implementation of systems, policies and practices to identify and address the needs of children of parents with mental health and/or addiction issues.)

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

Table 9: Priorities for action – Objective 9

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

Underlying principles: Accessibility

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

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

⁹ www.health.govt.nz/publication/supporting-parents-healthy-children (accessed 2 October 2015).

Objective 10:

Accessible, responsive and effective interventions are developed and maintained

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

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

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

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

Table 10: Priorities for action – Objective 10

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

Underlying principles: Accessibility

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

Objective 11:

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

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

A key component of the Ministry’s evaluation programme is its Outcomes Framework for Preventing and Minimising Gambling Harm. In July 2013 the Ministry published the *Baseline Report* for this Framework (Ministry of Health 2013b). The Ministry intends to review the current outcome indicators and produce update reports over the nine-year term of this Strategic Plan.

Table 11: Priorities for action – Objective 11

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

Underlying principles: Diversity

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

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

This is a hyperlink to *He Korowai Oranga: Māori Health Strategy*. Figure 2 below summarises the 2014 (most recent) version of this ‘living document’.

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

The Ministry has aligned the current nine-year Strategic Plan with *He Korowai Oranga*, in acknowledgement of the fact that the Strategy to Prevent and Minimise Gambling Harm contributes to Pae Ora.

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

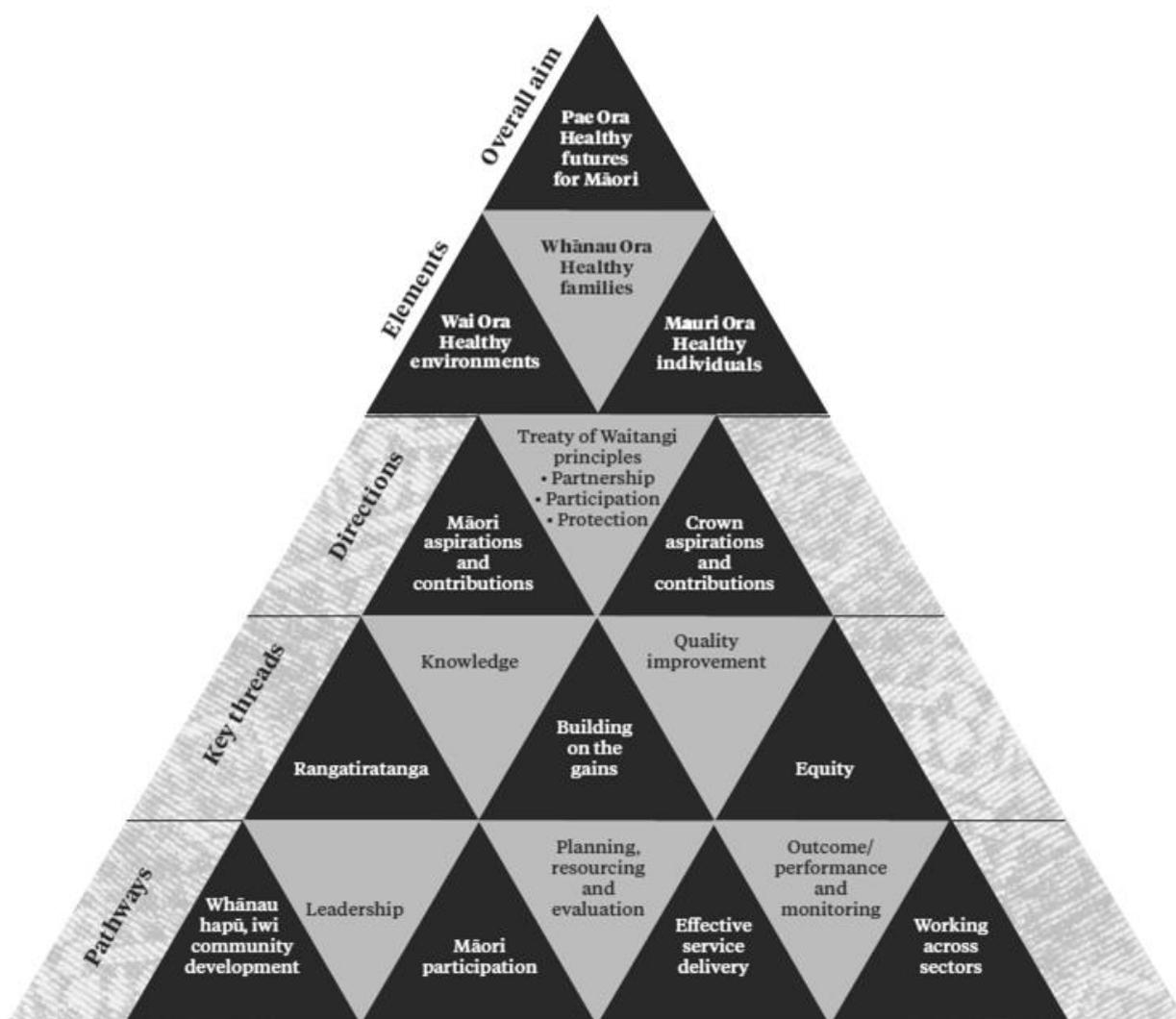


Table 12: Alignment of the strategy with *He Korowai Oranga*

He Korowai Oranga	Examples of the strategy's alignment
Overall aim	
Pae Ora	<ul style="list-style-type: none"> Principles underpinning the strategy – a focus on improving Māori health gain Objective 2 – a specific Pae Ora objective
Elements	
Mauri Ora	<ul style="list-style-type: none"> Public health service specification purchase unit 5 (effective screening environments) Free intervention services for individuals harmed by their own gambling or by someone else's gambling Intervention service specification purchase units: <ol style="list-style-type: none"> 1 – help line and information service 2 – help line and information service – brief interventions 3 – full interventions 4 – facilitation of access to other relevant services 5 – follow-up
Whānau Ora	<ul style="list-style-type: none"> Objectives 5 and 7, and public health service specification purchase unit 4 (aware communities) Public health service specification purchase unit 3 (supportive communities) Free intervention services for whānau, including dedicated Māori services
Wai Ora	<ul style="list-style-type: none"> Principles underpinning the strategy –public health services based on the Ottawa Charter and New Zealand models (healthy environments is a traditional element of a public health approach, and a component of Te Pae Mahutonga) Objective 8, which has a particular focus on NCGMs; Māori women are particularly vulnerable to harm from NCGMs Public health service specification purchase unit 2 (safe gambling environments)
Directions	
Māori aspirations and contributions	<ul style="list-style-type: none"> Objective 2 – a specific Pae Ora objective
Crown aspirations and contributions	<ul style="list-style-type: none"> The strategy is a Crown strategy Overall goal of the strategy – the Crown working with others, including families/whānau, to prevent and minimise gambling harm and to reduce related health inequities
Key threads	
Rangatiratanga	<ul style="list-style-type: none"> Dedicated Māori services using Māori-derived beliefs, values and practices
Building on the gains	<ul style="list-style-type: none"> Principles underpinning the strategy – a focus on improving Māori health gain Objective 2 – a specific Pae Ora objective
Equity	<ul style="list-style-type: none"> Overall goal of the strategy – a reduction in gambling-harm-related health inequities – and a principle underpinning the strategy – health equity Reference in health equity discussion to <i>Equity of Health Care for Māori: A framework</i> (Ministry of Health 2014) Objective 1 – a specific health equity objective Objective 2 – a specific Pae Ora objective – priority actions related to health equity for Māori Objectives 6 and 9, which require a health equity focus Planning and prioritisation processes – mapping need based on population-specific prevalence and access rates
Pathways for action	
Whānau, hāpu, iwi, community development	<ul style="list-style-type: none"> Principles underpinning the strategy – strengthen communities; and public health service specification purchase units 3 and 4 (aware and supportive communities) Requirements for services to be free of charge
Māori participation	<ul style="list-style-type: none"> Māori representation on key forums and bodies and dedicated Māori services Infrastructure intervention and public health service specification purchase unit 2 (workforce development)

He Korowai Oranga	Examples of the strategy's alignment
Effective service delivery	<ul style="list-style-type: none"> • Dedicated Māori services • Requirements for general services – Māori responsiveness, support for access to dedicated Māori services where available, and a focus on health literacy • Infrastructure intervention and public health service specification purchase unit 1 (kaumātua consultation and liaison)
Working across sectors	<ul style="list-style-type: none"> • Principles underpinning the strategy – intersectoral approach • Objectives 4 and 5 • Public health service specification purchase units 1 (policy development and implementation), 2 (safe gambling environments) and 5 (effective screening environments) • Intervention service specification purchase unit 4 (facilitation services)
Core components	
Treaty of Waitangi principles	<ul style="list-style-type: none"> • Partnership – Māori representation on key forums and bodies • Participation – dedicated Māori services using Māori-derived beliefs, values and practices • Protection – objective 2: priority actions related to health equity for Māori
Quality improvement	<ul style="list-style-type: none"> • Infrastructure intervention and public health service specification purchase unit 2 (workforce development) • Overall goal of the strategy, principles underpinning the strategy and objective 1 • Gambling Act 2003 requirements for a specified consultation process to develop the strategy and the problem gambling levy rates are intended to ensure best value for resources
Knowledge	<ul style="list-style-type: none"> • Gambling Act 2003 requirement for independent, scientific research • Objective 11 • A national coordination service and service provider hui to share best-practice examples and stories of innovation • The Ministry's Client Information Collection (CLIC) database – includes accurate ethnicity information • Funding for provider-initiated research projects that address issues of equity for Māori • Funding for research scholarships for Māori researchers
Leadership	<ul style="list-style-type: none"> • Māori representation on key forums and bodies • Health system leadership – an expectation that all New Zealanders will have health equity • Infrastructure intervention and public health service specification purchase unit 2 (workforce development)
Planning resourcing and evaluation	<ul style="list-style-type: none"> • Gambling Act 2003 requirements for the process to develop the strategy – a consultative process for planning and resourcing • Gambling Act 2003 requirement for evaluation • Research and audit projects evaluating intervention and public health services assess effectiveness and responsiveness for Māori
Outcome/performance measures and monitoring	<ul style="list-style-type: none"> • Outcomes framework baseline and update reports, which specifically address outcomes for Māori

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

This is a hyperlink to 'Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014–2018. It is the Government's plan for improving health outcomes for Pacific peoples. The long-term vision of 'Ala Mo'ui is that Pacific 'āiga, kāiga, magafaoa, kōpū tangata, vuvale and fāмили experience equitable health outcomes and lead independent lives. Figure 3 summarises the 2014 (most recent) version of 'Ala Mo'ui.

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

Figure 3: The components of 'Ala Mo'ui

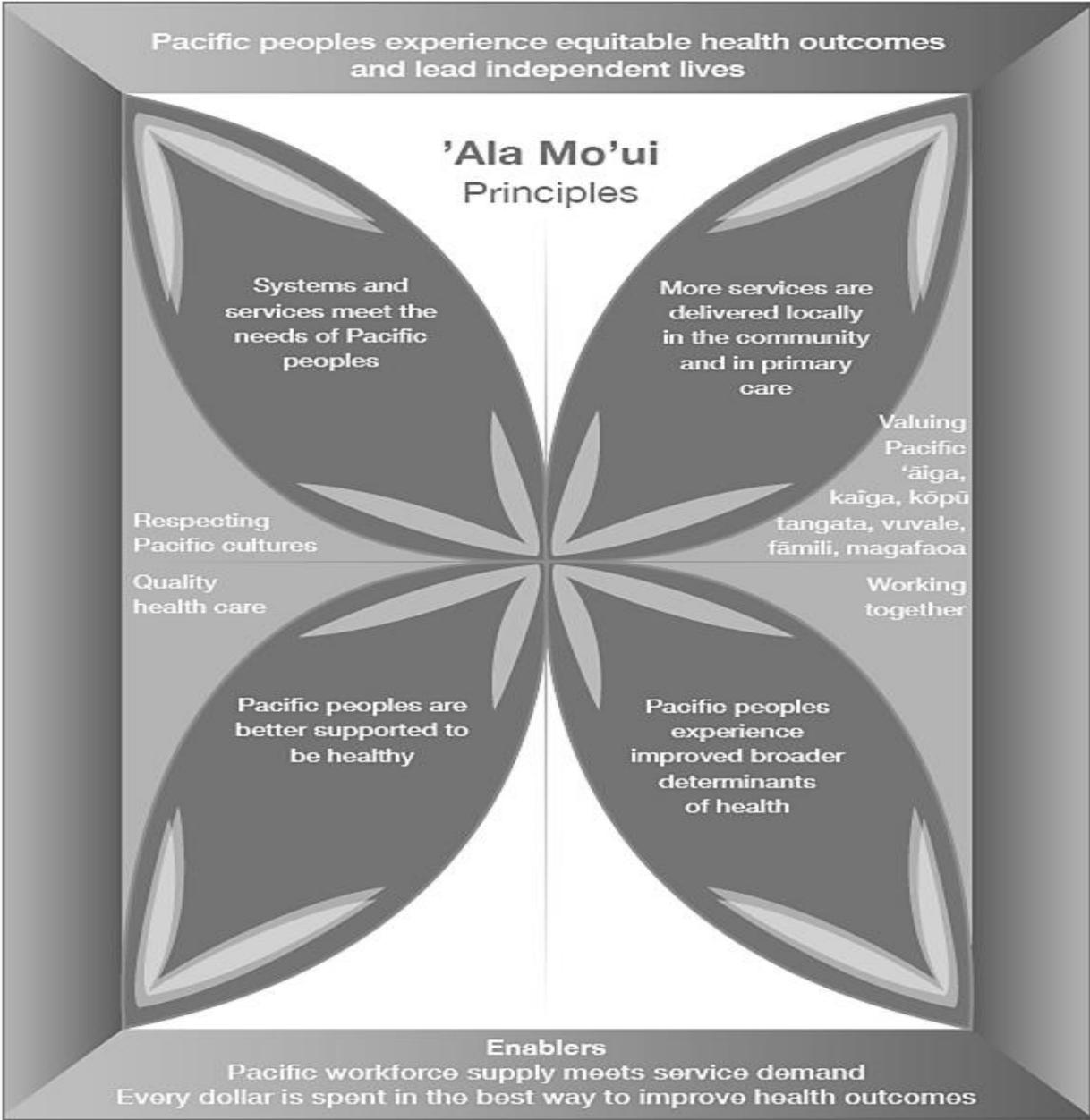


Table 13: Alignment of the strategy with 'Ala Mo'ui

'Ala Mo'ui	Examples of the strategy's alignment
Overall aim	
Health equity for all Pacific peoples	<ul style="list-style-type: none"> • Overall goal of the strategy – entails a reduction in gambling-harm-related health inequities • Principles underpinning the strategy – reduce health inequities • Objective 1 – a specific health equity objective • Planning and prioritisation processes – mapping need based on population-specific prevalence and access rates
Pacific principles	
Respecting Pacific culture	<ul style="list-style-type: none"> • Objectives 5 and 7, and public health service specification purchase unit 4 (aware communities) • Public health service specification purchase unit 3 (supportive communities) • Requirements for general services –meeting cultural needs of service users, and supporting them to access dedicated Pacific services where available
Family and communities	<ul style="list-style-type: none"> • Objectives 5 and 7, and public health service specification purchase unit 4 (aware communities) • Public health service specification purchase unit 3 (supportive communities) • Free intervention services for families
Quality health care	<ul style="list-style-type: none"> • Free intervention services for individuals and families • Overall goal of the strategy, principles underpinning the strategy, and objective 1 • Dedicated Pacific services, and requirements for general services – meeting cultural needs of service users, and supporting them to access dedicated Pacific services where available • Infrastructure intervention and public health service specification purchase unit 2 (workforce development) • Gambling Act 2003 requirements for research and evaluation – research and audit projects evaluating intervention and public health services
Working together – integration	<ul style="list-style-type: none"> • Principles underpinning the strategy – intersectoral approach • Objectives 4 and 5 and associated priority actions • Public health service specification purchase units 1 (policy development and implementation), 2 (safe gambling environments) and 5 (effective screening environments) • Intervention service specification purchase unit 4 (facilitation services)
Enablers of outcomes	
Pacific workforce supply meets demand	<ul style="list-style-type: none"> • Dedicated Pacific services based in a Pacific cultural paradigm and using Pacific-derived beliefs, values and practices • Planning and prioritisation processes – mapping need based on population-specific prevalence and access rates • Infrastructure intervention and public health service specification purchase unit 2 (workforce development)
Every dollar is spent in the best way to improve health outcomes	<ul style="list-style-type: none"> • Gambling Act 2003 requirements for a specified consultation process to develop the strategy and the problem gambling levy rates are intended to ensure best value for resources • Gambling Act 2003 requirements for research and evaluation – research and audit projects evaluating intervention and public health services

'Ala Mo'ui	Examples of the strategy's alignment
Priority outcomes	
Systems and services meet the needs of Pacific peoples	<ul style="list-style-type: none"> • Dedicated Pacific services based in a Pacific cultural paradigm and using Pacific-derived beliefs, values and practices • Requirements for general services –meeting cultural needs of service users, and supporting them to access dedicated Pacific services where available
More services delivered locally in the community and in primary care	<ul style="list-style-type: none"> • Planning and prioritisation processes – mapping need based on population-specific prevalence and access rates
Pacific peoples are better supported to be healthy	<ul style="list-style-type: none"> • Overall goal of the strategy, principles underpinning the strategy, and objective 1
Pacific peoples experience improved broader determinants of health	<ul style="list-style-type: none"> • Overall goal of the strategy, principles underpinning the strategy, and objective 1

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

2.1 Background

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

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

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

- a gradual increase in the total amount gamblers spent on the main forms of gambling
- an apparent levelling-off in the first two years of the three-year period in annual non-casino gaming machine (NCGM) expenditure, at just over \$800 million (this figure had been declining for around a decade)
- changes to the gambling legislative environment, most notably through the Gambling (Gambling Harm Reduction) Amendment Act 2013, the New Zealand International Convention Centre Act 2013 and the Gambling Amendment Act 2015
- the incorporation into all contracts for services to prevent and minimise gambling harm of a requirement under the Vulnerable Children Act 2014 to adopt a child protection policy
- the publication of *Supporting Parents Healthy Children*¹⁰, a guideline covering the implementation of systems, policies and practices to identify and address the needs of children of parents with mental health and/or addiction
- the publication of a refreshed *New Zealand Suicide Prevention Action Plan* (Ministry of Health 2013a)
- the development of an outcomes-focused commissioning framework for mental health and addiction
- the Ministry's request for proposals (RFP) for public health primary prevention and psychosocial intervention and support services, as specified in the Service Plan for 2013/14 to 2015/16
- a subsequent judicial review of the Ministry's RFP process, delaying the Ministry's implementation of its preferred service mix, and a judgment on 23 July 2015 setting aside the Ministry's decision on the RFP
- ongoing development of an integrated national telehealth service, which will incorporate the current Gambling Helpline

¹⁰ www.health.govt.nz/publication/supporting-parents-healthy-children (accessed 2 October 2015).

- a continuing increase in the number of Pacific people accessing intervention services for gambling problems
- finalisation of a set of public health core competencies to guide the public health workforce development provider
- roll-out of a multi-venue exclusion system, which at the time of writing was available in most New Zealand locations
- several developments in the context of research and evaluation, notably:
 - publication of the first report on a world-leading randomised controlled trial on brief telephone interventions for gambling harm, and completion of a three-year follow-up
 - completion of most aspects of the 2012 National Gambling Study (NGS), which includes several longitudinal follow-up components, and publication of several reports on the Study (Abbott et al 2014a, 2014b, 2014c and 2015)
 - an evaluation of public health primary prevention and psychosocial intervention service delivery in the area of gambling harm
 - a feasibility study on a smartphone application for preventing and minimising gambling harm
 - a pilot of a financial literacy education programme for Māori and Pacific clients
 - publication of the *Baseline Report* (Ministry of Health 2013b)
- the Health Promotion Agency (HPA) broadening its core programme of activity to include a component focusing on gambling venues, as specified in the service plan for 2013/14 to 2015/16.

2.1.2 Service delivery in 2013/14 to 2015/16

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

Public health

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

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

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

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

Intervention

The 2013/14 year saw a slight increase in the number of brief interventions, and a larger increase in the number of fuller interventions, and the 2014/15 year saw a further slight increase in both.

Accessibility for and responsiveness to Māori and Pacific peoples

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

Research and evaluation

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

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

- **commencement** of:
 - a clinical trial of face-to-face interventions for people with problem gambling
- **continuation** of:
 - a two-year follow-up component and a three-year follow-up component of the 2012 National Gambling Study, including a venue intercept phase
 - a study on community-level harm from gambling
 - a scholarship programme to encourage research into gambling and problem gambling.

2.1.3 Factors considered for 2016/17 to 2018/19

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

Update of the New Zealand Health Strategy

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

The Youth Mental Health Project

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

National telehealth services

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

Ongoing impact of the judicial review

The Crown has filed a notice appealing the judgment referred to in section 2.1.1. In the meantime, the Ministry has negotiated service contracts with existing providers through to 30 June 2017, to ensure service continuity. Given these developments, and based on its current experience and the Needs Assessment, the Ministry has left its indicative budgets for 2016/17 to 2018/19 largely unchanged from those in its 2013/14 to 2015/16 Service Plan.

Ongoing gambling-harm-related inequities

There is compelling evidence that Māori and Pacific peoples and some segments of the Asian population are more vulnerable to gambling harm (as a result of their own or someone else's gambling), than people in other ethnic groups. The 2012 NGS concluded in a report published during the 2013/14 to 2015/16 period that 'ethnic and other disparities in the burden of harm have persisted since the time the first gambling survey was conducted in 1991'. Reducing these inequities will be a particular focus in the 2016/17 to 2018/19 period.

Alignment with other health and social services

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

The drive for enhanced efficiency and effectiveness

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

Reporting against indicators in the outcomes framework

The Ministry published the *Baseline Report* in July 2013 (Ministry of Health 2013b). It intends to continue working with its broad sector advisory group to complete update reports for the period to 30 June 2016.

Outcomes-focused agreements

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

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

Changes in gambling participation and expenditure

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

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

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

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

The potential impact of additional casino facilities

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

On 17 June 2015, the media reported that SKYCITY had launched a free-play website with gaming machines, poker and blackjack. Promotion of this facility might result in some additional casino gambling expenditure in New Zealand and might also unintentionally result in some additional spending online with overseas operators.

Possible growth in online gambling

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

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

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

Technology-based and other innovative interventions

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

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

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

Legislative changes

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

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

2.2 Service Plan for 2016/17 to 2018/19

The 2015 Needs Assessment, which is summarised in section 1.1.1, informed the development of this draft Service Plan. A review of the Ministry's research agenda informed the research and evaluation programme (see section 2.2.3).

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

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

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

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

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

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

2.2.1 Public health services

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

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

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

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

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

Primary prevention (public health action)

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

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

There are five key service specifications¹¹ 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

¹¹ www.nsf.health.govt.nz/apps/nsfl.nsf/pagesmh/346, problem gambling services (accessed 17 June 2015).

- **effective screening environments:** to identify individuals at risk of experiencing harm from gambling as early as possible and to ensure they are made aware of where to access appropriate minimising gambling harm intervention services.

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

Workforce development (public health)

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

Awareness and education programme

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

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

National coordination and conference support

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

National coordination

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

Conference support

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

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

Audit activities

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

2.2.2 Intervention services

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

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

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

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

Helpline and web-based services

Helpline and web-based services provide:

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

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

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

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

Psychosocial interventions and support

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

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

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

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

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

Data collection and reporting

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

Workforce development (intervention)

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

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

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

Audit

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

2.2.3 Research and evaluation

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

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

The research and evaluation work programme

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

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

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

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

2.2.4 Ministry of Health operating costs

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

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

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

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

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

3 Proposed levy rates for 2016/17 to 2018/19

3.1 Background

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

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

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

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

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

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

3.2 Proposals to change the levy-paying sectors

There have been suggestions for some years that club NCGMs should pay a lower levy rate than non-club NCGMs (non-club NCGMs are referred to as ‘pub’ NCGMs, but not all of them are in pubs). In 2012, the NZRB suggested that its own NCGMs should also pay a lower levy rate.

The Ministry considers that the available evidence, taken as a whole, no longer supports the club proposal.

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

There is good research evidence that playing club NCGMs is less likely than playing pub NCGMs to be associated with moderate-risk and problem gambling (for example, pages 64 to 70 of Abbott et al 2014b). By contrast, there is little evidence that playing club NCGMs is less likely than playing pub NCGMs to be associated with either the harm from low-risk gambling or the harm from someone else’s gambling. But even if the research addressed all types of gambling harm and concluded that the club NCGM environment is demonstrably less harmful than the pub NCGM environment, that would not be enough to make out an argument that club NCGMs should be subject to a separate, lower, levy rate. It is a necessary but not a sufficient condition.

The levy rates are set as percentages of gambler expenditure. As a result, a single levy rate for all NCGMs adequately addresses any differences in gambling harm that are either attributable to or reflected in broadly equivalent differences in expenditure.

The total amount spent on pub NCGMs (and the total amount paid in levy) is around seven times the figure for club NCGMs. While more people play pub NCGMs, even the average expenditure (and the average amount paid in levy) *per player* is around three times the figure for club NCGMs. The lower expenditure on club NCGMs might be *the reason for* the lower rates of harm associated with them. Alternatively, the lower rates of harm associated with club NCGMs might be *the reason for* the lower expenditure on them. In either case, it is difficult to make out an argument that club NCGMs should be subject to a separate, lower, levy rate.

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

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

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

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

Year from 1 July to 30 June	%
2007/08	8.07
2008/09	10.06
2009/10	10.86
2010/11	9.71
2011/12	12.78
2012/13	14.81
2013/14	15.11
2014/15	17.12

There are two qualifications to the figures in Table 19.

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

Second, from 1 October 2011, the Ministry simplified its Client Information Collection (CLIC) database by removing a facility to record secondary modes of problem gambling and by changing the criterion for a primary mode from whether the mode was causing 'significant harm' to whether the mode was causing 'harm' (to align with the wording in the Act).

Some have argued that the 2011 changes to CLIC led to an increase in the club share of NCGM presentations. Others have argued that the changes reduced the overall NCGM percentage of the presentations attributed to the four levy-paying sectors. If both arguments were accepted, it would mean that from 1 October 2011 presentations attributed to club NCGMs made up a larger percentage but of a smaller overall share.

The Ministry accepts that the club share of NCGM presentations from 1 October 2011 to 30 June 2015 was much higher than the share from 1 July 2008 to 30 September 2011. However, as suggested above, table 20 in section 3.4.2 below also shows both that the NCGM share of the presentations attributed to the levy-paying sectors has been declining since 2004/05 and that this trend appeared to accelerate after 2010/11.

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

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

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

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

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

3.3 Process for setting the levy rates

The Act sets out the process to develop and set the levy rates needed to recover the cost of the strategy in sections 318 to 320. As part of this process, the Ministry has consulted on its estimated annual funding requirements and four alternative sets of estimated levy rates for 1 July 2016 to 30 June 2019.

The consultation document released on 31 July 2015 noted that, before the Gambling Commission's consultation meeting referred to below, the Ministry would update the indicative levy calculation figures used. The Ministry updated the figures, provided the updated levy rate tables to those who had been notified when the consultation document was released, published them on its website on 14 August 2015, and referred to them in its consultation meetings.

The Ministry's consultation period ran for six weeks, from 31 July 2015 until 11 September 2015. The Ministry considered submissions received during that period when it developed this proposals document. It has now submitted this proposals document to Ministers of Health and Internal Affairs and to the Gambling Commission.

The Gambling Commission obtains its own advice and convenes a consultation meeting. It subsequently makes recommendations to the responsible Ministers. After considering advice from the Gambling Commission, the Ministry and the Department of Internal Affairs (DIA), Ministers make recommendations to Cabinet. Cabinet approves the Strategic Plan and Service Plan, determines the funding that it will recommend to Parliament as the Ministry's appropriation, and endorses responsible Ministers recommending to the Governor-General regulations setting out the sectors that will pay the levy and the relevant levy rates.

3.4 The levy formula

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

The formula is:

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

where:

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

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

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

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

R = the estimated under-recovery or over-recovery of levy from a sector in the previous levy periods¹²

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

The top line of the formula determines the share that each sector must contribute to the levy requirement. The bottom line of the formula determines the levy rate that is thought to be necessary for a sector to pay its required contribution.

As required by the Act, the figures the Ministry used took into account the latest, most reliable, and most appropriate sources of information from the Ministry, IRD or DIA, as the case may be.

3.4.1 Estimated current player expenditure (A)

DIA has estimated current player expenditure using a variety of sources of information, including its NCGM electronic monitoring system, gambling operators' annual and half-yearly reports and information from IRD.¹³ Other data on gambling expenditure are available on the DIA website (www.dia.govt.nz).

¹² **R** was added to the formula by section 107 of the Gambling Amendment Act 2015, which came into effect on 3 March 2015.

¹³ IRD provides gaming duty and problem gambling levy data to DIA. The Tax Administration Act 1994 requires DIA to use its best endeavours to protect the integrity of the tax system by (among other things) maintaining the confidentiality of the affairs of taxpayers.

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

3.4.2 Presentations (B)

The formula in the Act requires the levy rate calculation to take into account the latest, most reliable, and most appropriate sources of information from the Ministry on customer presentations to problem gambling sources.¹⁴

The Ministry generated the presentation figures used in the levy calculations in this proposals document from data collected by its psychosocial intervention service providers. The figures relate to all clients who received a full, facilitation or follow-up intervention session during the 12-month period from 1 July 2014 to 30 June 2015.

As required by the Act, primary problem gambling modes (PPGMs) in gambling sectors that are not subject to the levy are excluded from the levy calculation (although they are recorded).

Brief interventions are also excluded. In this context, 'brief interventions' essentially means brief screenings carried out in non-clinical settings. They are excluded largely because the share of brief interventions attributed to each gambling sector will vary depending on the settings in which service providers decide to undertake them. That is, they cannot be considered representative.

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

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

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

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

¹⁴ This section outlines the Ministry's views on the latest, most reliable, and most appropriate sources of information on presentations. These views are canvassed in more detail in the Ministry's evidence for *Clubs New Zealand Inc v Minister of Internal Affairs* (8 April 2014), an unsuccessful application for a judicial review of the last levy-setting process.

Table 20 sets out presentations attributed to each of the four levy-paying sectors from 2004/05.

Table 20: Presentations attributed to the four levy-paying sectors, 2004/05 to 2014/15

	NCGMs		Casinos		NZRB		NZLC		Total n
	n	%	n	%	n	%	n	%	
2004/05	2386	75	505	16	237	7	52	2	3179
2005/06	2307	71	641	20	243	7	64	2	3255
2006/07	2981	71	814	19	311	7	76	2	4182
2007/08	3063	71	849	20	328	8	97	2	4337
2008/09	3933	69	1050	18	413	7	304	5	5700
2009/10	4160	69	1131	19	449	7	332	5	6072
2010/11	3945	68	1073	18	476	8	332	6	5825
2011/12	3708	64	1188	21	548	9	339	6	5783
2012/13	3721	59	1403	22	568	9	652	10	6344
2013/14	3871	59	1413	22	651	10	590	9	6525
2014/15	3674	57	1448	22	730	11	624	10	6476

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

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

First, from 1 April 2008, the Ministry formalised a requirement for service providers to enter as PPGMs all forms of gambling that were causing a client ‘significant harm’, and to enter as secondary modes of problem gambling all forms of gambling that were causing a client ‘harm’, up to a maximum of five in each case. Second, that system was changed from 1 October 2011, as described previously.

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

The *number* of NCGM presentations peaked in 2009/10. The *share* of NCGM presentations peaked in 2004/05, and has been dropping unevenly since. These patterns probably largely reflect reductions in the number of NCGMs and NCGM venues, and in the amount spent on NCGMs, since 2003/04. However, the latter trend also seemed to accelerate after 2010/11, and the acceleration might reflect the changes to CLIC from 1 October 2011.

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

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

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

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

3.4.3 The weights (W1 and W2)

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

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

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

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

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

NCGMs		Casinos		NZRB		NZLC	
Expenditure	Presentations	Expenditure	Presentations	Expenditure	Presentations	Expenditure	Presentations
0.397	0.567	0.258	0.224	0.157	0.113	0.189	0.096

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

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

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

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

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

However, as the Gambling Commission noted in its 2009 report,¹⁵ a very high weighting on presentations might mean that 'diligent host responsibility in detecting problem gambling and encouraging the seeking of assistance is punished not rewarded'.

Presentations are not the only available indicator of harm. Other examples include estimates of problem gambling prevalence using screening instruments such as the Problem Gambling Severity Index (PGSI),¹⁶ or survey questions that directly address the risk of harm (for example, questions about various forms of 'household harm') associated with particular gambling products. Some of these measures suggest that the proportion of gambling harm that is properly attributable to the NZRB and the NZLC in particular might be higher than their shares of the presentation figures in earlier years would have suggested. This is one reason why the Ministry considers that the latest presentation figures, in which the NZRB and NZLC shares of presentations are somewhat higher, are the most reliable and the most appropriate.

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

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

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

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.

¹⁵ [www.gamblingcommission.govt.nz/GCwebsite.nsf/wpg_URL/Reports-Publications-Proposed-Problem-Gambling-Levy-\(November-2009\)!OpenDocument](http://www.gamblingcommission.govt.nz/GCwebsite.nsf/wpg_URL/Reports-Publications-Proposed-Problem-Gambling-Levy-(November-2009)!OpenDocument) (accessed 17 June 2015).

¹⁶ <https://www.problemgambling.ca/EN/Documents/ProblemGamblingSeverityIndex.pdf> (accessed 17 June 2015).

3.4.4 The funding requirement (C)

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

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

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

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

The Ministry's total appropriation to prevent and minimise gambling harm from 1 July 2004 to 30 June 2016, as derived from its four service plans to date, was \$216.360 million. The Ministry expects its expenditure to 30 June 2016 to total no more than \$211.545 million, taking into account any possible expense transfers.¹⁷ This figure was derived by summing problem gambling expenditure as set out in the Ministry's annual reports to 30 June 2014 and an estimate of its likely expenditure for the two years to 30 June 2016. It is the latter figure (\$211.545 million) that the levy should have recovered from the four levy-paying gambling sectors by 30 June 2016. This amount is slightly lower than the amount originally set out in the Ministry's consultation document published on 31 July 2015, because an expense transfer that was thought to be \$1.8 million was actually only \$1.73 million. This change results in an inconsequential reduction in the amount required in levy from each gambling sector.

The Ministry obtained the *amount* that each sector was expected to pay in levy for each three-year period by referring to the relevant Cabinet paper. It used that information to calculate each sector's expected *share* of the levy requirement for each three-year period. It applied that *share* to the Ministry's spending for each period, to arrive at the *amount* that each sector was expected to pay towards the Ministry's spending in each period. It then summed those *amounts* across the four levy periods to arrive at the *amount* each sector was expected to pay in levy in order to recover the Ministry's total spending up to 30 June 2016.

The share of the total spending (rounded to four decimal places) that NCGMs were expected to pay was 68.2943 percent. The expected share for casinos was 18.7545 percent, for the NZRB 7.9399 percent, and for the NZLC 5.0113 percent.

This means that the total amount of levy that should have been collected from NCGMs over the 12-year period was \$144.473 million (that is, 68.2943% of \$211.545 million). The equivalent amount for casinos was \$39.674 million, for the NZRB was \$16.796 million, and for the NZLC was \$10.601 million.

¹⁷ An expense transfer makes money that was appropriated for a particular purpose in a particular financial year, but that was not spent in that year, available for spending on that purpose in a future financial year.

Note that this method of calculation is a little different from the method described in the consultation document published on 31 July 2015. The change responds to a submission that any Ministry underspending should be credited back to the levy period in which it occurred. Because most of the Ministry's underspending was attributable to levy periods in which the NCGM share of the levy was highest, this change in methodology (together with the slight reduction in the Ministry's spending) reduced the total amount required from the NCGM sector by around \$400,000 and increased the amount required from each of the other three sectors by between \$80,000 and \$150,000.

Table 22 shows DIA's estimates of the under-recovery or over-recovery for each sector for the 12-year period, using IRD figures for levy actually collected until late in the 2014/15 year. Unlike the equivalent table in the consultation document released on 31 July 2015 and in the updated levy rate tables released on 14 August 2015, it is expressed in GST exclusive terms. The GST exclusive figures are (correctly) used in tables 24 to 27 of this proposals document, and were (correctly) used in tables 24 to 27 of both the consultation document and the updated levy rate tables. Therefore, it would also have been, and still is, appropriate for table 22 to be expressed in GST exclusive terms.

Table 22: Under-recovery or over-recovery of levy, 2004/05 to 2015/16, by sector

Sector	\$m (GST exclusive)
NCGMs	-1.308
Casinos	-1.567
NZRB	1.364
NZLC	0.648

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

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

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

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

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

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

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

Expenditure on NZLC products is relatively volatile, depending on the number of large jackpots in any given financial year. The service plan forecasts for expenditure on NZLC products were too low for almost every year of the four levy periods to 30 June 2016, probably as a result of the NZLC's own published forecasts. This was the key reason for the over-recovery from this sector.

As outlined above, the calculation to determine any under-recovery or over-recovery credited Ministry underspending back to the levy-paying sectors. Otherwise, it simply compared the amount of levy that each sector was expected to pay in each of the four levy periods to 30 June 2016 with the amount actually paid in levy in each of those levy periods. Because the current levy period has not yet finished an estimate was required for around the last year of the three years.

During consultation, several submitters said that because the NCGM share of presentations had declined over each of the four levy periods, that sector had paid too much levy. They submitted that *actual* expenditure and presentation figures should be used to recalculate what each sector should have paid during each of the levy periods. That is, they proposed that for each levy period the *actual* figures for A and B, which are known only *after* the period has ended, should be inserted into the $\{[A \times W1] + [B \times W2]\}$ component of the formula, and the result multiplied by the Ministry's spending on problem gambling during the period, to determine the amount that each sector should have paid. This approach would have a major impact on the under-recovery or over-recovery figure for each of the four levy-paying sectors.

The Ministry carefully considered these submissions before concluding that the approach advocated is not the correct approach. There is nothing in the Act to suggest that each sector's levy liability for each period should be recalculated in this way.

3.4.6 Forecast player expenditure (D)

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

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

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

Non-casino gaming machines

The number of NCGMs is still declining. There were 20,302 licensed NCGMs in New Zealand on 31 March 2007, 18,484 on 31 March 2011 and 16,614 on 31 March 2015. By 30 June 2015, there were only 16,579.

NCGM expenditure has also declined for most of the last decade. DIA's electronic monitoring system (EMS) recorded reductions from \$854 million in 2011/12 to \$826 million in 2012/13 and \$806 million in 2013/14.

In 2014/15, the EMS recorded a small increase in NCGM expenditure.

During consultation, NCGM groups noted that the expenditure forecasts for its sector had historically been too high, and referred to pressures on the sector that they considered would result in a continuing decline. DIA considers further reductions in NCGM expenditure are less likely, and forecasts a period of relatively stable expenditure.

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

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

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

Casinos

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

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

New Zealand Racing Board

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

It is not yet clear that this growth will be sustained over the period from 2016/17 to 2018/19. Accordingly, DIA has forecast spending on NZRB that is nearer to the long term average growth rate. The Offshore Racing and Sports Betting Working Group is looking into the issue of competition from offshore betting agencies, and will report this year.

New Zealand Lotteries Commission

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

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

Table 23 shows the DIA forecasts of player expenditure for each levy-paying gambling sector for each year of the new three-year levy period that starts on 1 July 2016. With the exception of the NZLC these forecasts are all a little lower than those in the updated levy rate tables published on 14 August 2015. These changes reflect the availability of more up to date data.

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

Forecast expenditure	NCGMs	Casinos	NZRB	NZLC
2016/17 (\$m)	812.371	532.390	326.696	416.491
2017/18 (\$m)	812.371	537.714	329.963	428.986
2018/19 (\$m)	812.371	545.780	333.262	439.710

3.5 Levy calculations

The tables that follow set out the effect of each of the four alternative weightings described above on the draft levy rates for the four levy-paying sectors. There are some changes from the updated levy rate tables published on 14 August 2015.

Table 24: Estimated levy rates: 5/95 weighting

Collection period starts 1 July 2016 (all GST exclusive)	NCGMs	Casinos	NZRB	NZLC
Sector levy rates (%)	1.32	0.87	0.50	0.38
Expected levy (\$m)	32.170	14.058	4.950	4.884

Table 25: Estimated levy rates: 10/90 weighting

Collection period starts 1 July 2016 (all GST exclusive)	NCGMs	Casinos	NZRB	NZLC
Sector levy rates (%)	1.30	0.87	0.52	0.40
Expected levy (\$m)	31.683	14.058	5.148	5.141

Table 26: Estimated levy rates: 20/80 weighting

Collection period starts 1 July 2016 (all GST exclusive)	NCGMs	Casinos	NZRB	NZLC
Sector levy rates (%)	1.26	0.89	0.54	0.44
Expected levy (\$m)	30.708	14.381	5.346	5.655

Table 27: Estimated levy rates: 30/70 weighting

Collection period starts 1 July 2016 (all GST exclusive)	NCGMs	Casinos	NZRB	NZLC
Sector levy rates (%)	1.23	0.90	0.57	0.48
Expected levy (\$m)	29.977	14.543	5.643	6.169

References

- Abbott M, Bellringer M, Garrett N, et al. 2014a. *New Zealand 2012 National Gambling Study: Attitudes towards Gambling: Report Number 3*. Auckland: Gambling & Addictions Research Centre, National Institute for Public Health & Mental Health Research, AUT University.
- Abbott M, Bellringer M, Garrett N, et al. 2014b. *New Zealand 2012 National Gambling Study: Gambling Harm and Problem Gambling: Report Number 2*. Auckland: Gambling & Addictions Research Centre, National Institute for Public Health & Mental Health Research, AUT University.
- Abbott M, Bellringer M, Garrett N, et al. 2014c. *New Zealand 2012 National Gambling Study: Overview and Gambling Participation: Report Number 1*. Auckland: Gambling & Addictions Research Centre, National Institute for Public Health & Mental Health Research, AUT University.
- Abbott M, Bellringer M, Garrett N, et al. 2015. *New Zealand 2012 National Gambling Study: Report Number 4: 12-month Follow-up (Wave 2)*. Auckland: Gambling & Addictions Research Centre, National Institute for Public Health & Mental Health Research, AUT University.
- Abbott MW, Volberg RA. 1991. *Gambling and Problem Gambling in New Zealand*. Research Series No.12. Wellington: Department of Internal Affairs.
- Abbott MW, Volberg RA. 2000. *Taking the Pulse on Gambling and Problem Gambling in New Zealand: A report on phase one of the 1999 National Prevalence Survey*. Wellington: Department of Internal Affairs.
- Allen and Clarke. 2015. *Informing the 2015 Gambling Harm Needs Assessment: Report for the Ministry of Health*. Wellington: Allen and Clarke Policy and Regulatory Specialists Ltd.
- Bellringer M, Abbott M, Williams M, et al. 2008. *Problem Gambling: Pacific Islands Families Longitudinal Study*. Auckland: Gambling & Addictions Research Centre, AUT University.
- Bellringer M, Fa'amatuaianu B, Taylor S, et al. 2013. *Exploration of the Impact of Gambling and Problem Gambling on Pacific Families and Communities in New Zealand*. Auckland: Gambling & Addictions Research Centre, National Institute for Public Health & Mental Health Research, AUT University.
- Bellringer M, Garrett N, Kolandai-Matchett K, et al. In Press. *Offshore Gambling by New Zealanders Study*. Auckland: Gambling & Addictions Research Centre, National Institute for Public Health & Mental Health Research, AUT University.
- Bellringer M, Taylor S, Poon Z, et al. 2012. *Pacific Islands Families Study 2009: Mother and Child Gambling*. Auckland: Gambling & Addictions Research Centre, National Institute for Public Health & Mental Health Research, AUT University.
- DAPAANZ. 2011. *Addiction Intervention Competency Framework: A competency framework for professionals specialising in Problem Gambling, Alcohol and other Drug and Smoking Cessation intervention*. Wellington: Addiction Practitioners' Association Aotearoa-New Zealand.
- Daryshire P, Oster C, Carrig H. 2001. The Experience of Pervasive Loss: Children and Young People Living in a Family Where Parental Gambling is a Problem. *Journal of Gambling Studies*, Vol 17(1).
- DIA. 2008. *People's Participation in, and Attitudes towards, Gambling, 1985–2005: Results of the 2005 survey*. Wellington: Department of Internal Affairs.
- Kalischuk RG, Nowatzki N, Cardwell K, et al. 2006. Problem Gambling and its Impact on Families: A Literature Review. *International Gambling Studies*, Vol 6(1).

- Korn DA, Shaffer HJ. 1999. Gambling and the health of the public: adopting a public health perspective. *Journal of Gambling Studies* 15(4): 289–365.
- Ministry of Health. 2007. *Te Uru Kahikatea: The Public Health Workforce Development Plan 2007–2016*. Wellington: Ministry of Health.
- Ministry of Health. 2008. *Te Puāwaiwhero: The Second Māori Mental Health and Addiction National Strategic Framework 2008–2015*. Wellington: Ministry of Health.
- Ministry of Health. 2013a. *New Zealand Suicide Prevention Action Plan 2013–2016*. Wellington: Ministry of Health.
- Ministry of Health. 2013b. *Outcomes Framework for Preventing and Minimising Gambling Harm – Baseline Report*. Wellington: Ministry of Health.
- Ministry of Health. 2014. *Equity of Health Care for Māori: A framework*. Wellington: Ministry of Health.
- Ministry of Health. 2015a. *Framework for Health Literacy*. Wellington: Ministry of Health.
- Ministry of Health. 2015b. *Health Literacy Review: A guide*. Wellington: Ministry of Health.
- Productivity Commission. 1999. *Australia's Gambling Industries*, Report No. 10, Canberra AusInfo.
- Productivity Commission. 2010. *Gambling*. Report no. 50. Canberra: Australian Government Productivity Commission.
- Rossen F. 2014. *Gambling and Problem Gambling: Results of the 2011/12 New Zealand Health Survey*. Auckland: Auckland UniServices Ltd, Centre for Addiction Research, University of Auckland.
- Rossen F, Fleming T, Lucassen M, et al. 2013. *The Health and Wellbeing of New Zealand Secondary School Students in 2012: Youth gambling*. Auckland: University of Auckland.
- SHORE/Whāriki. 2008. *Assessment of the Social Impacts of Gambling in New Zealand*. Auckland: Centre for Social and Health Outcomes Research and Evaluation and Te Ropu Whariki, Massey University.
- Sobrun-Maharaj A, Rossen F, Wong ASK. 2012. *The Impact of Gambling and Problem Gambling on Asian Families and Communities in New Zealand*. Auckland: Centre for Asian & Ethnic Minority Health Research, Auckland UniServices Ltd, University of Auckland.
- Thomas J, Mora K, Rive G. 2012. *An Investigation of the Influence of Gambling Venue Characteristics on Gamblers' Behaviour*. Lower Hutt: Opus International Consultants Limited.
- Tu D, Puthipiroj P. In Press. *New Zealanders' Participation in Gambling: Results from the 2014 Health and Lifestyles Survey*. Wellington: Health Promotion Agency Research and Evaluation Unit.
- Watson K, Watson G. 2004. The effects of gambling on family members: suggestions for intervention. In: Tan R, Wurtzburg S (eds) *Problem Gambling: New Zealand Perspectives on Treatment*. Wellington: Steele Roberts Ltd.