

Strategy to Prevent and Minimise Gambling Harm

2019/20 to 2021/22

Consultation document

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Foreword

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

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

Consistent with these requirements, the Ministry is now seeking comment, through a consultation process, on its draft Strategy to Prevent and Minimise Gambling Harm for 2019/2020 to 2021/2022 and draft levy rates.

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

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

The Ministry encourages you to have your say to ensure an inclusive and comprehensive approach to preventing and minimising gambling harm for the three-year period from 1 July 2019 to 30 June 2022 and beyond.

Dr Ashley Bloomfield
Director-General of Health

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Executive summary

The Ministry of Health is seeking submissions by 21 September 2018 on its proposals to refresh of the Strategy to Prevent and Minimise Gambling Harm and the associated problem gambling levy for 2019/20 to 2021/22

The Gambling Act 2003 (the Act) recognises that gambling harm is a significant issue and requires the development and implementation of an ‘integrated problem gambling strategy focused on public health’. The Act specifies components of the strategy that include a needs assessment, measures to promote public health, services to treat and assist problem gamblers and their families and whānau, and independent scientific research and evaluation.

The Ministry of Health is responsible for the strategy and it is refreshed every three years. The Crown recovers the cost of developing and implementing the strategy using a ‘problem gambling levy’ set by regulation at a different rate for each of the main gambling sectors.

Gambling harm needs assessment

The Ministry conducted a needs assessment to help develop the draft strategy. Based on interviews with key stakeholders, a service provider survey and literature review, the needs assessment found that the number of people affected by gambling harm has increased in line with population growth, harm reduction impacts have plateaued over the past seven years and that health inequities persist for the most affected at-risk population groups. It concluded that changes are necessary to make inroads to reducing gambling harm.

The Ministry proposes the new strategy for 2019/20 to 2021/22 refocus and revitalise activities to achieve further gains in gambling harm reduction.

Section 2: Strategic direction

Section 2 sets out the strategic direction for 2019/20 to 2021/22. The Ministry proposes minor changes to the current strategic framework and is based on an outcomes framework agreed to by both the gambling industry and gambling harm services.

Proposed changes include promoting safer gambling environments and host responsibilities, and to target research and evaluation to strengthen our knowledge about harm reduction and prevention. This will address health inequities prevalent in Māori, Pacific and Asian communities and people in areas of high social deprivation.

Section 3: Service plan

Section 3 outlines the proposed services and indicative budgets for the next three years. The Ministry proposes to increase the range of services by introducing residential care and peer support. The Ministry also intends to pilot new service models, covering public health and intervention services, co-designed with stakeholders and consumers. The pilot will address service gaps and areas of systemic, persistent gambling harm, and will be evaluated.

The needs assessment also clearly shows that approximately 50 percent of all electronic gaming machines or ‘pokies’ are in the most socioeconomically deprived areas of the country. This consultation document seeks your views about whether gambling operators should be incentivised to move machines, and what barriers currently exist to doing so.

The Ministry does not propose to increase the three year appropriation of \$55.339 million to fund the proposed increased services, which will be funded from accumulated underspent funds of \$5 million.

Section 4: Problem gambling levy

Section 4 looks at the problem gambling levy and the proposed new levy rates for each gambling sector. The proposed new rates will be lower for each sector due to increases in each sector’s gambling expenditure and levy overpayments in the current levy period. The levy formula allows for these factors.

While the strategy is funded through an appropriation, the levy is set for a three-year period by regulation at different rates on each of the profits of the four main gambling sectors to reimburse the Crown the amount of the appropriation. The Act specifies the formula used to apportion levy payments to each gambling sector and calculate the levy rate that sector must pay. The formula requires ministers to determine the weightings between sector spending and presentations, which generates the levy rate and payments for each sector.

The new levy rates proposed in this consultation document are based on the formula currently set out in the Act. However this consultation document recognises that changes to the formula might be made in the future and seeks your views about what changes, if any, should be considered when setting the levy in the future.

The consultation process

The Act details a staged consultation process for the proposed strategy and levy rates.

The Act requires the Ministry to submit revised strategy and levy rate proposals to the Gambling Commission, after taking into account feedback from the consultation. The Commission must hold a consultation meeting and provide its own advice about the proposed levy rates to the Associate Minister of Health with responsibility for Problem Gambling and the Minister of Internal Affairs. Cabinet will subsequently make final decisions on the shape of the strategy and the new levy rates early in 2019. The new rates will come into effect on 1 July 2019.

Although gambling harm services are outside the scope of the Inquiry into Mental Health and Addiction, the inquiry panel has indicated it intends to explore gambling harm as a risk factor for other mental health and addiction issues. Any relevant findings from the inquiry report, expected in October 2018, could be integrated into the final strategy.

Submissions

The Ministry encourages you to have your say and make a submission on these proposals. Submissions can be made online or by completing the submission form at the back of this document (also available online) and sending it to gamblingharm@moh.govt.nz. Further information is available at www.health.govt.nz/consultgambling

Submissions must be received by **21 September 2018**.

Consulting on the proposed Strategy to Prevent and Minimise Gambling Harm 2019/20 to 2021/22

This document seeks your comment on the proposed future direction and content of the Ministry of Health's (the Ministry's) Strategy to Prevent and Minimise Gambling Harm-2019/20 to 2021/22 (the strategy).

Included in this consultation document are draft proposals for:

- the strategic plan, which sets out the general strategic direction and priorities that provides a framework for the activities described below
- the proposed funding levels for the Ministry, in relation to the gambling harm prevention and minimisation activities described in the strategy
- the proposed service plan, for the three years from 2019/20 to 2021/22
- the proposed problem gambling levy rates and weighting options per gambling sector, for the next three years.

The proposed strategy (this document) is informed by:

- a needs assessment, as required under the Gambling Act 2003 (the Act). This includes an independent 'needs assessment' review of gambling harm minimisation services and the sector generally
- a review of progress towards gambling harm reduction outcomes, to assess what has been achieved over time in gambling harm minimisation. This draws on key studies such as the New Zealand National Gambling Study (NGS) and Health and Lifestyles Survey (HLS).

This consultation document meets the consultation requirements specified in the Act to develop an integrated problem gambling strategy to prevent and minimise gambling-related harm.

More details about the consultation process, the needs assessment and the outcomes report can be found on the Ministry's website www.health.govt.nz/consultgambling

Following this consultation phase, the proposed strategy and levy rate may be revised, taking into account feedback received from the public consultation process, before they are submitted to the New Zealand Gambling Commission (the Gambling Commission) to consider. The Gambling Commission consults with stakeholders and makes recommendations to responsible Ministers about the total amount of the levy and levy rates for each gambling sector before the government finalises the strategy and the levy for the next three years.

Inquiry into Mental Health and Addictions

Services to prevent and minimise gambling harm are not included in the scope of the Inquiry into mental health and addictions, however the Inquiry panel has asked for gambling harm to be acknowledged and explored as a risk factor for other mental health and addition issues.

The Inquiry is due to report back in October 2018, so any relevant findings from the Inquiry report could be incorporated into the Strategy before the Strategy is finalised in early 2019.

Have your say

Please take the time to make a submission about the proposals outlined in this consultation document.

You can provide feedback by:

- making an online submission at <https://consult.health.govt.nz>
- using the form at the end of this document and emailing it to gamblingharm@moh.govt.nz
- sending a hard copy to:
Strategy to Prevent and Minimise Gambling Harm Consultation
Ministry of Health
PO Box 5013
Wellington 6140
- attending a discussion and consultation meeting (meeting details are available on our website www.health.govt.nz/consultgambling).

Your feedback is important. It will help shape the proposed Strategy to Prevent and Minimise Gambling Harm for 2019/20 to 2021/22 and the proposed levy rates that the Ministry submits to Ministers and the Gambling Commission for their consideration.

Your submissions are due with the Ministry by **5 pm Friday 21 September 2018**.

1 Introduction

This section provides the context and background that informs the strategy, strategic direction and service plan of the strategy.

Recent research notes that one in five New Zealand adults (22%) are affected some time in their lives by their own gambling or the gambling of others. Estimates suggest 37,000 people aged 15 years or older are at high risk of harm from gambling or are ‘problem gamblers’, about 47,000 were at moderate-risk and a further 106,000 were at low risk but would experience gambling-related harm during their lifetime.¹

Every year, some of these people seek help. For example, in the 2016/17 year, over 6,200 people sought help from services funded by the Ministry of Health (the Ministry) for problems due to their own or someone else’s gambling. Most of these people were in crisis. If brief interventions in non-clinical settings were included in the analysis, the total increases to more than 11,600.²

1.1 The role of the Ministry of Health

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

The Act says that the strategy must include:

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

The Act 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.’

¹ New Zealanders’ Participation in Gambling: Results from the 2016 Health and Lifestyles Survey meta-analysis.

² Ministry of Health Intervention client data website.

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.

1.2 Role of the Department of Internal Affairs

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

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

1.3 Key principles underpinning the strategy

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

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

1.4 Functions of the strategy

The strategy comprises a rolling six-year strategic plan and a three-year service plan and is refreshed every three years. Together, the strategic and service plans set out the Ministry’s

proposed approach and the range of activities it plans to undertake to minimise gambling harm from 2019/20 to 2021/22.

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

It reflects the Ministry's responsibility for a public health approach to gambling harm minimisation and its relationship to the complementary responsibility of the DIA in regulating gambling activity. The strategy is informed by and aligned with other key Ministry strategic documents.

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

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

1.5 Gambling harm needs assessment

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

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

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

1.6 Opportunities to learn

Overall, Sapere found that:

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

In response, the Ministry notes the strategic goal for gambling harm reduction is ‘Government, the gambling sector,³ communities and families/whānau working together to prevent and minimise gambling harm, and to reduce related health inequities’ (Ministry of Health 2016). The Ministry’s statutory responsibility is to promote harm minimisation through an informed, research-based public health approach.

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

The proposed service plan provides more detail about the Ministry’s response to the recommendations identified in the Sapere needs assessment and continue promoting gambling harm minimisation.

1.7 Outcomes monitoring

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

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

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

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

A refocusing and revitalisation of activities is warranted

As mentioned above, the outcomes review and the needs assessment together suggest while there has been some success in reducing gambling harm over time since the first strategy in 2005, in the past few years, the number of people affected by gambling harm has been growing. Gambling harm activities need to be refocused and revitalised in future service plans if further gains are to be made in reducing gambling harm and health inequalities and inequity in the experience of gambling harm by a range of population groups, particularly Māori and Pacific peoples.

³ In this context, ‘the gambling sector’ includes commercial and non-commercial gambling operators (including the New Zealand Racing Board and the New Zealand Lotteries Commission), member associations such as Clubs New Zealand Inc. and Hospitality New Zealand, operators of gambling venues (including publicans and operators of retail outlets), providers of services to prevent and minimise gambling harm and gambling researchers.

Inequalities and inequity in health

Differences in health experience occurring between population groups are usually referred to as 'health inequalities'. A 'health inequity' is an inequality that can be attributed to social, cultural and economic factors rather than biomedical ones.

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

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

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

1.8 A population-based public health approach

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

This approach recognises that people experience varying levels of harm from gambling. The framework, represented in Figure 1 below brings together the ideas of different levels of individual gambling behaviour, associated levels of harm and types of health intervention.

The levels of gambling behaviour and associated harm are described as non-problem (none), mild and moderate through to severe (problem) gambling. These categories can be overlaid with the three broad categories of population public health interventions, comprising 'primary', 'secondary' and 'tertiary' interventions. Figure 1 also shows examples of the related types of activity that have been delivered through each current service plan.

The categories of behaviour and harm have been aligned with the PGSI. Based on international research, the PGSI measures a person's risky gambling behaviour and harm, based on a clinical diagnosis. The Ministry uses the PGSI to monitor the level of harmful gambling behaviour occurring in the New Zealand population.⁴ Figure 1 includes the most robust estimates of the harm occurring for each category. The estimates are from a statistical meta-analysis of the pooled responses to the PGSI questions in the 2012, 2014, 2016 HLS. It is important to note that the PGSI measures the level of reported harm that is associated with the individual gambler and their immediately affected 'others' (family/whānau and affected others such as an employer or a community group).

The PGSI differentiates between different types of harm and frequency of harm occurring as reported by the survey respondent.

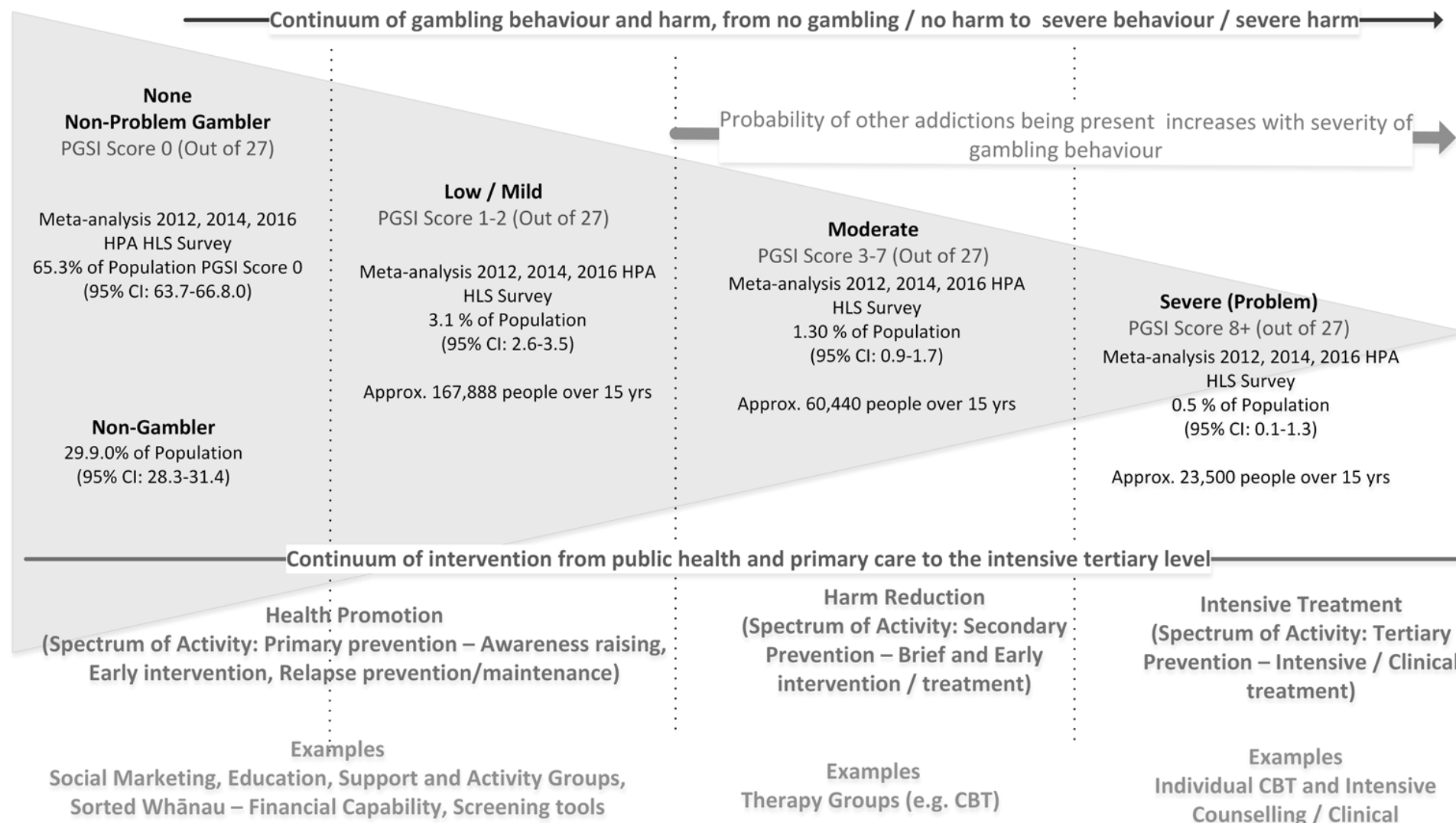
⁴ The estimates have been produced through the HLS – Gambling module and the NGS, which are both funded by the Ministry through the gambling levy.

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

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

Similarly, harmful gambling behaviour may impact significantly on women and children. There is a strong correlation between gambling and family/ whānau or partner violence, with 50 percent of problem gamblers also experiencing family/whānau violence. Women, as the most common primary caregivers in the family/whānau are also particularly vulnerable to the economic strain caused by problem gambling.

Figure 1: Gambling behaviour and harm: the continuum of prevention and harm reduction



1.9 Gambling harm inequality and inequity

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

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

What the research tells us

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

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

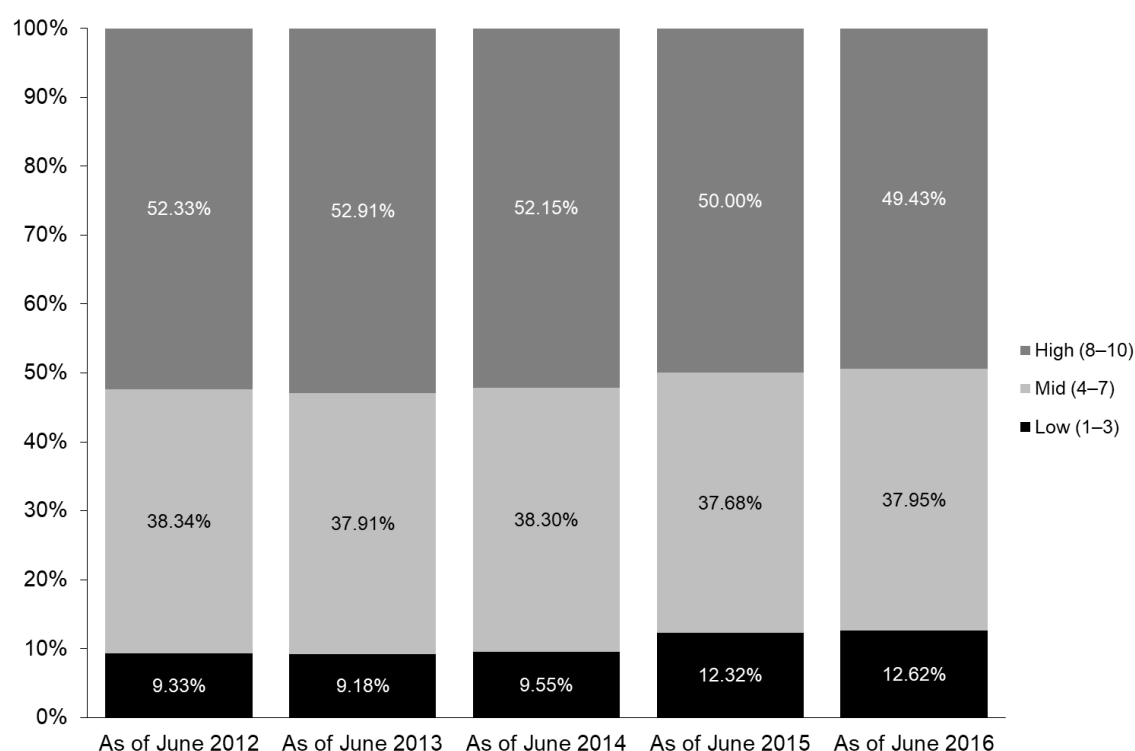
In terms of overall gambling service use, analysis indicates that there is substantive underuse of services by the Pacific and Asian groups. Similarly, an analysis using the social deprivation index shows significant inequality, disparity and inequity between New Zealand populations groups by socioeconomic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

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

Consultation questions – Concentration of class 4 NCGMs in lower socioeconomic areas (section 1.9)

- A. Do you think operators of class 4 venues should be incentivised to move from lower socioeconomic areas to higher socioeconomic areas?
- B. What barriers, if any, do you think currently exist to moving class 4 gambling venues out of lower socioeconomic areas?
- C. If barriers do exist, how do you think venues can be incentivised to move?

Figure 2: Distribution of class 4 NCGMs by low, mid and high deprivation areas



Source: Department of Internal Affairs

How do inequities come about?

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

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

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

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

2 Draft six-year strategic framework 2019/20 to 2024/25

The Ministry proposes relatively minor changes to the strategic plan/framework that was published in 2016/17, to better target reductions in health inequities. The strategic framework is based on an outcomes framework agreed by both the gambling industry and gambling harm services.

2.1 Overall goal of the strategic plan

The Ministry is committed to a long-term approach that has not significantly changed from the approach outlined in its first six-year strategic plan in 2005. The overall goal is:

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

2.2 Eleven strategic objectives

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

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

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

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

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

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

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

Objective 7: Services enhance people’s mana and build life skills and resiliency to improve healthy choices that prevent and minimise gambling harm.

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

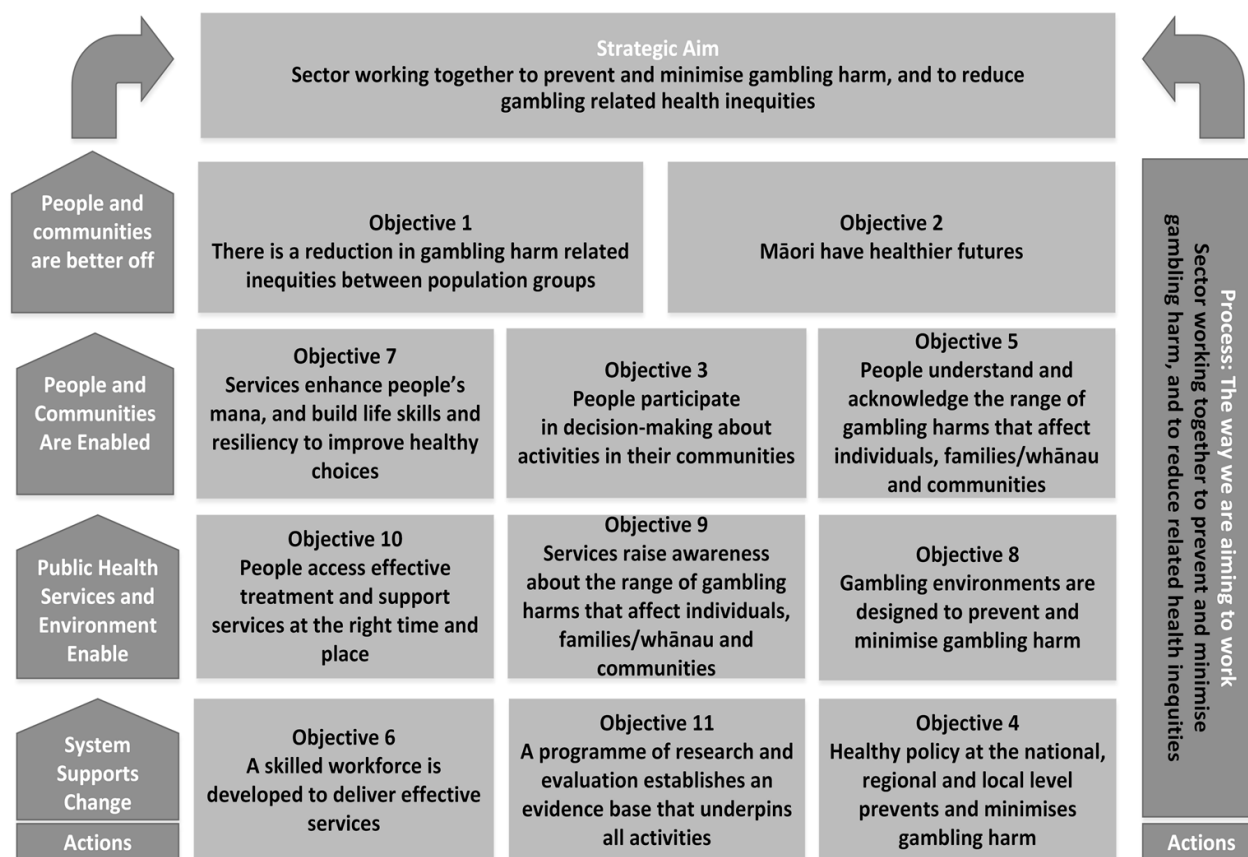
Objective 9: Services raise awareness about the range of gambling harms that affect individuals, families/whānau and communities.

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

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

Figure 3 shows how the strategic objectives described above contribute to the strategy's key outcomes and goal.

Figure 3: Framework for organising the strategic objectives



No substantive change proposed to the 11 strategic objectives

There are no substantive changes proposed to the 11 strategic objectives. However, based on insights from the 2016 HLS, it is proposed to include a focus on reducing inequalities and inequities in Objectives 9 and 10.

Alignment with other strategic documents

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

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

2.3 Outline of each of the strategic objectives

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

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

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

Sections 2.4 and 2.5 below compare this strategy's alignment with He Korowai Oranga and *'Ala Mo'ui: Pathways to Pacific Health and Wellbeing*.

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

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

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

Table 1: Objective 1 priorities for action

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

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

We need to do better for the population groups that do not enjoy the same health as the general New Zealand population. In relation to gambling harm, these groups include Māori and Pacific peoples, and the growing Asian population in particular. To achieve better outcomes, our focus must be on removing the infrastructural, financial, physical and other barriers to delivering high-quality health services. We must also consider tailoring services so that they are available in more accessible places or at more suitable times and are delivered in more culturally appropriate ways.

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

Objective 2: Māori have healthier futures

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

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

Table 2: Objective 2 priorities for action

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

Underlying principles: Pae Ora – healthy futures

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

Objective 3: People participate in decision-making about activities in their communities

Increased community awareness of gambling harm, grant distribution and related issues through public discussion and debate will continue to be a focus for this strategic plan. This objective acknowledges the important role of people and communities participating in decision-making about local activities that prevent and minimise gambling harm.

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

The local government gambling venue policy process (set out in sections 101 to 102 of the Gambling Act 2003) allows communities to address their councils and discuss the effectiveness of councils’ venue policies. This includes the availability and accessibility of class 4 gambling in the community. Community ownership and empowerment are important aspects of healthy and responsive communities and are key aspects of a public health approach.

Table 3: Objective 3 priorities for action

Objective 3: People participate in decision-making about activities in their communities that prevent and minimise gambling harm	
Priorities for action	
Short- to medium-term priorities	Long-term priorities
Enhance the capacity and capability of communities (particularly those communities that are most vulnerable to gambling harm) to:	
<ul style="list-style-type: none">• participate in decision-making about the availability and accessibility of gambling and the allocation of gambling profits, in their areas• develop and implement policies that prevent and minimise gambling harm to individuals, families/whānau and communities• take action on gambling-harm-related issues in their areas.	

Underlying principles: People-powered / Mā te iwi hei kawē

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

These and other barriers need to be addressed to empower individuals and their communities to engage and participate effectively around gambling harm related matters in their local communities.

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

Successfully preventing and minimising gambling harm relies on a foundation of relevant and effective public policy at the national, regional and local levels.

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

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

Table 4: Objective 4 priorities for action

Objective 4: Healthy policy at the national, regional and local level prevents and minimises gambling harm	
Priorities for action	
Short- to medium-term priorities	Long-term priorities
Work closely with the DIA in developing gambling policy and regulations to ensure that harm minimisation continues to be a core aspect in both organisations' work.	
Continue to provide information to other government sectors and agencies (eg, Local Government New Zealand; Te Puni Kōkiri; Department of Corrections; Oranga Tamariki; Ministry for Children and the Ministries of Business, Innovation and Employment; Education; Justice and Social Development) to increase understanding and acknowledge the need to link policies across related areas to prevent and minimise gambling harm and work with those sectors and agencies to develop a whole-of-government approach to preventing and minimising gambling harm.	
	Develop effective policy frameworks to guide the development and implementation of policies at the national, regional and local levels that prevent and minimise gambling harm.
	Work with DIA to ensure local authorities can access quality information to help them develop effective gambling policies at the local level

Underlying principles: Closer to home / Ka aro mai ke te kāinga

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

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

This objective acknowledges that people need to have the life skills and resilience to make healthy choices that prevent and minimise gambling harm.

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

The Ministry will continue to design public health programmes, and allocate resources, for vulnerable groups in the population, including resources to raise awareness and develop resilient life skills to prevent or minimise gambling harm. The Ministry will continue to provide information to support making healthy choices at an individual and community level.

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

Table 5: Objective5 priorities for action

Objective 7: People understand and acknowledge the range of gambling harms that affect individuals, families/whānau and communities	
Priorities for action	
Short- to medium-term priorities	Long-term priorities
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 families/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 families/whānau. This will include trialling collective impact approaches.	
Enhance communication and referral processes to ensure that other services that offer support to people experiencing harm from gambling address the needs of a referred client (and their family/whānau).	
Continue to identify and monitor protective and resiliency factors for gambling harm.	Develop initiatives that build protective factors, life skills and resilience for people who gamble.
Increase the links between services to prevent and minimise gambling harm and broader mental health promotion life skills and resiliency programmes.	Support community-based life skills and resiliency programmes that help people to make healthy choices that prevent and minimise gambling harm.

Underlying principles: People-powered / Mā te iwi hei kawē

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

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

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

The Ministry expects the gambling harm workforce to have a robust health equity, cultural competency and health literacy focus to prevent and reduce gambling harm. 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.

The Ministry has worked with the gambling harm sector to identify the core competencies (including cultural competencies) required for the public health workforce. The focus for the draft strategic plan is to increase uptake of a training programme to ensure that members of the workforce demonstrate those core competencies and have achieved, or are on a pathway to achieving, appropriate qualifications. A review of *Te Uru Kahikatea: The Public Health Workforce Development Plan* (Ministry of Health 2007) is under way. The Ministry will ensure that any changes resulting from that review are taken into account in the strategic plan.

For the intervention workforce, the Ministry will focus on training to ensure that all practitioners demonstrate the gambling harm competencies under the Addiction Intervention Competency Framework (DAPAANZ 2011). The Ministry’s expectation is that all intervention practitioners will be registered as 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 the Addiction Practitioners’ Association Aotearoa New Zealand

(DAPAANZ) as having demonstrated the relevant specific competencies or will be equivalently registered with another relevant professional organisation (for example, a counsellor registered with the New Zealand Association of Counsellors).

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

Table 6: Objective 6 priorities for action

Objective 6: A skilled workforce is developed to deliver effective services to prevent and minimise gambling harm	
Priorities for action	
Short- to medium-term priorities	Long-term priorities
Continue and increase uptake of training for staff working within services to prevent and minimise gambling harm.	Identify and implement workforce development training, career pathways and training opportunities for staff working within services to prevent and minimise gambling harm, so that all staff demonstrate the required competencies and have relevant qualifications, registration or endorsement.
Support the introduction and training of peer support and other allied health workers where appropriate.	

Underlying principles: One Team / Kotahi te tīma

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

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

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

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 as responsible hosts will also be a key focus.

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

Table 7: Objective 7 priorities for action

Objective 5: Services enhance people's mana and build life skills and resiliency to improve healthy choices that prevent and minimise gambling harm	
Priorities for action	
Short- to medium-term priorities	Long-term priorities
Identify, monitor and provide information and education on the impacts of gambling, including the range of gambling harms that affect individuals, families/whānau and communities.	
Support communities to incorporate a robust understanding of gambling harm into community social initiatives and public service delivery.	
Together with the HPA and the DIA, support gambling operators and gambling venue operators to incorporate a robust understanding of gambling harm into their operations and activities, to improve their ability to recognise and respond to indicators of gambling harm.	

Underlying principles: One team / Kotahi te tīma

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

Building on the experience in the addictions sector in particular (addressing harms from alcohol, tobacco and drugs), the Ministry will encourage appropriate collaborative partnerships among services providers and related stakeholders.

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 technologies and environments over the course of this 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. This will include exploring the value and merit of using facial recognition software as a tool to promote treatment and administrative efficiency respectively.

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

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

Table 8: Objective 8 priorities for action

Objective 8: Gambling environments are designed to prevent and minimise gambling harm	
Priorities for action	
Short- to medium-term priorities	Long-term priorities
Continue to build strong relationships with the DIA, gambling operators and gambling venue operators and communities to encourage safer gambling environments.	
Support the DIA in the proportionate and effective use of its regulatory tools to prevent and minimise gambling harm, including a continued focus on harm prevention and minimisation in gambling venues, for example through inspections and the DIA's Mystery Shopper campaign.	
Encourage consumer and service involvement in monitoring gambling operators' and gambling venue operators' compliance with their harm prevention and minimisation responsibilities.	
Continue to work with the DIA to encourage and support regional gambling harm service providers to work with venues in their area and to educate and support their harm minimisation practices.	
Support the HPA and the DIA to embed work with class 4 gambling operators to identify potentially harmful gambling behaviour and take effective action to prevent and minimise harm.	<p>Develop and refine guidelines / train-the-trainers training to promote host responsibility in other gambling environments (including online environments) so operators can identify potentially harmful gambling behaviour and take effective action to prevent and minimise gambling harm and create safer gambling environments.</p> <p>Work with DIA to explore technologies, such as for facial recognition that can be used to make gambling environments safer.</p>

Underlying principles: Closer to home / Ka aro mai kit e kāinga

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

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

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

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

The Ministry expects the services it funds to have a robust health equity, cultural competency and health literacy focus. As 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: Objective 9 priorities for action

Objective 9: Services 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
Promotional activities to reduce gambling harm and increase awareness of the range of gambling harms are targeted specifically at high-risk communities.	
Work to increase problem gamblers' access to services and access to services by their families/whānau, including in rural areas.	
Develop tools and protocols to support the primary health care sector and other community services to include screening, brief assessment and brief and early intervention for problem gambling as part of general health screening and day-to-day delivery, where appropriate.	

Underlying principles: People-powered / Mā te iwi hei kawe

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

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

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

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

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

Continuing to provide dedicated Māori, Pacific and Asian services is crucial to help reduce gambling-harm-related inequity and inequality. The Ministry will increase the emphasis on including consumer perspectives in service design and delivery (informed by research and evaluation).

While it is not financially feasible to provide face-to-face services in every location where gambling occurs, New Zealand does have a large rural population that does not always receive the level of service it requires. Also, many rural areas have a comparatively high Māori population. To address these discrepancies, the Ministry will work with intervention and public health service providers to ensure equity of access, both for rural populations and for Māori.

The Ministry will continue to provide a toll-free helpline offering referrals to face-to-face services and intervention services for those who cannot access face-to-face services or prefer a helpline service. The Ministry will also work to increase the range of self-help online tools available to further support hard-to-reach populations.

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. A short-term aim will be to increase the availability of peer support for those experiencing gambling harm and broaden the range of organisations and community groups screening for gambling harm.

Table 10: Objective 10 priorities for action

Objective 10: People access effective treatment and support services at the right time and place	
Priorities for action	
Short- to medium-term priorities	Long-term priorities
Ensure that problem gamblers and their family/whānau have access to a range of client-centred culturally responsive services, including by increasing peer support.	
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.	
Increase consumer input into the design and evaluation of services.	
Develop and enhance accessible and culturally responsive online tools, including self-help tools, to help prevent and minimise gambling harm.	

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

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

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

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

A research programme will run in parallel to this strategic plan. It aims to fulfil both short- and long-term strategic research priorities and includes longitudinal studies. The programme addresses the requirements of the Gambling Act 2003 for ‘independent scientific research associated with gambling’ and for ‘evaluation’.

The Ministry will increase its emphasis on evaluation, particularly of the design, delivery and outcomes of services (both public health and clinical). This work will incorporate a consumer experience perspective. This will inform best practice and future service options in both intervention and public health services.

Table 11: Objective 11 priorities for action

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
Ensure that research on gambling participation, gambling behaviours, attitudes to gambling, the prevalence and incidence of gambling harm, risk and resiliency factors for gambling harm, and co-morbidities is available to inform policy and service development.	
Ensure that research and evaluation projects funded by the Ministry contribute to strategic outcomes, including supporting opportunities for innovation and enhancing the quality, responsiveness, effectiveness and value for money of services to prevent and minimise gambling harm.	
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 and other vulnerable groups.

Underlying principles: Smart system / He atamai te whakaraupapa

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

Gambling harm minimisation research funded by the Ministry will:

- be undertaken with integrity, independence and accountability by researchers
- be undertaken using appropriate methods for the research question and resources available
- be delivered in a timely manner to inform policy and operational decision-making, and public debate
- be commissioned with transparency, follow best research management practices and comply with the government policy direction about the ownership and use of research deliverables funded by government
- represent value for money.

2.4 Aligning the strategy with He Korowai Oranga

He Korowai Oranga is New Zealand's Māori Health Strategy. It is a 'living document' that was most recently updated in 2014 (summarised in Figure 4 below).

Pae Ora – healthy futures is the Government's vision and overarching aim for Māori health. Pae Ora is a holistic concept that includes three interconnected and mutually reinforcing elements – mauri ora (healthy individuals), whānau ora (healthy families) and wai ora (healthy environments).

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

Figure 4: He Korowai Oranga: ‘the cloak of wellness’

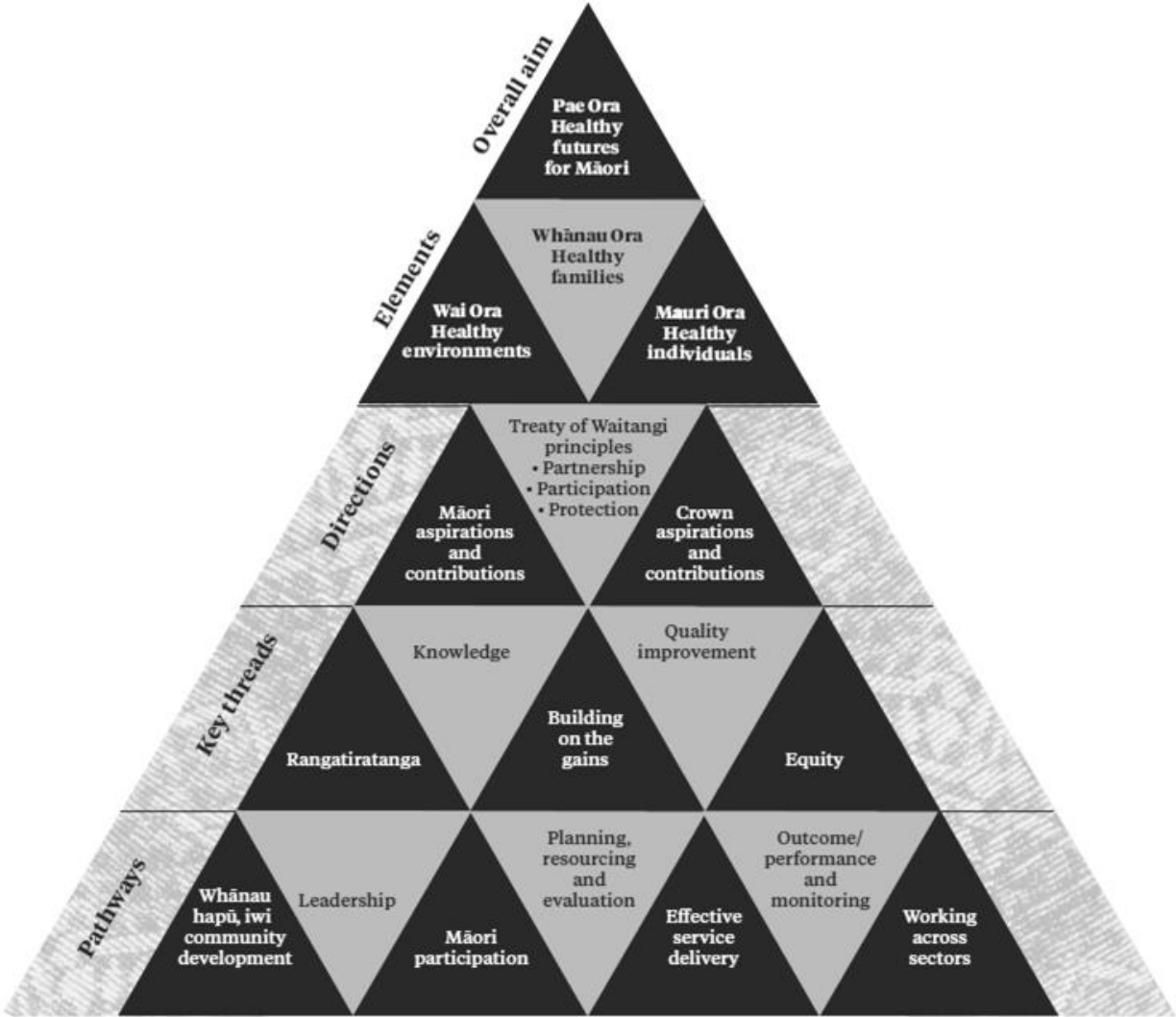


Table 12: Aligning the Strategy with He Korowai Oranga

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

He Korowai Oranga	Examples of the strategy's alignment
Pathways for action	
Whānau, hapū, iwi, community development	Principles underpinning the strategy – strengthen communities and public health service specification purchase units 3 and 4 (aware and supportive communities) Requirements for services to be free
Māori participation	Māori representation on key forums and bodies and dedicated Māori services Infrastructure intervention and public health service specification purchase unit 2 (workforce development)
Effective service delivery	Dedicated Māori services Requirements for general services – Māori responsiveness, support for access to dedicated Māori services where available and a focus on health literacy Infrastructure intervention and public health service specification purchase unit 1 (kaumātua consultation and liaison)
Working across sectors	Principles underpinning the strategy – intersectoral approach Objectives 4 and 5 Public health service specification purchase units 1 (policy development and implementation), 2 (safe gambling environments) and 5 (effective screening environments) Intervention service specification purchase unit 4 (facilitation services)
Core components	
Principles of Te Tiriti o Waitangi	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
Knowledge	Gambling Act 2003 requirement for independent, scientific research Objective 11 A national coordination service and service provider hui to share best-practice examples and stories of innovation The Ministry's Client Information Collection (CLIC) database – includes accurate ethnicity information Funding for provider-initiated research projects that address issues of equity for Māori Funding for research scholarships for Māori researchers
Quality improvement	Infrastructure intervention and public health service specification purchase unit 2 (workforce development) Overall goal of the strategy, principles underpinning the strategy and objective 1 Gambling Act 2003 requirements for a specified consultation process to develop the strategy and the problem gambling levy rates to ensure best value for resources
Leadership	Māori representation on key forums and bodies Health system leadership – an expectation that all New Zealanders will have health equity Infrastructure intervention and public health service specification purchase unit 2 (workforce development)
Planning resourcing and evaluation	Gambling Act 2003 requirements for the process to develop the strategy – a consultative process for planning and resourcing Gambling Act 2003 requirement for evaluation Research and audit projects evaluating intervention and public health services assess effectiveness and responsiveness for Māori
Outcome/performance and monitoring	Outcomes framework baseline and update reports, which specifically address outcomes for Māori

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

'Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014–2018 is the government's plan for improving health outcomes for Pacific peoples (Ministry of Health 2014a). The long-term vision of 'Ala Mo'ui is that: 'Pacific 'āiga, kāiga, magafaoa, kōpū tangata, vuvale and fāмили experience equitable health outcomes and lead independent lives' (page 1). Figure 5 summarises the 2014 (most recent) version of 'Ala Mo'ui.

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

Figure 5: The components of 'Ala Mo'ui

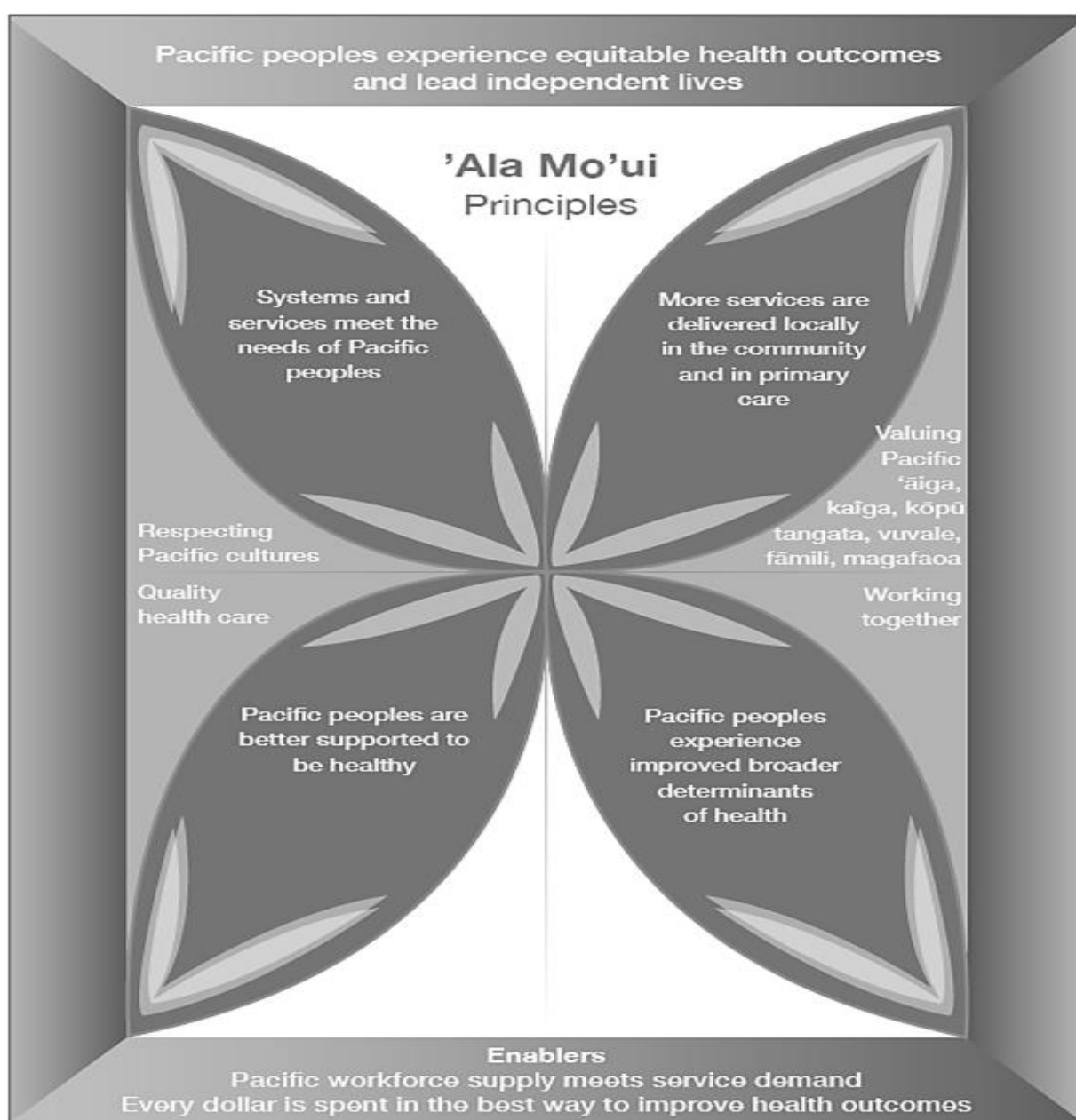


Table 13: Aligning the strategy with 'Ala Mo'ui

'Ala Mo'ui	Examples of the strategy's alignment
Overall aim	
Health equity for all Pacific peoples	<p>Overall goal of the strategy – entails a reduction in health inequities related to gambling harm</p> <p>Principles underpinning the strategy – reduce health inequities</p> <p>Objective 1 – a specific health equity objective</p> <p>Planning and prioritisation processes – mapping need based on population-specific prevalence and access rates</p>
Pacific principles	
Respecting Pacific culture	<p>Objectives 5 and 7 and public health service specification purchase unit 4 (aware communities)</p> <p>Public health service specification purchase unit 3 (supportive communities)</p> <p>Requirements for general services –meeting cultural needs of service users and supporting them to access dedicated Pacific services where available</p>
Valuing Pacific 'āiga, kāiga, magafaoa, kōpū tangata, vuvale and fāмили	<p>Objectives 5 and 7 and public health service specification purchase unit 4 (aware communities)</p> <p>Public health service specification purchase unit 3 (supportive communities)</p> <p>Free intervention services for families</p>
Quality health care	<p>Free intervention services for individuals and families</p> <p>Overall goal of the strategy, principles underpinning the strategy and objective 1</p> <p>Dedicated Pacific services and requirements for general services – meeting cultural needs of service users and supporting them to access dedicated Pacific services where available</p> <p>Infrastructure intervention and public health service specification purchase unit 2 (workforce development)</p> <p>Gambling Act 2003 requirements for research and evaluation – research and audit projects evaluating intervention and public health services</p>
Working together – integration	<p>Principles underpinning the strategy – intersectoral approach</p> <p>Objectives 4 and 5 and associated priority actions</p> <p>Public health service specification purchase units 1 (policy development and implementation), 2 (safe gambling environments) and 5 (effective screening environments)</p> <p>Intervention service specification purchase unit 4 (facilitation services)</p>
Enablers of outcomes	
Pacific workforce supply meets demand	<p>Dedicated Pacific services based in a Pacific cultural paradigm and using Pacific-derived beliefs, values and practices</p> <p>Planning and prioritisation processes – mapping need based on population-specific prevalence and access rates</p> <p>Infrastructure intervention and public health service specification purchase unit 2 (workforce development)</p>
Every dollar is spent in the best way to improve health outcomes	<p>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</p> <p>Gambling Act 2003 requirements for research and evaluation – research and audit projects evaluating intervention and public health services</p>

'Ala Mo'ui	Examples of the strategy's alignment
Priority outcomes	
Systems and services meet the needs of Pacific peoples	Dedicated Pacific services based in a Pacific cultural paradigm and using Pacific-derived beliefs, values and practices Requirements for general services –meeting cultural needs of service users and supporting them to access dedicated Pacific services where available
More services are delivered locally in the community and in primary care	Planning and prioritisation processes – mapping need based on population-specific prevalence and access rates
Pacific peoples are better supported to be healthy	Overall goal of the strategy, principles underpinning the strategy and objective 1
Pacific peoples experience improved broader determinants of health	Overall goal of the strategy, principles underpinning the strategy and objective 1

Consultation questions – Sections 1 and 2: strategic direction

The Gambling Act 2003 defines harm, the purpose of the strategy (to prevent and minimise gambling harm) and key components that a strategy must include. Neither these legislative provisions nor the content of the other strategic documents and frameworks with which the proposed strategy is expected to align are under consideration in this consultation.

In terms of the strategic direction, objectives and associated priority actions for the Strategy (sections 1 and 2):

1. Do you support the strategic direction outlined in the proposed strategy? If not, please explain why.
2. Does the draft strategic plan adequately reflect changes in the gambling environment? If not, what else should be included and why?
3. Are there any objectives or priority actions that you feel are more important or less important than the others? If yes, please identify these and explain why.
4. Do you think the inclusion of the priority actions to reduce inequality and inequity in Objectives 9 and 10 will help reduce gambling harm for the groups identified? If not, what suggestions do you have about how we can do this?
5. Are there other actions to prevent and minimise gambling harm that should be included as priority actions? If yes, please explain what and why.

3 Draft three-year service plan 2019/20 to 2021/22

This section provides some background and further context to inform development of the draft service plan. This introduction covers:

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

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

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

- the total amount gamblers spent on the main forms of gambling experienced a general increase. For example, total expenditure rose from \$2,091 million in the 2014/15 financial year, to \$2,334 million in the 2016/17 financial year (the most recent year for all four gambling sectors)
- annual NCGM expenditure continues to increase, from a low in 2013/14, with increases of around 3 percent per year since 2014/15
- a significant increase in expenditure on Lotto New Zealand (Lotto) products in 2016/17, after a number of years averaging smaller increases (note: annual expenditure on Lotto products can be volatile, depending on the number and size of Powerball jackpots)
- annual expenditure on casinos and New Zealand Racing Board (NZRB) products remained fairly steady, with both experiencing small reductions in 2016/17
- analysis of Pacific gambling behaviours, using the Pacific Island Families Study, identified particular areas of risk
- service outcome agreements, incorporating results based accountability measures, were negotiated and implemented from 1 January 2018.

3.2 Service delivery in 2016/17 to 2018/19

This section discusses service delivery during the 2016/17 to 2018/19 period in terms of public health activity, intervention activity, accessibility for and responsiveness to the needs of Māori and Pacific peoples, and research and evaluation.

Public health

The HPA's health promotion programme is central to the Ministry's national public health activity. This programme focuses on encouraging positive behaviour change among at-risk gamblers and raising awareness about risky gambling behaviours. The aims are to encourage more at-risk people to check whether their gambling is OK before harm escalates in severity and to motivate those who are at risk to get help earlier (or change their behaviour through self-help). The programme actively promotes the Gambling Helpline, Choice Not Chance⁵ and face-to-face support services.

During the 2016/17 to 2018/19 period, the HPA extended its core programme of activities to include a component focused on promoting safer gambling environments in gambling venues.

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

Service providers participated in reviews of national and local gambling venue policies, providing a community perspective to the three-yearly consultation process undertaken by territorial authorities. This process has resulted in a number of authorities introducing either gaming machine caps or sinking-lid policies in their regions.

Intervention

In the 2016/17 year, over 6,200 people sought help from Ministry-funded services, for problems due to their own or someone else's gambling. Most of these people were in crisis. If brief interventions in non-clinical settings are included in this analysis, the total increases to more than 11,600 people.

In the three years 2015/2016 to 2017/2018, there has been a slight decrease in the total numbers of reported interventions. The slight decline over the period is attributable to fewer new clients coming forward. The numbers of existing clients receiving interventions has been relatively static over the period. Going further back, the number of people seeking interventions has been relatively stable for five to seven years. Similarly, the proportion of people reporting some form of harmful gambling behaviours in the HLS surveys remained static at 5 percent of the population, from 2012 to 2016. Importantly, these static rates belie the fact that the actual number of people affected by problem gambling is increasing in line with population growth, and intervention services are not keeping up.

⁵ www.choicenotchance.org.nz/the-latest-campaign

Similarly, needs assessment and outcomes monitoring reports show there is a disconnect between potential clients for gambling support services (that is, people whose reported harm results in a moderate to high PSGI score and the number of people who actually access / present at these services). Service utilisation for gambling harm is in line with utilisation rates of 25–30 percent observed for other forms of addiction.

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

Accessibility for Māori, Pacific and other vulnerable groups

As noted above, there are substantially fewer people accessing services than one would expect from estimates of gambling harm prevalence. Analysis of Ministry gambling service administrative data for 2016/17 shows that of the approximately 6,300 gamblers who sought treatment:

- 38.1 percent identified as European/other
- 33.0 percent identified as Māori
- 21.2 percent identified as Pacific
- 7.7 percent identified as East Asian
- 53.1 percent were men.

From the review of outcomes and research noted earlier:

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

Research and evaluation

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

- completing the fourth data collection wave and associated report for the NGS, which comprises a longitudinal cohort study of gambling participation and harm
- the biennial gambling module in the HPA's HLS (Additional meta-analysis comprising analysis of pooled data, change over time and evidence for inequalities in gambling harm has been commissioned and reported.)
- The University of Auckland developing and trialling a mobile-phone-based app that provides timely messages to at-risk gamblers who have sought help (the SPAGeTTI Trial)
- clinical evaluation by Auckland University of Technology (AUT) of a range of interventions

- the Central Queensland University Australia and AUT study on the Burden of Gambling Harm, which used the Disability-Adjusted Life Year measure to understand the level of harm associated with gambling in the population (This approach is novel to the gambling research field and provides an alternative measure of harm compared with the limited and more clinically orientated measure in the PGSI scale.)
- Commissioning from the Pacific Island Families Study, a study of Pacific Island youth, aged under 17 years, exposure to gambling.

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

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

3.3 Factors considered for 2019/20 to 2021/22

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

The New Zealand Health Strategy

The Ministry led the development of the New Zealand Health Strategy: Future Direction, which sets out a vision of the future for the health sector in the 10 years from 2016 to 2026 and five strategic themes for the changes that will take the health system towards this future. These five strategic themes have been explicitly linked to each of the 11 strategic objectives and priority actions described in section 2.3.

Ongoing gambling-harm-related inequities

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

There is compelling evidence that Māori and Pacific peoples are more likely to suffer gambling harm as a result of their own or someone else's gambling and are more likely to be at risk of future harm than other ethnic groups. The 2016 HLS shows that inequities remain. Ethnic and other disparities in the burden of harm have persisted since the first gambling survey was conducted in 1991. Reducing these health inequities will continue to be a focus in the 2019/20 to 2021/22 period.

The Ministry proposes to reorient its strategic reporting to develop more timely and accessible data for the next strategy period to better inform the prevalence of gambling activities and harm in New Zealand, as well as information arising from the actions set out in the draft strategy.

Alignment with other health and social services

Rates of harmful drinking, tobacco use, other drug use and psychological distress tend to be much higher among problem gamblers (and to a lesser extent, among moderate- and low-risk gamblers) than among the general population. Those living in more deprived areas are also more likely to experience gambling harm. Actions to better align services that prevent and minimise gambling harm with other health and social services will continue to be a focus in the 2019/20 to 2021/22 period.

Outcomes-focused agreements

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

The Ministry implemented outcomes-focused agreements incorporating these principles for its preventing and minimising gambling harm contracts during the 2016/17 to 2018/19 period but expects to refine these based on learnings from evaluation and research.

Changes in gambling participation and expenditure

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

Changes in gambling participation and expenditure tend to have long-term flow-on effects on the prevalence of gambling harm and the number of people seeking help for gambling problems, although the causes of problem gambling behaviour are complex.

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

Changes in expenditure of each of the main forms of gambling are outlined in section 4.4: The levy formula.

Possible growth in online gambling

There are concerns about the potential opportunities for online gambling leading to increased gambling harm. 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 an increase in online providers and products facilitated by rapid changes in technology, increasing ease of access to the internet and prevalence of digital devices.

The Ministry commissioned AUT to examine New Zealanders overseas gambling patterns in the NGS (2012, 2013, 2014). Overall, the researchers found the proportion of the population that took part in offshore online/remote interactive gambling in 2012, 2013 and 2014 was very low (1.7%, 1.2% and 0.9% respectively). Similarly, of the total population, self-reported annual expenditure on offshore online/remote gambling was \$47.6 million, \$14.6 million and \$36.2 million in 2012, 2013 and 2014 respectively (Bellringer et al 2015). However, since that time, there has been a continuing increase in the availability of smart, internet-based technologies and devices that, coupled with convergence as discussed below, continues to present an emerging risk of gambling harm.

Convergence between gambling and gaming

What is described here as the convergence of gambling and gaming includes two main examples:

- where video games include elements of what appears to be gambling (but does not currently meet the definition of gambling under the Gambling Act 2003), for example, loot boxes and spinning wheels to unlock ‘power ups’
- where gambling takes on the visual and aural queues associated with gaming, for example, virtual reality-enabled Instant Kiwi tickets here in New Zealand (These games are also an example of continuous gambling and therefore pose an increased risk of harm).

These factors, alongside associated increased levels of advertising and internet-based payment systems that make it easier to spend money on gambling products, suggest the emergence of new levels of exposure to high-risk gambling products in New Zealand, and the associated probability of gambling related harm. This includes potential harm from the growing opportunities to play simulated gambling ‘games’ that look and feel like gambling but do not meet the definition under the Gambling Act 2003(eg, there is no opportunity to stake, win or lose real money). For example, many online gambling websites promote their main site with free-to-play games that appear to be gambling. These free-to-play sites appear to avoid the Gambling Act 2003 prohibition on advertising overseas gambling as, by definition, no gambling is taking place on the site advertised. For example, SKYCITY launched a free-to-play online gaming site in 2015 with virtual gaming machines (simulated pokies) and table games.

Other gambling providers in New Zealand have expressed interest in broadening their gambling products (moving online, increasing competitiveness with overseas markets, etc).

Technology-based and other innovative interventions

In previous years, the Ministry commissioned a feasibility study on a smart-phone application to prevent and minimise gambling harm, which was followed in the 2016/17 to 2018/19 period by a clinical trial of the app. The Ministry has also funded a multi-venue exclusion (MVE) service, part of the remit of which is to manage a secure database for all MVEs.

During the 2019/20 to 2021/22 period, the Ministry will continue to pilot technology-based and other innovative interventions and implement them, if pilot projects show that such interventions are cost effective. In particular, industry support has grown for facial recognition software to be incorporated into MVE processes within NCGM venues. The Ministry will monitor developments and evaluate its effectiveness at preventing and minimising gambling harm.

Legislative changes

There have been no recent amendments to the Gambling Act 2003, and none are yet pending for the 2019/20 to 2021/22 period.

Proposed changes to the Racing Act 2003 introduced in the Racing Amendment Bill 2017 seek to implement a range of provisions to enhance the ability of the NZRB to compete with offshore betting operators. The Bill is currently on hold pending a review of the New Zealand racing industry's governance structures.

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

The needs assessment and insights from the 2016 HLS and 2018 NGS reports have informed the development of this draft service plan. The research and evaluation programme was also informed by a review of the Ministry's research agenda (see section 3.7: Research and evaluation) and changes in the operating environment.

The needs assessment makes the case for changes in service delivery. During this period the Ministry will introduce two new models of care into the service mix: residential care and peer support. It will also use opportunities to address gaps in current service provision to pilot other new service models. The pilots will include both public health and intervention components and will be evaluated to inform future service provision and address areas of systemic, persistent gambling harm. To support this work, the Ministry also intends to support the establishment of a consumer network, which will inform service design and delivery.

In addition, the Ministry proposes to refocus the mix of services for 2018/19 to 2021/22 to increase awareness and engagement by those at risk (for example, with a greater focus on health literacy, service responsiveness and gambling host responsibility) and to explore new intervention initiatives, based on learning about what works from current activities, evaluation and research. This will include an emphasis on addressing long-standing inequities for Māori and other ethnicities, both through culturally-specific services and through 'mainstream' services.

The draft service plan below also maintains the existing emphasis on an outcomes- and results-based approach to funding services to prevent and minimise gambling harm, with a focus on achieving value for money alongside optimal service coverage. These will be further refined as findings become available from ongoing outcomes monitoring, relevant research and evaluation as noted above.

Indicative budget for 2019/20 to 2021/22

The draft service plan outlines the services that the Ministry considers it will require for the 2019/20 to 2021/22 period to make further progress towards the objectives in the strategic plan. It also sets out indicative budgets for preventing and minimising gambling harm under the Ministry's four main budget lines (listed under Service Area):

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

Table 14 shows indicative 2019/20 to 2021/22 budgets. The sections that follow discuss each budget line in more detail.

The draft three-year service plan proposes that the Ministry be appropriated \$55.339 million for the strategy to address each of the four elements specified in the Gambling Act 2003, as set out in Table 14. This proposed level of funding remains the same as the amount appropriated for the 2016/17 to 2018/19 service plan. However the Ministry will increase the total level of funding for its workplan by carrying over underspent funding of approximately \$5 million from the current appropriation. The increase in total funding is proposed because:

- service funding levels and appropriations have remained largely unchanged since the 2008/09 year, but the number of people affected has increased in line with population growth over the past seven years
- for the next levy period the Ministry proposes to change the service mix to address matters and priorities noted above.
- additional funding will help sustain and strengthen the new interventions to address areas of systemic, persistent gambling harm and hard-to-reach communities; targeted at the priority areas indicted in the strategy.

The Ministry will consider whether this increase should be maintained in full or part in future years. However, should the pilots proposed below during the next levy period be evaluated as being successful, the Ministry will seek an increase in the appropriation accordingly for the 2022/23–2025/26 levy period.

Please note that for transparency, the underspend has not been included in the indicative budget below, and, aside from the indicative cost of the consumer network establishment the carried over funding will likely be split between public health, intervention and evaluation budgets in the work programme for next levy period.

Table 14: Indicative budget to prevent and minimise gambling harm (GST exclusive), 2019/20–2021/22

Service area	2019/20 (\$m)	2020/21 (\$m)	2021/22 (\$m)	Total (\$m)
Public health services (harm prevention and minimisation)	6.870	6.840	6.880	20.590
Intervention services (treat and help problem gamblers and their families/whānau)	8.461	8.361	8.361	25.183
Research and evaluation	2.209	2.210	2.210	6.629
Ministry operating costs	0.957	0.990	0.990	2.937
Total (\$m)	18.497	18.401	18.441	55.339

3.5 Public health services

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

The indicative budget for public health services for the 2019/20 to 2021/22 period is largely unchanged from the previous funding period (see Table 15). However, within that overall budget, the Ministry intends to explore the potential for different ways of delivering public health services (for example, using a community mobilisation approach) and how contracts are funded (the budget currently assumes the use of full-time equivalent employees, FTEs).

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

- Review and apply knowledge from successful local models of public health service delivery, including methods such as community mobilisation, and the wealth of health services research available to provide smarter services that deliver improved health outcomes.
- Increase screening as a key tool for: promoting awareness of the harm caused by gambling, early identification of harmful addictive behaviour patterns and identifying appropriate forms of treatment.
- Consider future proofing our approaches, for example, assessing whether new screening tools are more appropriate for New Zealand's public health needs. This could include the short gambling harms scale (SGHS), which has been suggested as a better way of measuring the harm caused by gambling.
- Work to improve the infrastructure that connects the gambling sector in order to: increase cohesion and collaboration; share best practices; boost coordination; increase transparency; support the whole gambling sector workforce, including venue staff; and share learnings and data across the wider health sector – such as mental health and other addictions.

Table 15: Indicative public health budget (GST exclusive), by service area, 2019/20 to 2021/22

Service area	2019/20 (\$m)	2020/21 (\$m)	2021/22 (\$m)	Total (\$m)
Primary prevention (public health action)	4.690	4.700	4.700	14.090
Workforce development (public health)	0.180	0.180	0.180	0.540
Awareness and education programme	1.680	1.680	1.680	5.040
National coordination service	0.130	0.130	0.130	0.390
Consumer networks	0.100	0.100	0.100	0.300
Conference support	0.040	–	0.040	0.080
Audit activities	0.050	0.050	0.050	0.150
Total (\$m)	6.870	6.840	6.880	20.590

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

Primary prevention (public health action)

Primary prevention services cover health promotion, increasing community action, raising community awareness about gambling and problem gambling, working with territorial authorities on their gambling venue policies and supporting the 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.

The Ministry intends that services work across the five general domains listed below. However, it is clear that some innovation is required, and further advice will be sought before any tender process is instigated during this levy period.

1. **Policy development and implementation:** The Ministry engages with other government agencies, social organisations and private industries and businesses to reduce gambling harm.

2. **Safe gambling environments:** Environments that provide gambling opportunities are encouraged to actively minimise harm, and individuals are supported to recognise and seek support to minimise gambling harm.
3. **Supportive communities:** People live in communities that provide strong protective factors and that support individuals' and family resilience.
4. **Aware communities:** Agencies, communities, families and individuals are aware of the range of harms arising from gambling.
5. **Effective screening environments:** Individuals at risk of experiencing harm from gambling are identified as early as possible, and they are made aware of where to access appropriate minimising gambling harm intervention services.

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

Workforce development (public health)

In the 2013/14 to 2015/16 period, the Ministry's gambling harm public health workforce development provider identified the core competencies (including the cultural competencies) required for that workforce. In the most recent period, a website was built that contains the e-learning packages for each of the competencies to support other training opportunities. The focus in the 2019/20 to 2021/22 period will be increasing uptake of a training programme to help the workforce identify and achieve appropriate formal qualifications.

Awareness and education programme

The HPA's health promotion programme focuses on encouraging positive behaviour change among at-risk gamblers. The HPA will continue to actively promote the Gambling Helpline, Choice Not Chance (www.choicenotchance.org.nz) and face-to-face services, with key messages to target Māori, Pacific and Asian audiences, and other vulnerable groups for the 2019/20 to 2021/22 period.

The HPA will develop and promote self-help digital tools to increase accessibility to help and provide online support information to prevent and minimise gambling harm. It will also continue to work in partnership with the DIA and the Ministry to promote safer gambling environments and gambling host responsibilities, including embedding work with class 4 venues and expanding these activities to address other modes of gambling.

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

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

National coordination, consumer networks and conference support

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

National coordination service

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

Consumer network

The Ministry will provide funding and support for a national consumer network during this levy period. The network will inform service design and evaluation, particularly when innovative services are being piloted, and will assist with laying the foundations for introducing peer support into intervention services over time.

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 twice in the 2019/20 to 2021/22 period, in February 2020 and 2022. The Ministry is budgeting for an \$80,000 contribution towards the costs of each conference and think tank.

Holding international conferences in New Zealand promotes us 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.

Audit activities

The Ministry audits its services periodically. The audits allow for independent review and continuous quality improvement. A governance and financial audit of intervention and public health preventing and minimising gambling harm providers was undertaken during the 2017/2018 financial year and provides a baseline for assessing progress to strengthen the governance of funding agreements and future audits. Lessons learned will be implemented and future audits are likely, in line with the Ministry's audit policies.

3.6 Intervention services

The indicative budget for intervention services for the 2019/20 to 2021/22 period has increased from the previous period to accommodate an increased focus on evaluation and service development to address persistent gambling harm (see Table 16). Within the indicative budget, the Ministry intends to explore the potential for more innovative intervention services. In particular, it will seek to fund or develop services that are patient-centred and enhance the mana of consumers. New approaches will be based on successful regional or local models, where they exist, and will be co-designed with stakeholders and particularly with consumers.

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

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

Table 16: Indicative intervention budget (GST exclusive), by service area, 2019/20 to 2021/22

Service area	2019/20 (\$m)	2020/21 (\$m)	2021/22 (\$m)	Total (\$m)
Helpline and web-based services	1.167	1.067	1.066	3.300
Psychosocial interventions and support	7.079	7.079	7.080	21.238
Data collection and reporting	0.015	0.015	0.015	0.045
Workforce development (intervention)	0.150	0.150	0.150	0.450
Audit	0.050	0.050	0.050	0.150
Total (\$m)	8.461	8.361	8.361	25.183

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 available 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.

An Asian Gambling Helpline is currently provided by the PGF (funding for that helpline is included within the psychosocial interventions and support service area).

Psychosocial interventions and support

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

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

During this period, the Ministry intends to add residential care and peer support to the service mix. The Ministry currently funds some gambling harm support to people in Alcohol and Other Drug residential treatment, however demand does exist for gambling support first and foremost in a residential setting. The Ministry will work with providers to develop an appropriate model of care, based on intensive treatment for people experiencing severe gambling harm, but likely allowing for support for co-existing issues in addition.

The formal evidence for peer support ('peer' in this context meaning a person who has had a similar kind of experience to another person or people, that has had a significant impact on their lives) in mental health and addiction is growing, and shows high satisfaction from services that use all kinds of peer support as well as positive outcomes for people who receive peer services. Outcomes from peer services are as good if not better than conventional services. There are currently no funded peer support positions within gambling harm services. The Ministry proposes to encourage training and support the introduction of peer services during this levy period.

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

Many people of all ethnicities will access 'mainstream' services, rather than culturally-specific services. Given the long-standing inequities for Māori, and the Crown's responsibilities under Te Tiriti o Waitangi, the Ministry will consider how it can ensure that 'mainstream' services go beyond cultural competence, and actively imbed Te Ao Māori concepts into their clinical interventions. In addition, dedicated Māori, Pacific and Asian services will continue to provide culturally appropriate interventions and support for those population groups. The Ministry expects all services to be clinically safe.

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

Data collection and reporting

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

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

Workforce development (intervention)

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

The Ministry will continue to support intervention practitioners to either:

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

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

Audit

The Ministry audits its services periodically. The audits allow for independent review and continuous quality improvement. Where appropriate, lessons learned from the service funding audits noted above will also be applied to managing intervention service funding (and vice versa).

3.7 Research and evaluation

The Gambling Act 2003 Section 317 specifies that the strategy must include independent scientific research associated with gambling, including (for example) longitudinal research on the social and economic impacts of gambling, particularly the impacts on different cultural groups. It must also include evaluation.

Over the 2019/20 to 2021/22 period, the Ministry will review and fund specific projects that it believes best address the objectives of the strategy.

Indicative priority areas for 2019/20–21/22 are:

- researching vulnerable at-risk populations, particularly Māori, Pacific peoples, Asian and youth/children, including ways to strengthen their participation
- introducing programme evaluation more widely into activities funded by the Ministry
- researching the convergence of gaming and gambling, in particular, how this may impact in the next two to three years as opportunities to gamble online from traditional providers increase (eg, Lotto's online instant win and online offerings).

Table 17: Indicative research and evaluation budget (GST exclusive), 2019/20 to 2021/22

Service area	2019/20 (\$m)	2020/21 (\$m)	2021/22 (\$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

The research and evaluation work programme

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

- the prevalence and incidence of problem gambling and gambling-related harms and risk factors
- inequality and inequity: what drives the differences among and between population groups and how these differences are changing
- evaluation to identify what works and why; what works best; and based on learnings from past activities, how to improve and innovate services, research and intervention
- research into relapse prevention (this research is intended to cover gambling addiction specifically in the first instance, however, further work could be commissioned to inform treatment of other addictions)
- emerging issues such as the convergence of gambling and gaming, and the use of the internet or other digital distribution platforms to provide access to gambling opportunities.
- Investigate the effects of the range of territorial authority policies and venue licence conditions on gambling harm minimisation, with particular reference to high social deprivation localities.

Appendix 1 includes a full list of potential research and evaluation activities the Ministry may undertake over the 2019/20 and 2021/22 years.

Please indicate in your submission which activities you consider should be a high priority and which should be a low priority for our limited research and evaluation budget and please explain why.

3.8 Ministry of Health operating costs

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

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

In the past, the Ministry devised the budget for its operating costs on the assumption that more funding would be required in the final year of each three-year period, when the strategy for the next three-year period was being developed. In fact, much of this work occurs in the second half of the second year of each three-year period. For 2019/20 to 2021/22, the Ministry has phased the budget accordingly.

Table 18: Indicative budget for Ministry operating costs (GST exclusive), 2019/20 to 2021/22

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

Consultation questions – Section 3: Service plan and funding

The Gambling Act 2003 requires the service plan, and by implication the indicative budget appropriations, to have a focus on public health. The legislation is not under consideration in this consultation.

In terms of the content of the service plan and indicative budgets (section 3):

6. Does the draft service plan adequately cover what it needs to cover, for example, does it include the right types of services and activities? If not, what is not adequately covered and why?
7. Does the draft service plan provide the right mix of activities (public health, intervention and research/evaluation), including line item activities in Tables 14 to 17? This may include considering whether the Ministry should stop an activity or add a new one. If not, what changes should be made and why?
8. Which research and evaluation areas/items listed in the proposed strategy in section 3.7 and Appendix 1 do you consider to be a high priority or a low priority? Please explain why.
9. Do you think the total indicative funding appropriation (\$55.339 million over three years) proposed in the draft service plan is appropriate? If not, please explain what amount that funding appropriation should be and why.
10. Do you think that the service plan would more effective if some funding amounts allocated in Tables 14–17 were shifted from one budget line item or service area to another? This may include considering whether the Ministry should stop funding an activity or should fund something not already covered in the proposals. If yes, please explain what changes are required and why.

4 Draft levy rates for 2019/20 to 2021/22

4.1 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 Gambling Act 2003 (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 2019 to 30 June 2022, matching the period of the next strategy.

4.2 The levy-paying sectors

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

- NCGM operators
- casinos
- the NZRB
- the New Zealand Lotteries Commission (NZLC).

While it is possible that there could be changes to the number or composition of each gambling sector used to calculate the levy, the Ministry is not aware of any research indicating a need to do so. Similarly, there have been no proposals to adjust the levy paying sectors made during the current levy period by any part of the gambling sector. The Ministry therefore does not propose any changes to the four gambling sectors from which the levy is collected.

4.3 Process for setting the levy rates

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

As part of this process, the Ministry is now consulting on its estimated annual funding requirements and four alternative sets of estimated levy rates for 1 July 2019 to 30 June 2022. The figures in the four alternative levy calculation options below should be considered indicative at this stage. The Ministry will update them before the Gambling Commission’s consultation meeting referred to below.

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

4.4 The levy formula

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

The formula is:

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

where:

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

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

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

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

R = the estimated under-recovery or over-recovery of levy from a sector in the previous levy periods⁶

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

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

Note: Since the levy rate calculations 'must take into account the latest, most reliable and most appropriate sources of information' from the Ministry, Inland Revenue Department (IRD) or the DIA, as the case may be, the Ministry will update these figures later in 2018, before the Gambling Commission's consultation meeting, and will include the updated information in its proposals document submitted for that meeting.

The Ministry will use 2017/18 data if available for the final strategy document and levy calculations, but these were not available at the time of preparing this consultation document.

⁶ **R** was added to the formula by section 107 of the Gambling Amendment Act 2015, which came into effect on 3 March 2015.

The levy proposed below is set using current settings. However the Ministry and DIA are interested in your views of what elements in the formula could change in the future, including any additional elements that should be considered, and any elements you think should be removed from the formula.

Estimated current player expenditure (A)

Player expenditure by the four main gambling sectors for the eight years up to 2016/17 is shown below in Table 19 and Figure 6.

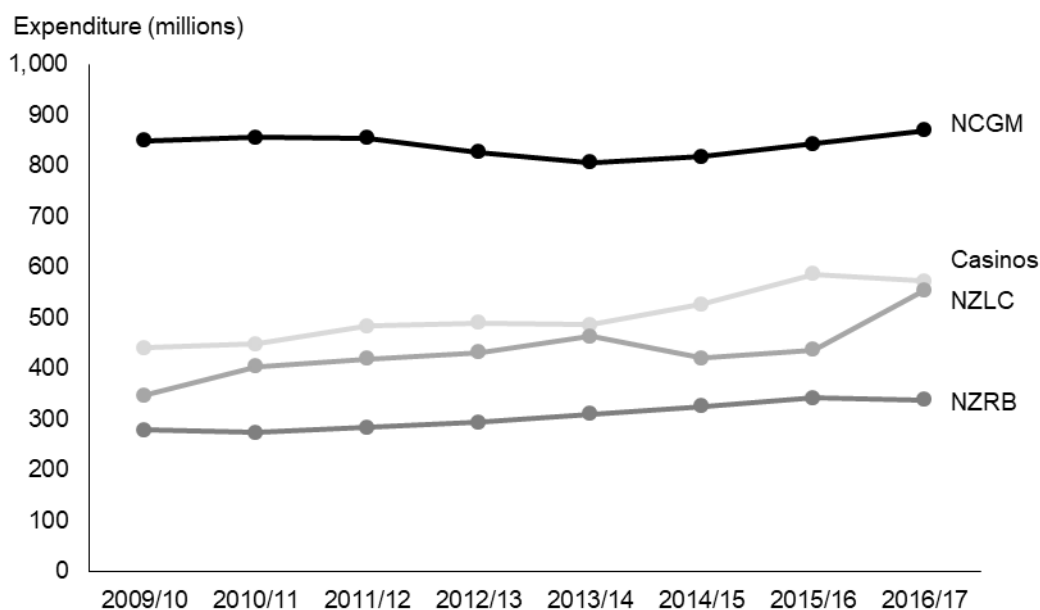
Table 19: Gambling expenditure and proportions from the four main sectors, 2009/10 to 2016/17

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

Source: The DIA expenditure figures from its website. URL: www.dia.govt.nz/diawebsite.nsf/wpg_URL/Resource-material-Information-We-Provide-Gambling-Expenditure-Statistics (accessed 10 June 2018).

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

Figure 6: Gambling expenditure by year from the four main sectors, 2009/10 to 2016/17



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

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

The DIA has estimated current player expenditure using a variety of sources of information, including its NCGM electronic monitoring system (EMS), gambling operators' annual and half-yearly reports and information from IRD.⁷ Other data on gambling expenditure are available on the DIA website (www.dia.govt.nz).

Presentations (B)

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

The Ministry generated the presentation figures used in the levy calculations in this consultation document from data collected by its psychosocial intervention service providers. The figures relate to all clients who received a full facilitation or follow-up intervention session during the 12-month period from 1 January to 31 December 2017. The figures exclude brief screening interventions, and primary problem gambling modes (PPGMs) in gambling sectors that are not subject to the levy are excluded (for reasons that have been canvassed in detail in documentation of previous levy-setting processes).

The Ministry will update the presentation figures before the Gambling Commission's consultation meeting, to the year ending 30 June 2018, and will include the updated figures in its proposals document for that meeting. Past experience suggests there should be very little, if any, change to the levy rates in that updated data.

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).

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

Table 20 and Figure 5 below show the presentations attributed to each of the four levy-paying sectors each year from 2004/05 onwards. Note that the 2017 figures are for the 12-month period from 1 January 2017 to 31 December 2017, not for the year ended 30 June 2018.

⁷ IRD provides gaming duty and problem gambling levy data to the DIA. The Tax Administration Act 1994 requires the IRD to use its best endeavours to protect the integrity of the tax system by (among other things) maintaining the confidentiality of the affairs of taxpayers.

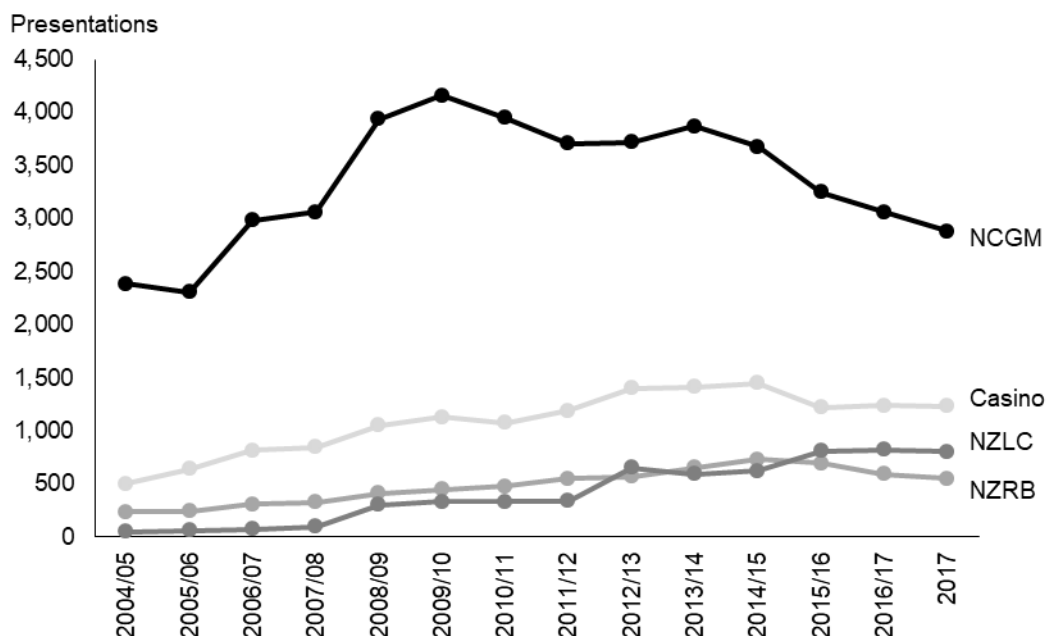
Table 20: Presentations and proportions attributed to the four main sectors, 2004/05 to 2016/17

	NCGMs		Casinos		NZRB		NZLC		Total n
	n	%	n	%	n	%	n	%	
2004/05	2,386	75	505	16	237	7	52	2	3,179
2005/06	2,307	71	641	20	243	7	64	2	3,255
2006/07	2,981	71	814	19	311	7	76	2	4,182
2007/08	3,063	71	849	20	328	8	97	2	4,337
2008/09	3,933	69	1,050	18	413	7	304	5	5,700
2009/10	4,160	69	1,131	19	449	7	332	5	6,072
2010/11	3,945	68	1,073	18	476	8	332	6	5,825
2011/12	3,708	64	1,188	21	548	9	339	6	5,783
2012/13	3,721	59	1,403	22	568	9	652	10	6,344
2013/14	3,871	59	1,413	22	651	10	590	9	6,525
2014/15	3,674	57	1,449	22	729	11	624	10	6,476
2015/16	3,251	54	1,221	20	696	12	812	14	5,980
2016/17	3,060	54	1,240	22	593	10	820	14	5,713
2017	2,877	53	1,235	23	553	10	802	15	5,466

Source: Service user data, Ministry of Health (downloaded March 2018) and 2017 CLIC data. URL: www.health.govt.nz/our-work/mental-health-and-addictions/problem-gambling/service-user-data/intervention-client-data (accessed 10 June 2018).

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

Figure 7: Presentations by year attributed to the four main sectors, 2004/05 to 2016/17



There are three qualifications to bear in mind when considering the data presented in Table 20 and Figure 7.

- 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).
- That system changed from 1 October 2011, and 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 figure for 2017 relates to the 12 months from 1 January 2017 to 31 December 2017 (the latest figures available at the time of drafting this consultation document), not the standard 1 July 2017 to 30 June 2018 year.

Other points to note from these table are as follows.

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

It is also worth noting that the changes the Ministry made to its systems from April 2008 and October 2011 might mean that, after those dates, some presentations that would previously have been attributed solely to NCGMs were attributed partly to NCGMs and partly to one or more other types of gambling (and vice versa but to a far lesser extent). Accordingly, the Ministry considers that these changes are likely to have resulted in more accurate presentation data.

The funding requirement (C)

The funding requirement represented by C in the formula is the amount that the Ministry considers it requires to implement the strategy. For 2019/20 to 2021/22, the Ministry is proposing an appropriation of \$55.339 million. Details about this appropriation are set out in the draft three-year service plan (see sections 3.4 to 3.8).

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 2019/20 to 2021/22. The higher forecast expenditure is, the lower the levy rate necessary for a sector to pay its required contribution (as determined by the top line of the formula).

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

There may be changes in gambling expenditure as a result of future changes to the Gambling Act 2003 or regulations. However, it is not possible to forecast the likely impact of any changes until the nature of any legislative or policy changes are clearer.

Non-casino gaming machines

The number of NCGMs has declined from 20,302 on to 15,632 as of 31 December 2017.⁸

Expenditure also declined for a number of years but has seen yearly increases since 2013/14. For example, from an historical low of \$806 million in 2013/14, expenditure increased to \$818 million in 2014/15, \$843 million in 2015/16 and \$870 million in 2016/17.⁹

Recent EMS data suggest that NCGM expenditure will increase in 2017/18. The DIA forecasts expenditure to continue with small annual increases in the next three years.

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

In the NCGM sector, club expenditure continues to decrease while non-club expenditure has increased. Non-club expenditure has historically been around 86 to 87 percent of total NCGM expenditure every quarter since 30 June 2007, which was the first full quarter after the EMS began operating. Club expenditure has varied from around 13 percent to around 14 percent of the total. However, since 2016/17, non-club expenditure has increased to around 89 percent of total expenditure, with club expenditure at around 11 percent of the total.

Casinos

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

The DIA anticipates some growth in expenditure for 2018/19 to 2020/21, but the forecast is relatively conservative.

⁸ www.dia.govt.nz/diawebsite.nsf/wpg_URL/Resource-material-Information-We-Provide-Summary-of-Venues-and-Numbers-by-Territorial-AuthorityDistrict (accessed 10 June 2018).

⁹ www.dia.govt.nz/diawebsite.nsf/wpg_URL/Resource-material-Information-We-Provide-Gambling-Expenditure-Statistics (accessed 10 June 2018).

New Zealand Racing Board

Spending on NZRB products was relatively flat for some years. However, it increased from \$283 million in 2011/12 to \$342 million in 2015/16, with a slight decline to \$338 million in 2016/17.

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

New Zealand Lotteries Commission

Spending growth on NZLC products has been relatively high but volatile, since 2005/06. This volatility appears to relate to the number of large jackpots in a year. Strong growth has continued over recent years; the DIA reports expenditure of \$420 million in 2014/15, \$437 million in 2015/16 and \$555 million in 2016/17.

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

The forecast is for continued expenditure growth for the 2018/19 to 2020/21 period across all four sectors, as shown in Table 21 below.

Table 21: Forecast expenditure by sector (GST inclusive), 2019/20 to 2021/22

Forecast expenditure	NCGMs	Casinos	NZRB	NZLC
2019/20 (\$m)	951.143	645.345	383.428	668.119
2020/21 (\$m)	981.184	667.463	395.794	710.884
2021/22 (\$m)	1,012.173	689.581	408.161	756.386

Note: These forecasts are for the next levy period. They are based on best estimates at this time; but are made before the actuals for 2017/18 (expected late in 2018) and 2018/19 (expected in late 2019) were available. The further we forecast out the less reliable that forecast can be. Therefore we advise that while these 'out years' follow a general trend, they are not as reliable as a yearly forecasts, for the next year ahead.

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

Section 107 of the Gambling Amendment Act 2015, which came into effect on 3 March 2015, requires the calculation of each sector's levy rate to take into account any underpayment or overpayment from that sector in previous levy periods. This legislative change ended the previous system, deemed unfair, whereby all four gambling sectors were required to meet any net underpayment or overpayment of the levy amount across all sectors from the previous levy period.

The Ministry's total appropriation to prevent and minimise gambling harm from 1 July 2004 to 30 June 2019, as derived from its five service plans to date, was \$266.922 million. The Ministry expects that IRD will have received payments totalling \$274.680 million for the period to 30 June 2019.¹⁰ This figure was derived by summing the expenditure in its annual reports to 30 June 2017 and an estimate of its likely expenditure for the two years to 30 June 2019. It is the former figure (\$266.233 million) that the levy should have recovered from the four levy-paying gambling sectors.

The Ministry obtained each sector's expected contribution to the levy requirement for each three-year period by referring to the relevant three-year appropriation. It used that information to calculate each sector's expected contribution to the Ministry's appropriation for each period. It then summed those expected contributions across the five periods to arrive at each sector's expected contribution to the total amount appropriated to the Ministry across the 15 years and to calculate each sector's expected share of the total amount appropriated.

The share of the total appropriation (rounded to three decimal places) that the NCGM sector was expected to pay was 65.519 percent. The expected share for: casinos was 19.537 percent, the NZRB was 8.741 percent and the NZLC was 6.203 percent.

This means that the total amount of levy that should have been collected from the NCGM sector since 2004 (15 years) was \$174.884 million (that is, 65.519% of \$266.233 million). The equivalent amount for casinos was \$52.149 million, for the NZRB was \$23.331 million and for the NZLC was \$16.558 million.

The DIA used IRD figures for the levy actually collected up to February 2018 to estimate the levy underpayment or overpayment for each sector for the 15-year period. Table 22 shows these amounts. This calculation shows that each sector is expected to have overpaid its share of the levy by 30 June 2019 (shown as negative amounts in Table 22).

Table 22: Estimated underpayment or overpayment of problem gambling levy, 2004/05 to 2018/19, by sector

Sector	\$m (GST inclusive)
NCGMs	-3.509
Casinos	-1.963
NZRB	-0.438
NZLC	-1.848

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

The levy formula accounts for under- or over-recovery in calculating the levy rate for the next period. Overpayment amounts are deducted from the amounts required while any underpayments are added. For each sector, the previous forecasts underestimated the actual gambling spend (for 2016/17 to 2018/19 years), which will have resulted in a greater amount in levy payments than expected. The total amount of the overpayment for a sector is deducted from its share of the levy for 2019/20 to 2021/22.

NZGM expenditure for 2016/17 was about 6 percent greater than the \$812 million forecast in 2015/16. If this continues for the remainder of the levy period, it will result in a \$3.5 million overpayment, which will be used to offset levy payments for the next levy period.

¹⁰ 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.

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

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

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

The weights (W1 and W2)

The Gambling Act 2003 (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.

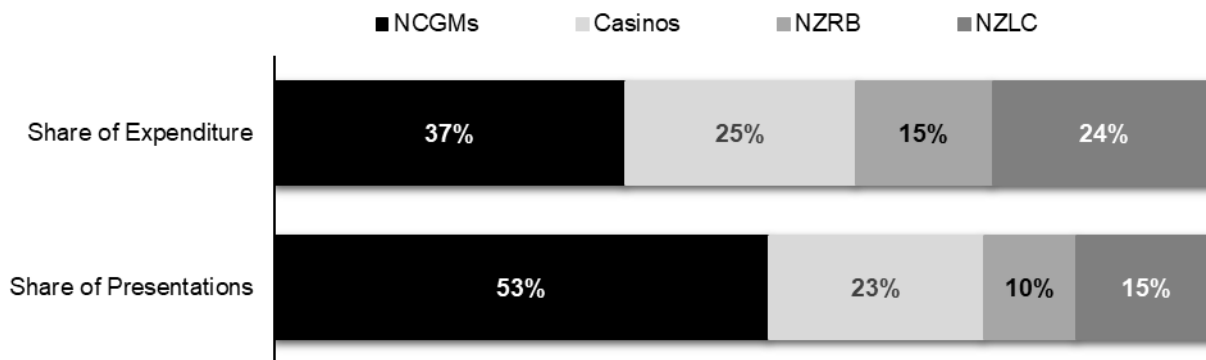
The proportion of presentations to intervention services attributable to a particular gambling sector is not necessarily an appropriate indicator for determining the share that sector should bear of public health, research and evaluation costs.

Table 23 and Figure 8 shows the proportion of presentations attributed to each levy-paying sector for the 12-month period from 1 January to 31 to December 2017 and each levy-paying sector's proportion of expenditure for the 2016/17 financial year (to be updated when 2017/18 data become available).

Table 23: Share of presentations and expenditure by sector, for 2017

NCGMs		Casinos		NZRB		NZLC	
Presentations	Expenditure	Presentations	Expenditure	Presentations	Expenditure	Presentations	Expenditure
0.53	0.373	0.23	0.245	0.10	0.145	0.15	0.238

Figure 8: Share of presentations and expenditure by sector, for 2017



The top line of the formula determines the amount to be paid by each sector. When a sector's proportion of expenditure is substantially different from its proportion of presentations (W1 and W2 respectively), the weighting between expenditure and presentations is critical to determine how much each sector will be required to pay. Weighting options are described in Tables 24 to 27.

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

The strategy is intended to prevent and minimise gambling *harm*; it is not intended to address the amount spent by gamblers per se. Therefore, the Ministry considers that any weighting of more than 30 percent on expenditure 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 a report on the proposed problem gambling levy, submitted to the Ministers in November 2009, a very high weighting on presentations might mean that 'diligent host responsibility in detecting problem gambling and encouraging the seeking of assistance is punished not rewarded' (Gambling Commission New Zealand 2009).

Presentations are not the only available indicator of harm. Other examples include estimates of problem gambling prevalence using screening instruments such as the PGSI, or survey questions that 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 presentation figures for the more recent levy periods, in which the NZRB and NZLC shares of presentations are somewhat higher, are the most reliable and appropriate.

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

For the 2019/20 to 2021/22 period, a change to a 20/80 weighting may be appropriate, given the presentation trends noted above. However, the Ministry considers that any weighting from 30/70 to 5/95 would be reasonable.

Consultation question

The Ministry is seeking feedback through this consultation document on which weighting option of presentations and weightings (W1 and W2) – stakeholders prefer and why. It is important to note that the levy weighting options do not affect the total amount of the levy. The weighting chosen only affects the share of the levy to be paid by each gambling sector.

While the proposed levy is based on and will be set using the current formula set out in the Act, the Ministry and DIA are also interested in your views of what could change in the future.

- D. Does the current formula provide a reasonable way to reflect the relative harm caused by each gambling sector? If not, what sort of formula would better reflect the relative harm caused by each sector and what factors, if any, other than presentations and expenditure could be considered?

4.5 Levy calculations

Tables 24–27 set out the implications for each of the four alternative levy weightings 5/95, 10/90, 20/80 and 30/70 respectively based on an appropriation of \$55.339 million to the Ministry for problem gambling activities for 2019/20–2021/22. Each table shows the levy rate per sector and the expected amount of levy payments over the three-year period and compares these with each sector's levy payments for the current levy period. A positive figure indicates that the sector is expected to pay more in the next levy period, and a negative figure indicates that the sector is expected to pay less.

Table 24: Estimated levy rates and payments (\$m) per sector: 5/95 weighting

Collection period starts 1 July 2019 (all GST exclusive)	NCGMs	Casinos	NZRB	NZLC
Sector levy rates (%)	0.86	0.53	0.44	0.31
Expected levy payment (\$m)	25.323	10.613	5.224	6.620
(\$m) Comparison with current levy payments (negative = less)	-6.360	-3.445	0.076	1.479

Table 25: Estimated levy rates and payments (\$m) per sector: 10/90 weighting

Collection period starts 1 July 2019 (all GST exclusive)	NCGMs	Casinos	NZRB	NZLC
Sector levy rates (%)	0.84	0.53	0.45	0.32
Expected levy payment (\$m)	24.734	10.613	5.343	6.833
(\$m) Comparison with current levy payments (negative = less)	-6.949	-3.445	0.195	1.685

Table 26: Estimated levy rates and payments (\$m) per sector: 20/80 weighting

Collection period starts 1 July 2019 (all GST exclusive)	NCGMs	Casinos	NZRB	NZLC
Sector levy rates (%)	0.81	0.54	0.48	0.34
Expected levy payment (\$m)	23.850	10.813	5.699	7.260
(\$m) Comparison with current levy payments (negative = less)	-7.833	-3.245	0.551	2.119

Table 27: Estimated levy rates and payments (\$m) per sector: 30/70 weighting

Collection period starts 1 July 2019 (all GST exclusive)	NCGMs	Casinos	NZRB	NZLC
Sector levy rates (%)	0.78	0.54	0.50	0.36
Expected levy payment (\$m)	22.967	10.813	5.937	7.687
(\$m) Comparison with current levy payments (negative = less)	-8.716	-3.245	0.789	2.546

4.6 Comment on weighting options

Tables 24–27 show that under each scenario:

- 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 higher the share to be paid by 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.

Overall, the amount of money raised by the proposed levy would be less than that required for the proposed budget appropriation of \$55.339 million because in total more levy is expected to be paid for the three years to 30 June 2019 than was forecast when the levy was set. This overpayment carries over into the next period (as prescribed in the levy formula).

The proposed levy rates for each gambling sector would be lower under any weighting option for 2019/20 to 2021/22 than they are for the current levy period; based on levy payments received, forecast expenditure for the remaining three year period to 30 June 2019 and the proposed budget appropriations.

While the levy rates would decrease, sector payments by NZLC and NZRB would increase compared with what they pay now. However, NCGM sector and casino payments would decrease compared with what they are expect to pay in the current levy period.

For example, from Table 25 (the 10/90 weighting option), it is expected over the next three years that:

- NZLC would pay \$1.685 million more compared with the current period, partly due to NZLC products contributing an increase in the proportion of both gambling expenditure and gambling presentations

- the NCGM sector would still be the main source of levy payments but would pay \$6.949 million less compared with what they will have paid in the current period (this in line with a steady decrease in the proportion of people presenting with harm due to NCGM gambling, although this sector still contributes about half of all presentations)
- Casino payments would be \$3.445 million less than their payments in the current levy period
- NZRB payments would be \$0.195 million more compared with its payments in the current period.

These changes are a result of:

- changes in the proportions of gambling expenditure and presentations in each sector (A reduction in a sector's share of expenditure or presentations would reduce that sector's share of payments.)
- actual gambling expenditure for the current levy period exceeding forecasts, helping to create levy overpayments
- forecast increases in gambling expenditures for a sector, increasing the size of the pool to levy.

The levy formula adjusts for these factors in generating levy rates for the next levy period.

Consultation questions – Section 4: Levy formula and rates

The proposed figures are set out using the levy formula currently prescribed in legislation. The Ministry and DIA do not propose to change the formula at this time. However the Ministry and DIA are interested in your views of what could change in the future (see question D).

The figures for variables A, B and R are derived from data held by the Ministry, the DIA and IRD and are a matter of record. Comment on variable C (the \$55.339 million funding appropriation proposed for the strategy) is covered by the questions in section 3.

In terms of the other components of the levy formula in section 4:

11. Are the player expenditure forecasts for each gambling sector (D) realistic? If not, please explain why not.
12. Are there realistic pairs of weightings (W1 and W2) other than those discussed in this consultation document? If so, what and why?
13. Which pair of weighting options for W1 and W2 do you prefer, if any, and why? Please keep in mind that the levy weighting options only affect the proportion of levy to be paid by each gambling sector and do not affect the total amount of the levy.
14. Do you have any comment on the estimated levy rates for each sector, keeping in mind that the levy formula itself is set out in legislation?

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Glossary

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

Appendix 1: Potential research and evaluation activities for 2019/20 to 2021/22

Below is a list of potential research and evaluation activities/areas the Ministry may undertake in the next three years.

Please indicate in your submission which items you consider should be a high priority and which should be a low priority, for our limited research and evaluation budget, and please explain why.

1. The prevalence and incidence of problem gambling and gambling-related harms and risk factors

- Conduct a secondary analysis of the existing four waves of National Gambling Study (NGS) data and the analysis of the Health and Lifestyles Survey (HLS) gambling module data held by the Health Promotion Agency (HPA).
- Complete a meta-analysis of previous years' HLS data to explore a range of topics of interest, including: change over time in gambling participation and harm, evidence for inequalities and inequities in exposure to sources of gambling harm, attitudes to gambling and access to gambling services.
- Refresh the NGS to develop a new gambling behaviour longitudinal cohort study commencing 2019/20. This would include considering long-term funding, with regular reviews. Note: this would require a review of the NGS in 2018/19 to identify learnings from its design and delivery, to incorporate into the refresh; which would focus on understanding in detail the drivers of gamblers' behaviour.
- Continue the biennial national prevalence survey through the HLS of gambling participation and harm in New Zealand. Survey results are particularly useful for informing outcomes against a number of the strategy objectives.
- Promote in-depth analyses using innovative and new perspectives on: changes over time in gambling participation and harm; evidence for inequalities and inequities in exposure to sources of gambling harm and in attitudes to gambling; and access to gambling services.
- Place/promote the New Zealand experience of gambling participation, gambling harm and harm minimisation activities in an international context.
- Explore the development and use of new methods to estimate the burden of gambling harm occurring in the New Zealand population.
- Develop a better understanding of gambling advertising exposure on a range of population groups and the effects of the advertising on those groups' propensity to gamble.
- Explore the social and economic trade-off between gambling participation and gambling harm.

2. Inequality and inequity / research into vulnerable at-risk populations, particularly Māori, Pacific and Asian peoples and youth/children

- Improve our understanding of the causes of gambling harm inequality and inequities between a range of New Zealand population groups.
- Consider what drives the differences among and between population groups and how those differences are changing.
- Target populations experiencing the most harm from gambling – in particular Māori, Pacific peoples and those in high-deprivation populations.
- Develop methods and approaches that build the capacity and capability for Māori and Pacific peoples and other vulnerable groups to become involved with and participate in research and evaluation.
- Develop knowledge about the New Zealand Asian population's gambling participation, harm and help-seeking behaviour.
- Build gambling harm research capacity by supporting projects that develop new and emerging gambling harm researchers.
- Enable the development and piloting of new research methods, such as KidsCam.

3. Evaluation to identify what works and why; what works best; and based on learnings from past activities, how to improve and innovate services, research and intervention

- Strengthen evaluation of the design, delivery and outcomes of services – particularly new services.
- Introduce programme evaluation more widely into Ministry-funded activities.
- Evaluate new and innovative approaches, for example, such as:
 - develop consumer-based peer support networks
 - test the effectiveness of facial recognition technology (FRT) within the multi-venue exclusion process (MVE)
 - modify existing service provision with better outcome measures
 - investigate ways to provide ongoing support and prevent relapse within provider client populations.
- Consider consumers' experiences of service delivery and what makes for successful services.
- Explore evidence for under and over utilisation of harm-reduction services and the reasons for such utilisation.
- Investigate the effects of the range of territorial authority policies on gambling harm minimisation.
- Investigate/evaluate the design and delivery of gambling products to the New Zealand market, to better understand implications for harm minimisation.
- Explore how to effectively transfer what we learn about gambling harm in academic research to key stakeholders: the gambling sector, policy and operational decision-makers; groups that are receiving or likely to need harm-minimisation services and the general public.

4. Emerging issues

- Consider the use of internet or other digital distribution platforms in providing increased access to gambling opportunities and potentially increasing the prevalence of harm.
- Research the convergence of gambling and gaming:
 - examine the convergence between gaming and gambling product design and products
 - consider how this may impact in the next 2–3 years as opportunities to gamble online from new and traditional providers increase (eg, Lotto’s online instant win and online offerings).
- Conduct ad hoc investigations/responses to questions that emerge due to changes in the gambling environment.

Making a submission

Strategy to Prevent and Minimise Gambling Harm: Consultation document

Your feedback

The Ministry welcomes your thoughts and feedback on this draft strategy, which outlines the proposed strategic direction and services to prevent and minimise gambling harm, and the associated gambling levy rates, to apply from 1 July 2019 to 30 June 2022.

Your feedback is vital to help us develop the final strategy.

How to provide feedback

You can provide feedback by:

- making an online submission at <https://consult.health.govt.nz>
- using the form at the end of this document and emailing it to gamblingharm@moh.govt.nz
- sending a hard copy to:
Strategy to Prevent and Minimise Gambling Harm Consultation
Ministry of Health
PO Box 5013
Wellington 6140
- attending a discussion and consultation meeting (meeting details are available on our website www.health.govt.nz/consultgambling).

Publishing submissions

We may publish all submissions or a summary of submissions on the Ministry of Health's website, unless you have asked us not to.

If you are submitting as an individual, we will automatically remove your personal details and any identifiable information. You can also choose to have your personal details withheld if your submission is requested under the Official Information Act 1982.

Closing date for submissions

The Ministry of Health must receive your submission by Friday 21 September 2018.

Any submissions received after this due date may not be included in the analysis of submissions, even if they have been posted earlier. You might prefer to email your submission to ensure that the Ministry receives it on time.

Information about the person/organisation providing feedback

You are encouraged to fill in this section. The information you provide will help the Ministry analyse your feedback. However, your submission will still be accepted if you do not fill in this section.

This submission was completed by: (name) _____

Address: (street/box number) _____

(town/city) _____

Email: _____

Organisation (if applicable): _____

Position (if applicable): _____

This submission (tick one box only):

- ☐ is made by an individual or individuals (not on behalf of an organisation nor in their professional capacity)
- ☐ is made on behalf of a group or organisation(s).

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

- | | |
|---|---|
| <input type="checkbox"/> Māori | <input type="checkbox"/> Family/whānau |
| <input type="checkbox"/> Pacific | <input type="checkbox"/> Consumer |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Local government |
| <input type="checkbox"/> Service provider | <input type="checkbox"/> Central government |
| <input type="checkbox"/> Gambling industry (levy payer) | <input type="checkbox"/> Researcher |
| <input type="checkbox"/> Other (please specify) _____ | |

Summary of submissions

If you wish to be notified when a summary of submissions is available, please ensure your contact details are provided above and tick the box below.

- ☐ I wish to be informed when the summary of submissions is available.

Privacy

We may publish all submissions, or a summary of submissions, on the Ministry's website. If you are submitting as an individual, we will automatically remove your personal details and any identifiable information.

If you do not want your submission published on the Ministry's website, please tick this box:

- ☐ Do not publish this submission.

Your submission will be subject to requests made under the Official Information Act. If you want your personal details removed from your submission, please tick this box:

- ☐ Remove my personal details from Official Information Act responses.

If your submission contains commercially sensitive information, please tick this box:

- ☐ This submission contains commercially sensitive information.

Consultation questions

The following questions about the *Strategy to Prevent and Minimise Gambling Harm: Consultation document* (the draft strategy) are designed to help you prepare your feedback. However, you do not have to answer the questions if you prefer to structure your submission in some other way.

Please include or cite relevant supporting evidence in your submission, if you can.

You are also welcome to provide any other feedback on the draft strategy or more generally any ideas on preventing or minimising gambling harm in New Zealand (refer question 16).

Strategic direction

The Gambling Act 2003 defines harm, the purpose of the strategy (to prevent and minimise gambling harm) and key components that a strategy must include. Neither these legislative provisions nor the content of the other strategic documents and frameworks with which the proposed strategy is expected to align are under consideration in this consultation.

In terms of the strategic direction, objectives and associated priority actions (sections 1 and 2):

1. Do you support the strategic direction outlined in the proposed strategy?

☐ Yes ☐ No. If not, please explain why.

2. Does the draft strategic plan adequately reflect changes in the gambling environment?

☐ Yes ☐ No. If not, what else should be included and why?

3. Are there any objectives or priority actions that you feel are more important or less important than the others?

☐ Yes. If yes, please identify these and explain why? ☐ No.

4. Do you think the inclusion of the priority actions to reduce inequality and inequity in Objectives 9 and 10 will help reduce gambling harm for the groups identified?

☐ Yes ☐ No. If not, what suggestions do you have about how we can do this?

5. Are there other actions to prevent and minimise gambling harm that should be included as priority actions?

☐ Yes. If yes, please explain what and why. ☐ No

Service plan and funding

The Gambling Act 2003 requires the service plan, and by implication the indicative budget appropriations, to have a focus on public health. The legislation is not under consideration in this consultation.

In terms of the content of the service plan and indicative budgets (section 3):

6. Does the draft service plan adequately cover what it needs to cover, for example, does it include the right types of services and activities?

☐ Yes ☐ No. If not, what is not adequately covered and why?

7. Does the draft service plan provide the right mix of activities (public health, intervention and research/evaluation) including line item activities in tables 14–17 ?

☐ Yes ☐ No. If not, what changes should be made and why? This may include suggesting the Ministry stop an activity or add a new one.

8. Which research and evaluation areas/items listed in the proposed strategy in Section 3.7 and Appendix 1 do you consider to be a high priority or a low priority? Please explain why.

High priority:

Low priority:

9. Do you think the total indicative funding appropriation (\$55.339 million over three years) proposed in the draft service plan is appropriate?

☐ Yes ☐ No. If not, please explain what that funding appropriation should be and why.

10. Do you think that the service plan would be more effective if some funding amounts allocated in Tables 14–17 were shifted from one budget line item or service area to another? This may include proposing the Ministry stop funding some activities or should fund something not already covered in the proposals.

☐ Yes ☐ No. If yes, please explain what changes in funding are required and why.

Levy formula and levy rates

The levy formula is prescribed in legislation and is not under consideration in this consultation. The figures for variables A, B and R are derived from data held by the Ministry, the DIA and IRD and are a matter of record. Comment on variable C (the \$55.339 million funding appropriation proposed for the strategy) is covered in questions 9 and 10 above.

In terms of the other components of the levy formula (section 4):

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

☐ Yes ☐ No. If not, please explain why not.

12. Are there realistic pairs of expenditure/presentation weightings (W1 and W2) other than those discussed in this consultation document?

☐ Yes ☐ No. If yes, please explain what and why.

13. Which pair of weighting options for W1 and W2 do you prefer, if any, and why? Please keep in mind that the levy weighting options only affect the proportion of levy to be paid by each gambling sector and do not affect the total amount of the levy.

14. Do you have any comment on the estimated levy rates for each sector, keeping in mind that the levy formula itself is set out in legislation and is not under consideration in this consultation?

Policy in relation to electronic gaming machines (NCGMs) and the levy formula

The Ministry and DIA are interested in your views about the location of NCGMs and the operation of the levy formula, in achieving gambling harm reduction. Following your comments, if the Government determines that changes may be required, specific proposals would be consulted on separately at a later date. Please note that the current Act and policy settings will be used to set the levy for the next levy period from 1 July 2019 to 30 June 2022.

Concentration of class 4 NCGMs in lower socioeconomic areas (section 1.9)

- A. Do you think operators of class 4 NCGM venues should be incentivised to move from lower socioeconomic areas to higher socioeconomic areas?

☐ Yes ☐ No. If yes, please explain what and why.

- B. What barriers, if any, do you think currently exist to moving class 4 gambling venues out of lower socioeconomic areas?

- C. If barriers do exist, how do you think venues can be incentivised to move?

The levy formula (section 4)

While the proposed levy is based on, and will be set using, the current levy formula set out in the Act, the Ministry and DIA are also interested in your views about the levy formula and what could change in the future. Keep in mind the formula helps to apportion the levy to each sector and itself does not change the total amount levied.

- D. Does the current formula provide a reasonable way to reflect the relative harm caused by each gambling sector? If no, what sort of formula would better reflect the relative harm caused by each sector? Please explain what changes should be made and indicate if there are any additional elements that you think should be included in the formula and/or whether any of the current elements should be removed from the formula.

Anything else?

15. Is there anything else you would like to tell us about the draft strategy or preventing and minimising gambling harm more generally?

Thank you for taking the time to provide feedback.