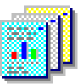

Document Profile

Minimising Gambling Harm Filing

Status: Final
Date: 21/06/2019
Title: RE: Racing Reform - Officials Group
Author: Murray Johnson
Document Type: Email
Summary:
Knowledge Content: Med

Drawer: Sector Liaison
Folder: Department of Internal Affairs (DIA)\2019
File Location:
Unit: Ministry of Health
Mental Health and Addiction
Addictions
Maintainer(s): Mental Health and Addiction
MHA-Addiction
Richard Taylor

Kia ora koutou

Another brief email, just to keep you all up to date with developments on the racing front.

The Racing Reform Bill was passed last evening and is currently awaiting Royal Assent. Two Supplementary Order Papers were lodged, the first from our Minister, who proposed a number of minor amendments to clarify the transitional provisions for betting information use agreements in force or under negotiation immediately prior to the commencement date of 1 July 2019.

The second was from Chris Bishop MP, who proposed an amendment to the Sale and Supply of Alcohol Act 2012 to provide an exemption to section 235 of that Act for certain race meetings. This was ruled outside the scope of this Bill.

As a result of the passage of the Bill, the Racing Industry Transition Agency (RITA) will come into being on 1 July 2019. Appointments to the RITA Board were announced this morning.

As I signalled in my last email, we will shortly get in touch to organise a discussion on Bill #2 and the development of regulations.

Kind regards, Murray

From: Murray Johnson
Sent: Wednesday, 12 June 2019 11:34 AM
To: 'xxxx.xxxxx@xxx.xxxx.xx' <xxxx.xxxxx@xxx.xxxx.xx>; 'xxxxxxx.xxxxxxxx@xxxxxxxx.xxxx.xx' <xxxxxxx.xxxxxxxx@xxxxxxxx.xxxx.xx>; 'Clara Rowe [TSY]' <Clara.xxxx@xxxxxxxx.xxxx.xx>; 'Jen Jamieson' <xxx.xxxxxxxx@xxx.xxxx.xx>; 'Maria Cassidy' <Maria.Cassidy@mpi.govt.nz>; 'Victoria Bowes' <Victoria.Bowes@mpi.govt.nz>; 'Kate Littin' <xxxx.xxxxxx@xxx.xxxx.xx>; 'David.xxxx@xxx.xxxx.xx' <David.xxxx@xxx.xxxx.xx>; 'Richard_Taylor@MOH.govt.nz' <Richard_Taylor@MOH.govt.nz>; Dave Adams <xxxx.xxxxx@xxxxxxx.xxx.xx>; 'Franc Mills' <xxxxx.xxxxx@xxx.xxxx.xx>; 'Stace, Rachael' <Rachael.Stace@justice.govt.nz>; Hannah Cobb <Hannah.Cobb@justice.govt.nz>
Cc: Zachery Branham <xxxxxxx.xxxxxxx@xxx.xxxx.xx>; 'John_xxxx@xxx.xxxx.xx' <John_xxxx@xxx.xxxx.xx>; 'Marie McAninch' <Marie.McAninch@mpi.govt.nz>; Hayden Kerr <xxxxxx.xxxx@xxx.xxxx.xx>
Subject: Racing Reform - Officials Group

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Kia ora koutou

Just a quick email to say that we've been a bit swamped with getting the Racing Reform Bill through Select Committee and haven't had a chance to organise an official's meeting – so I'm sending out a brief update in the meantime.

Racing Reform Bill

The Racing Reform Bill was reported back from the Transport and Infrastructure Select Committee yesterday (with minor technical amendments) and will receive its second reading speech next Tuesday. The Committee of whole House is scheduled to take place next Wednesday and we are expecting to see some Supplementary Order Papers appear recommending changes to the Bill. These could include:

- Immediate repeal of the Betting Levy (totalisator duty) from 1 July 2019 instead of phasing it in
- Explicit requirements for harm minimisation for overseas betting agencies
- Increased penalties
- Some form of 'guarantee' to sports bodies that they will be no worse off as a result of the changes
- Requirements for racing and sports representation on the Board of the Racing Transition Agency

The likely issues are most likely to involve IRD, Treasury, Health, Justice and Sport NZ. This is just a 'heads up' at this stage – just in case we need to get in touch.

We will organise a meeting of officials on the policy development for the second Bill and regulations flowing from this Bill once the Racing Reform Bill has been enacted.

Please get back to me if you need any clarification.

Kind regards, Murray

Murray Johnson | Policy Programme Manager | Policy, Regulation & Communities
The Department of Internal Affairs Te Tari Taiwhenua
DDI: +64 495 9490 | Extn: 5490 | s 9(2)(a)
45 Pipitea Street | PO Box 805, Wellington 6140, New Zealand | www.dia.govt.nz

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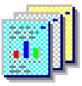

Document Profile

Minimising Gambling Harm Filing

Status:	Final	**Drawer:**	Sector Liaison
Date:	06/05/2019	**Folder:**	Department of Internal Affairs (DIA)\2019
Title:	RE: Fw: Draft LEG Paper and Racing Reform Bill for consultation [budget sensitive]	**File Location:**	
Author:	Nicholas Harman	**Unit:**	Ministry of Health Mental Health and Addiction Addictions
Document Type:	Email	**Maintainer(s):**	MHA-Addiction Sean-Paul Kearns
Summary:			
Knowledge Content:	Med		

Out of scope

From: Sean-Paul_xxxxxx@xxx.xxxx.xx <Sean-Paul_xxxxxx@xxx.xxxx.xx>
Sent: 3 May 2019 14:40
To: Georgia Banks <xxxxxxx.xxxxx@xxx.xxxx.xx>; Nicholas Harman <xxxxxxxx.xxxxxx@xxx.xxxx.xx>
Cc: John_xxxx@xxx.xxxx.xx; Richard_Taylor@MOH.govt.nz
Subject: Re: Fw: Draft LEG Paper and Racing Reform Bill for consultation [budget sensitive]

Hi Georgina

Thanks for providing us the opportunity to comment. Here's our thoughts (our comments underlined). Please let us know if you have any questions.

Cheers,
Sean-Paul

s11(4) - Membership of governing body. In appointing members, the Minister must have regard to the need for the governing
body to have available to it, collectively, from its members,—
(a) knowledge of, or experience in, the racing industry or sport administration at a national level; and
(b) expertise in organisational change and governance, including relevant commercial or legal expertise to manage organisational change; and

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(c) expertise in business, marketing, or economics.

We noted that expertise in public health and specifically gambling harm prevention experience was missing from the list. It would be good to have this perspective represented, as otherwise we suggest any nominations could be challenged and the inclusion also then specifically acknowledges/allows for this perspective to be articulated at the table.

s17A(1)(b) - Regulations relating to distribution and use of betting profits
The Governor-General may, by Order in Council made on the recommendation of the Minister, make regulations prescribing the method to be used for determining the amounts that may be,
retained by the Agency from its betting profits for the purpose of carrying out its duties in relation to harm prevention and minimisation in respect of racing betting and sports betting.

Will be interesting to see how the amounts/rates on betting profits are applied in the regulations. There isn't much detail here. We are wondering if it might be useful to reference the current gambling harm levy setting model for bench marking the rates - however we are quite conscious of the sports levy component and are wondering about room for confusion and thus challenge. We also note elsewhere that the rate is the Minister's discretion effectively subject to a 'fair and reasonable statement'. We suggest it might be useful to reference the gambling levy formula as an example of 'fair and reasonable' as far as the gambling harm minimisation component goes products?

s17A(2)
In subsection (1), **betting profits** means profits for totalisator racing betting, sports betting, and fixed-odds racing betting conducted by the Agency calculated in accordance with the following formula:
a – b – c
where—a is the total of all amounts received by the Agency or its agents (including the net return from bets laid off) for—
(a) totalisator racing betting:
(b) sports betting:
(c) fixed-odds racing betting

We were unclear about the definition of the 3 betting profit categories. It would be useful to include specific definitions of these in the bill, particularly with reference to 'fixed odds betting'. It is our view that how fixed odds betting unless defined, can be interpreted to apply to virtual racing and class 4 EGMs, which could have consequences for Bill 2.

Here's what's in the current Racing Act 2003. Note that fixed-odds is listed under 'racing betting', but it is not defined under Interpretation on it's own. :
racing betting means betting (including totalisator racing betting, equalisator betting, and fixed-odds betting) conducted by, or on behalf of, the Board on any race or races run at 1 or more racecourses within or outside New Zealand or both, or on any contingency arising from a sequence of any races, whether the betting takes place on or off a racecourse and within or outside New Zealand
sports betting means betting (including totalisator betting and fixed-odds betting) conducted by, or on behalf of, the Board on any sporting event or events, whether held within or outside New Zealand, or on any contingency arising from a sequence of sporting events, whether held within or outside New Zealand or both, and whether the betting takes place at the event or events or not and within or outside New Zealand
totalisator racing betting means a form of betting in which bets are made by means of a totalisator on horses or greyhounds competing in 1 or more races, and in which the dividends

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payable are determined in the manner prescribed by the relevant racing betting rules.
http://www.legislation.govt.nz/act/public/2003/0003/latest/whole.html#DLM184055

65AP (1)(c) Application of money received from offshore betting charges
The designated authority must apply the money received from offshore betting charges for the following purposes: (c) funding measures to prevent and minimise harm from gambling.

65AM Further provisions relating to setting rates of charges
After setting rates of betting information use charges or consumption charges, the Minister must publish a statement of reasons on an Internet site maintained by or on behalf of the designated authority that explains how the rates were set and why the rates are considered to be fair and reasonable.

Similarly to previous comments, it will be interesting to see how the amounts/rates on betting profits are applied in the regulations. There isn't much detail here, and we are wondering if it me useful in the Explanation notes to at least reference the current regulatory arrangements as a template?.

Sean-Paul Kearns
Data Analyst
Addictions
Mental Health and Addiction
Ministry of Health
DDI: 04 816 2035

http://www.health.govt.nz
mailto:Sean-Paul_Kearns@moh.govt.nz
----- Forwarded by Richard Taylor/MOH on 01/05/2019 02:55 p.m. -----

From: Georgia Banks <Georgia.Banks@dia.govt.nz>
To: "YONG, Nicola (LGL/TLU)" <Nicola.Yong@mfat.govt.nz>, "KRAKOSKY, Olivia (AUS)" <Olivia.Krakosky@mfat.govt.nz>, "Richard_Taylor@moh.govt.nz" <Richard_Taylor@moh.govt.nz>, "John_Wren@moh.govt.nz" <John_Wren@moh.govt.nz>, Dave Adams <dave.adams@sportnz.org.nz>, Jen Jamieson <Jen.Jamieson@mpi.govt.nz>, "michael.lonergan@treasury.govt.nz" <michael.lonergan@treasury.govt.nz>, "clara.rowe@treasury.govt.nz" <clara.rowe@treasury.govt.nz>, David Berg <David.Berg@ssc.govt.nz>, "Gary White" <Gary.White@ird.govt.nz>,
Cc: Nicholas Harman <Nicholas.Harman@dia.govt.nz>
Date: 01/05/2019 10:42 a.m.
Subject: Draft LEG Paper and Racing Reform Bill for consultation [budget sensitive]

Good morning,

Following your involvement in the Cabinet papers for the Racing Reform Bill (formerly referred to as the Racing Amendment Bill), please find attached for your review and feedback the draft LEG paper for the introduction of the Bill, and the latest version of the Bill. The Bill reflects the policy decisions made within the three Cabinet papers that you were consulted on. Please note that the Bill is still in draft form, as a few details are still being worked through.

Due to the tight timeframes we are working to, these are being circulated to you at the same time as the Ministerial consultation. With the papers due for lodgement on 10 May, any comment is due back to DIA by

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Tuesday 8 May.

As I will be away from Monday 6th to Friday 17th of May – please send any feedback through to Nicholas Harman at Nicholas.Harman@dia.govt.nz.

Regards,

Georgia Banks |Policy Analyst
Policy, Regulation and Communities Branch
Department of Internal Affairs Te Tari Taiwhenua
Direct Dial: 04 382 3491 | Extn: 4491
45 Pipitea Street | PO Box 6011, Wellington 6140 | www.dia.govt.nz

[attachment "Racing Reform Bill-v4.2.pdf" deleted by Sean-Paul Kearns/MOH] [attachment "Racing Reform Bill LEG Paper - Approval for Introduction.pdf" deleted by Sean-Paul Kearns/MOH]

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From: Murray Johnson <Murray.Johnson@dia.govt.nz>
To: "Richard_Taylor@MOH.govt.nz" <Richard_Taylor@MOH.govt.nz>,
Cc: Hayden Kerr <Hayden.Kerr@dia.govt.nz>, "John_Wren@moh.govt.nz" <John_Wren@moh.govt.nz>
Date: 24/04/2019 10:10 a.m.
Subject: RE: Revised MOH wording: Racing Amendment Bill

Hi Richard

We are currently seeking nominations for the Board of RITA and have taken on board your advice that it might be useful if the board membership contains some person(s) that can provide it with a harm minimisation perspective.

The information we have sent out to the racing Codes is attached, with a summary set out below.

We will be approaching the usual nomination agencies but I thought that you might be able to suggest some folk that would bring this perspective to board deliberations.

Regards, Murray

Murray Johnson | Policy Programme Manager | Policy, Regulation & Communities
The Department of Internal Affairs Te Tari Taiwhenua
DDI: +64 495 9490 | Extn: 5490 | s 9(2)(a)
45 Pipitea Street | PO Box 805, Wellington 6140, New Zealand | www.dia.govt.nz

The Minister for Racing is seeking candidates for the Board of the Racing Industry Transitional Agency (RITA) to enable it to drive a successful transition to a more sustainable future state for the New Zealand racing industry. To achieve this, the Board of RITA must have members with a mix of change management and business as usual (BAU) skills and experience. The main BAU functions of RITA will comprise the racing, betting, gaming, and broadcasting functions of the current New Zealand Racing Board.

A candidate information sheet is attached which summarises the skills and attributes sought, along with information on the nomination process. We are looking for members with the governance expertise and experience to occupy a senior change-leadership role.

The information sheet should be copied and distributed to nominees, along with the Appointment Disclosure Form (also attached).

RITA members must be prepared to commit time to attend meetings, for reading and preparation, and any necessary travel. The workload of members will vary but is expected to be between 6 and 8 days per month, with the workload of the Chair being more than this.

Candidate attributes sought include:
• a good knowledge of, or expertise in, the racing industry;
• expertise in business, marketing or economics;
• knowledge and experience of sport at a national level;
• commercial and/or legal expertise to manage devolution of assets, functions and responsibilities; and
• change management expertise to oversee the transition process.

Also desirable is knowledge of running a betting operation, the impact of technology on business and gambling harm minimisation. Diversity among the membership is also sought.

Given the transitional nature of RITA, these are skill-based rather than representative roles. Board members are expected to act in the best interests of the industry as a whole.

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From: Richard_Taylor@MOH.govt.nz [mailto:Richard_Taylor@MOH.govt.nz]
Sent: Thursday, 4 April 2019 4:57 PM
To: Murray Johnson
Cc: Hayden Kerr; John_Wren@moh.govt.nz
Subject: Revised MOH wording: Racing Amendment Bill

Hi Murray

As discussed. Not sure if "sports that can be wagered on" is the right technical language but hopefully close enough in the time frames. Just to be clear, we're basing this on the proposals in the papers, and not considering any other proposals mentioned in the Messara Report (eg, virtual racing etc).

Racing Amendment Bill: Ministry of Health Risk Assessment

Ministry of Health considers that there is a low risk of increased gambling harm from the proposals in these papers. Increasing the number of sports that can be wagered on could lead to increased expenditure on gambling, which is linked to increased levels of harm. However any increase from this is likely to be low, and manageable within current regulations, assuming responsible marketing and good gambling harm minimisation practices are in place at the point of purchase.

Happy to discuss,

Richard Taylor | Manager | Addictions
Mental Health and Addiction | Ministry of Health
p: 64 4 816 3437 | m: s 9(2)(a) **|e: Richard_Taylor@moh.govt.nz**

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[attachment "RITA Candidate information sheet 2019.pdf" deleted by Richard Taylor/MOH] [attachment "Appointment Disclosure Form - RITA.DOCX" deleted by Richard Taylor/MOH]

****

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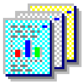

Document Profile

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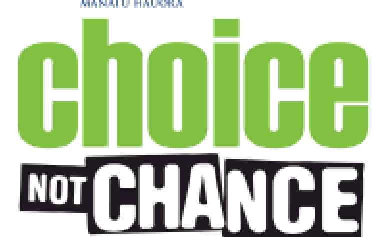
Status:	Final	**Drawer:**	Sector Liaison
Date:	01/05/2019	**Folder:**	Department of Internal Affairs (DIA)\2019
Title:	Fw: Draft LEG Paper and Racing Reform Bill for consultation [budget sensitive]	**File Location:**	
Author:	Richard Taylor	**Unit:**	Ministry of Health Mental Health and Addiction Addictions
Document Type:	Email		
Summary:		**Maintainer(s):**	MHA-Addiction Sean-Paul Kearns
Knowledge Content:	Med		

For review please. NB the tight time frame :(

Richard Taylor | Manager | Addictions
Mental Health and Addiction | Ministry of Health
p: 64 4 816 3437 | m: s 9(2)(a) |e: Richard_Taylor@moh.govt.nz



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Need to talk? Text or call 1737

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From:	Georgia Banks <Georgia.Banks@dia.govt.nz>
To:	"YONG, Nicola (LGL/TLU)" <Nicola.Yong@mfat.govt.nz>, "KRAKOSKY, Olivia (AUS)" <Olivia.Krakosky@mfat.govt.nz>, "Richard_Taylor@moh.govt.nz" <Richard_Taylor@moh.govt.nz>, "John_Wren@moh.govt.nz" <John_Wren@moh.govt.nz>, Dave Adams <dave.adams@sportnz.org.nz>, Jen Jamieson <Jen.Jamieson@mpi.govt.nz>, "michael.lonergan@treasury.govt.nz" <michael.lonergan@treasury.govt.nz>, "clara.rowe@treasury.govt.nz" <clara.rowe@treasury.govt.nz>, David Berg <David.Berg@ssc.govt.nz>, "Gary White" <x@xx>,
Cc:	Nicholas Harman <Nicholas.Harman@dia.govt.nz>
Date:	01/05/2019 10:42 a.m.
Subject:	Draft LEG Paper and Racing Reform Bill for consultation [budget sensitive]

Good morning,

Following your involvement in the Cabinet papers for the Racing Reform Bill (formerly referred to as the Racing Amendment Bill), please find attached for your review and feedback the draft LEG paper for the introduction of the Bill, and the latest version of the Bill. The Bill reflects the policy decisions made within the three Cabinet papers that you were consulted on. Please note that the Bill is still in draft form, as a few details are still being worked through.

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Due to the tight timeframes we are working to, these are being circulated to you at the same time as the Ministerial consultation. With the papers due for lodgement on 10 May, any comment is due back to DIA by Tuesday 8 May.

As I will be away from Monday 6th to Friday 17th of May – please send any feedback through to Nicholas Harman at Nicholas.Harman@dia.govt.nz.

Regards,

Georgia Banks |Policy Analyst
Policy, Regulation and Communities Branch
Department of Internal Affairs Te Tari Taiwhenua
Direct Dial: 04 382 3491 | Extn: 4491
45 Pipitea Street | PO Box 6011, Wellington 6140 | www.dia.govt.nz

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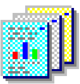

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Status:	Final	**Drawer:**	Sector Liaison
Date:	17/04/2019	**Folder:**	Department of Internal Affairs (DIA)\2019
Title:	Fw: Public announcements regarding racing industry reforms	**File Location:**	
Author:	Richard Taylor	**Unit:**	Ministry of Health Mental Health and Addiction Addictions
Document Type:	Email		
Summary:			
Knowledge Content:	Med	**Maintainer(s):**	MHA-Addiction Sean-Paul Kearns

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From: Georgia Banks <Georgia.Banks@dia.govt.nz>
To: "Richard_Taylor@moh.govt.nz" <Richard_Taylor@moh.govt.nz>, "John_Wren@moh.govt.nz" <John_Wren@moh.govt.nz>, "KRAKOSKY, Olivia (AUS)" <Olivia.Krakosky@mfat.govt.nz>, "YONG, Nicola (LGL/TLU)" <Nicola.Yong@mfat.govt.nz>, Jen Jamieson <Jen.Jamieson@mpi.govt.nz>, "michael.lonergan@treasury.govt.nz" <michael.lonergan@treasury.govt.nz>, "clara.rowe@treasury.govt.nz" <clara.rowe@treasury.govt.nz>, Dave Adams <dave.adams@sportnz.org.nz>, David Berg <David.Berg@ssc.govt.nz>, "gary.white@ird.govt.nz" <gary.white@ird.govt.nz>,
Date: 17/04/2019 11:35 a.m.
Subject: Public announcements regarding racing industry reforms

Tēnā koutou

The Minister for Racing has made announcements today regarding reforms to the racing industry. You can read a copy of the Minister's news release here.

Further information on the decisions that underpin the announcements are available here.

Thank you for all your input into this work so far.

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Ngā mihi

Georgia Banks |Policy Analyst
Policy, Regulation and Communities Branch
Department of Internal Affairs Te Tari Taiwhenua
Direct Dial: 04 382 3491 | Extn: 4491
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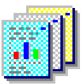

Document Profile

Minimising Gambling Harm Filing

Status: Final
Date: 09/04/2019
Title: [Budget sensitive] Revised Cabinet Papers - Racing Amendment Bill
Author: Georgia Banks
Document Type: Email
Summary:
Knowledge Content: Med

Drawer: Sector Liaison
Folder: Department of Internal Affairs (DIA)\2019
File Location:
Unit: Ministry of Health Mental Health and Addiction Addictions
Maintainer(s): Mental Health and Addiction MHA-Addiction Richard Taylor

Good morning,

Please find attached the revised Cabinet Papers for the Racing Amendment Bill – the table below outlines the changes made to the papers as a result of the consultation process. These papers have now been lodged for DEV tomorrow.

Regards,
Georgia

Feedback description	How feedback included
Add a comment regarding the appointments process for the membership of RITA and how MAC is a precursor to RITA.	Discussion included into paper 2 -paragraphs 17 & 18.
Request that the sports sector be represented on RITA and that the Minister for Racing consult on this appointment.	Added to paper 2 - paragraph 33 and recommendation 10.
Request to modify RITA objective to become 'to assess whether betting should be outsourced'.	Added to paper 3 – paragraph 27.3.1 and recommendation 5.3.1.
Request to add a paragraph to highlight that distribution to sports will not materially change.	Included paper 3 – paragraph 49.
Request for a proportion of the repealed betting levy be directed to problem gambling initiatives.	Added to paper 3 -paragraph 61 and recommendation 16.
Request to delete detail of current NZRB revenue growth strategic initiatives.	Removed from paper 2 - paragraph 27.3 and recommendation 5.3.
Concern about introduction of in-the-race betting	Proposal removed from all papers.
Request to add a Ministry of Health risk assessment (note this has been modified and agreed with the Ministry of Health based on the removal of in-the-race	Added to paper 3 paragraph 72.

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betting).	
Change the approximate financial impact of repealing the betting levy from $65 million to $57 million over the next four financial years (following updated Treasury figures).	Changes made to paper 1 - paragraph 53; and paper 3 - paragraph 52.
Request to add a proposal to establish an appropriation for one or more offshore betting charges.	Added to paper 3 - paragraph 31.
Request to add Treasury comments regarding the justifications for the reforms.	Added to paper 3 - paragraph 71.
Request to add comment regarding the international obligations of adhering to the Australia New Zealand Closer Economics Relations Trade Agreement.	Added to paper 3 - paragraph 35.

Georgia Banks |Policy Analyst
Policy, Regulation and Communities Branch
Department of Internal Affairs Te Tari Taiwhenua
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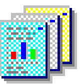

Document Profile

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Status:	Final	**Drawer:**	Sector Liaison
Date:	04/04/2019	**Folder:**	Department of Internal Affairs (DIA)\2019
Title:	Revised MOH wording: Racing Amendment Bill	**File Location:**	
Author:	Richard Taylor	**Unit:**	Ministry of Health Mental Health and Addiction Addictions
Document Type:	Email		
Summary:			
Knowledge Content:	Med	**Maintainer(s):**	Mental Health and Addiction MHA-Addiction Richard Taylor

Hi Murray

As discussed. Not sure if "sports that can be wagered on" is the right technical language but hopefully close enough in the time frames. Just to be clear, we're basing this on the proposals in the papers, and not considering any other proposals mentioned in the Messara Report (eg, virtual racing etc).

Racing Amendment Bill: Ministry of Health Risk Assessment

Ministry of Health considers that there is a low risk of increased gambling harm from the proposals in these papers. Increasing the number of sports that can be wagered on could lead to increased expenditure on gambling, which is linked to increased levels of harm. However any increase from this is likely to be low, and manageable within current regulations, assuming responsible marketing and good gambling harm minimisation practices are in place at the point of purchase.

Happy to discuss,

Richard Taylor | Manager | Addictions
Mental Health and Addiction | Ministry of Health
p: 64 4 816 3437 | m: s 9(2)(a) **|e: Richard_Taylor@moh.govt.nz**

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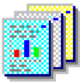

Document Profile

Minimising Gambling Harm Filing

Status:	Final	**Drawer:**	Sector Liaison
Date:	04/04/2019	**Folder:**	Department of Internal Affairs (DIA)\2019
Title:	Fw: Ministerial consultation on Racing Amendment Bill Cabinet papers	**File Location:**	
Author:	Richard Taylor	**Unit:**	Ministry of Health Mental Health and Addiction Addictions
Document Type:	Email		
Summary:		**Maintainer(s):**	MHA-Addiction Sean-Paul Kearns
Knowledge Content:	Med		

Out of scope

choice NOT CHANCE

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----- Forwarded by Richard Taylor/MOH on 04/04/2019 03:37 p.m. -----

From: Amanda Hinkley <Amanda.Hinkley@parliament.govt.nz>
To: Robyn Shearer <robyn_shearer@moh.govt.nz>, Richard Taylor <richard_taylor@moh.govt.nz>, "Ashley_Bloomfield@moh.govt.nz" <Ashley_Bloomfield@moh.govt.nz>,
Date: 04/04/2019 02:35 p.m.
Subject: Ministerial consultation on Racing Amendment Bill Cabinet papers

---

Good afternoon,

Following Ministerial consultation on the Racing Amendment Bill Cabinet papers, the office of the Minister of Racing has advised:

- the proposal for the 'in-race betting' product will be removed
- a portion of the repealed betting levy will be directed to problem gambling initiatives
- Ministry of Health feedback will be incorporated into Cab paper number 3.

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I'm waiting to hear back on considerations for a gambling harm minimisation perspective to be part of the transitional governance group.

Thanks very much for the work you've put into balancing the proposals in these Cabinet papers.

Kind regards

Amanda Hinkley | Private Secretary – Health
Office of Hon Jenny Salesa
4.1L Exec Wing, Parliament Buildings |Direct Line: 04 817 9727|Mobile: 021 196 0514
amanda.hinkley@parliament.govt.nz

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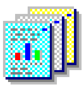

Document Profile

Minimising Gambling Harm Filing

Status:	Final	**Drawer:**	Sector Liaison
Date:	02/04/2019	**Folder:**	Department of Internal Affairs (DIA)\2019
Title:	Update on Racing - revised draft assessment	**File Location:**	
Author:	Richard Taylor	**Unit:**	Ministry of Health Mental Health and Addiction Addictions
Document Type:	Email		
Summary:			
Knowledge Content:	Med	**Maintainer(s):**	Mental Health and Addiction MHA-Addiction Richard Taylor

Hi Amanda

We've received DIA's Impact Assessment - it's 79 pages long so still digesting but they have summarised a few points for us via email.

I've had a go at revising our recommended wording following their email. Basically trying to make it more specific. Apologies for this, we are trying to work at speed, but I will need until tomorrow morning to ensure it responds to the points raised in the RIA. Here is a revised draft at this stage. The important thing is that we still think there's an increase risk of harm.

Racing Amendment Bill: Ministry of Health Risk Assessment

Based on information available at this stage, the Ministry of Health assesses that the Bill's proposals represent a medium to high risk of increased gambling harm.

The introduction of new betting products is likely to lead to increased expenditure on gambling either by expanding the number of gamblers or by encouraging individuals to spend more. Increased expenditure on gambling is linked to increased levels of harm. In particular in-the-run race betting and its availability in an on-line setting creates the opportunity for continuous gambling - a form of gambling that is associated with more severe levels of harm.

The Ministry of Health recommends that, should the changes be agreed, an enhanced product regulation process be implemented. Particular consideration should be given to gambling harm prevention and minimisation, including in relation to marketing, product design and the payments system. This could be similar to the process for approval of Lotto NZ products.

Cheers,

Richard Taylor | Manager | Addictions
Mental Health and Addiction | Ministry of Health
p: 64 4 816 3437 | m: s 9(2)(a) **|e: Richard_Taylor@moh.govt.nz**

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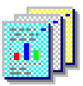

Document Profile

Minimising Gambling Harm Filing

Status:	Final	**Drawer:**	Sector Liaison
Date:	02/04/2019	**Folder:**	Department of Internal Affairs (DIA)\2019
Title:	RE: Racing Amendment Bill: MOH Risk Assessment	**File Location:**	
Author:	Richard Taylor	**Unit:**	Ministry of Health Mental Health and Addiction Addictions
Document Type:	Email	**Maintainer(s):**	Mental Health and Addiction MHA-Addiction Richard Taylor
Summary:			
Knowledge Content:	Med		

Kia ora ano Hayden

Thank for your this. In short, we continue to respectfully disagree with your assessment of these two proposals regarding gambling harm.

To summarise:

- The two proposals both aim to increase revenue from gambling. The products will be more publically accessible and advertised which may widen the pool of gamblers, and/or encourage current gamblers to spend more.
- Increasing player expenditure will increase gambling harm - this is recognised in the Gambling Act, specifically by the inclusion of a weighting for expenditure in the Levy. Comments during both the Ministry's consultation and the Gambling Commission's consultation supported a higher weighting on expenditure as a better reflection of the public health approach inherent in the Act.
- Given that, we believe the link between expenditure and gambling harm should be acknowledged explicitly in the papers.
- While we understand that regulations will be dealt with at a later stage, the papers do not reference regulation of any kind, and include only a short section on gambling harm.
- The risk level will be influenced by the marketing campaign, the design of the products and the spending limits applied to them. Given the overall drive for increased revenue outlined in the paper (which implies extensive marketing to drive increased spending on gambling), the Ministry recommends that an explicit reference to a robust regulatory system is made in the paper, to give Ministers and agencies assurance that harm will be minimised and prevented.

s 9(2)(g)(i)

While it is possible that some harm may be mitigated by legalising certain types of gambling within the New Zealand context, that is reliant on a regulatory regime being applied which is sufficiently robust. Yes, DIA has promised that sufficient acknowledgement of this will be made when we come to designing regulations, and we trust that this will occur. However the current regulatory regime for TAB products reflects a lower risk of harm from the current range of products - we are recommending that for higher risk products there should come increased regulation.

While I acknowledge that our previous comments in 2016 lacked this level of specificity, we did mention the link between expenditure and harm.

I've revised the wording we're suggesting to make it a bit more specific to the proposals in paper 3.

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Racing Amendment Bill: Ministry of Health Risk Assessment

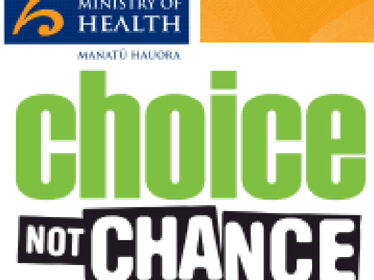
Based on information available at this stage, the Ministry of Health assesses that the Bill's proposals represent a medium to high risk of increased gambling harm.

The introduction of new betting products is likely to lead to increased expenditure on gambling by expanding the number of gamblers and/or by encouraging individuals to spend more. Increased expenditure on gambling is linked to increased levels of harm. In particular in-the-run race betting and its availability in an on-line setting creates the opportunity for continuous gambling - a form of gambling that is associated with more severe levels of harm.

The Ministry of Health recommends that, should the changes be agreed, an enhanced product regulation process be implemented. Particular consideration should be given to gambling harm prevention and minimisation, including in relation to marketing, product design and the payments system. This could be similar to the process for approval of Lotto NZ products.

Happy to discuss,

Richard Taylor | Manager | Addictions
Mental Health and Addiction | Ministry of Health
p: 64 4 816 3437 | m: s 9(2)(a) **|e: Richard_Taylor@moh.govt.nz**



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Hayden Kerr   Kia ora Richard Thanks for your comments. I a...   02/04/2019 03:39:54 p.m.

From: Hayden Kerr <Hayden.Kerr@dia.govt.nz>
To: "Richard_xxxxxx@xxx.xxxx.xx" <Richard _xxxxxx@xxx.xxxx.xx>, Georgia Banks <Georgia.Banks@dia.govt.nz>,
Cc: "John_Wren@moh.govt.nz" <John_Wren@moh.govt.nz>, Murray Johnson <Murray.Johnson@dia.govt.nz>, Misty Parbhu <Misty.Parbhu@dia.govt.nz>
Date: 02/04/2019 03:39 p.m.
Subject: RE: Racing Amendment Bill: MOH Risk Assessment

Kia ora Richard

Thanks for your comments. I appreciate that you hadn't seen a copy of the Racing Reform RIA when you sent your feedback through. We have now forwarded a copy of the Racing Reform RIA which summarises the analysis provided in the previous RIS for the discharged Bill.

The two new betting products that are the subject of this paper are:

- permitting in-the-run race betting

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- the New Zealand Racing Board (NZRB) to offer betting products on sports not represented by a qualifying domestic national sporting organisations (NSO).

Both of these products are currently available to New Zealanders through overseas operators.

The two new betting products that are being proposed formed part of the Racing Amendment Bill 2017, which was discharged in late 2018 to enable a broader reform of the racing industry. The contents of the Bill were subject to a public submission process and select committee scrutiny.

The assessment from the previous RIS considered the risks of increased gambling harm as a result of the new products being proposed, and found on balance that this was manageable (and in the case of sports betting, minimal). The reasons for this were:

- That the products already exist on the market (offered by offshore operators), so it would likely see a movement of customers from offshore operators to the TAB, rather than a significant change in actual customer behaviour, or additional new customers;
- That those accessing the new wagering products would be betting within an existing regulatory framework that has a focus on harm prevention and minimisation – and hence provides some form of protection (currently these betting products are only accessible through offshore operators which are not subject to New Zealand's regulatory requirements)
- Regarding the change to allow in-race betting, it does not permit new types of gambling. It simply allows bets on the final outcome to continue to be taken once the race has started. It was considered this would help to mitigate the risk of increased gambling harm because the opportunity to place a high number of bets in a short space of time is limited and that the risk of gambling harm associated with this change is manageable.
- Regarding the change to betting on sports products, it was unlikely that the overall number of sports on which bets are offered will increase significantly because the majority of sports which are not represented by an NSO are likely to be of limited interest to bettors and, on that basis, the NZRB would not offer bets on them. The NZRB already chooses not to offer bets on many lower profile sports that already have NSO representation. The risk of increasing gambling harm is therefore considered to be minimal.

We note that we did consult with the Ministry of Health on these proposals at the time and that the Ministry's position has changed significantly since this time. **Given this, and the information above, can you please confirm whether you still wish for your current assessment of the probability of increased gambling harm as a result of these two products as medium to high, to stand.**

Separate but related to this, the broader Messara recommendations to expand betting will be considered in a policy process leading up to the second Racing Reform Bill. This will look at these recommendations in the context of the Government's wider gambling policy framework. It is our intention to work with the Ministry on this and Misty will be in touch with you soon about this.

Regards

Hayden

Hayden Kerr | Policy Manager | Policy Group
Department of Internal Affairs | Te Tari Taiwhenua
Phone: s 9(2)(a) | www.dia.govt.nz

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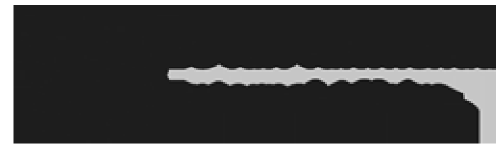

From: Richard_Taylor@MOH.govt.nz <Richard_Taylor@MOH.govt.nz>
Sent: Monday, 1 April 2019 4:08 PM
To: Hayden Kerr <xxxxxx.xxxx@xxx.xxxx.xx>; Georgia Banks <xxxxxxx.xxxxx@xxx.xxxx.xx>
Cc: John_xxxx@xxx.xxxx.xx
Subject: Fw: Racing Amendment Bill: MOH Risk Assessment

Kia ora Hayden / Georgia

Some wording for the Cab paper / RIS. Let me know if you have any questions.

Racing Amendment Bill: Ministry of Health Risk Assessment

Based on information available at this stage, the Ministry of Health assesses that the Bill's proposals represent a medium to high probability of increased gambling harm.

The increased harm arises from the introduction of new betting products and the new avenues for purchase through on-line betting. These developments are highly likely to expand the pool of gamblers, and the design of the products is likely to have features associated with more severe levels of harm.

The Ministry of Health recommends that, should the changes be agreed, an enhanced product regulation process be implemented. Particular consideration should be given to gambling harm prevention and minimisation, including in relation to marketing, product design and the payments system. This could be similar to the process for approval of Lotto NZ products.

Ngā mihi,

Richard Taylor | Manager | Addictions
Mental Health and Addiction | Ministry of Health
p: 64 4 816 3437 | m: s 9(2)(a) **|e: Richard_Taylor@moh.govt.nz**

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----- Forwarded by Richard Taylor/MOH on 01/04/2019 10:52 a.m. -----

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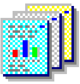

Document Profile

Minimising Gambling Harm Filing

Status:	Final	**Drawer:**	Sector Liaison
Date:	02/04/2019	**Folder:**	Department of Internal Affairs (DIA)\2019
Title:	*Confidential: MOH feedback to Ministers office on Racing papers	**File Location:**	
Author:	Richard Taylor	**Unit:**	Ministry of Health Mental Health and Addiction Addictions
Document Type:	Email	**Maintainer(s):**	Mental Health and Addiction MHA-Addiction Richard Taylor
Summary:			
Knowledge Content:	Med		

Kia ora korua

Hon Salesa asked us for urgent feedback on the Racing Cabinet papers by COB today. Attached is the draft (just waiting on Tier 2 sign out), FYI. It incorporates what we spoke about at our meeting and the wording we sent through yesterday, which they requested ahead of the meeting. We will also be providing talking points by COB Thursday, which will be based on the attached.

One slight difference from what we've discussed is that we've expanded a bit on our concerns regarding in-race betting, particularly in an online setting. The main point there is that it's a form of continuous gambling - something we (MOH) really should have identified back in 2016. We've also provided some information on other jurisdictions, as requested by the Minister. I know we're all running down to the wire on this but it might be useful for you guys ahead of lodging, and we are (as always) happy to discuss.

Ngā mihi,

Richard Taylor | Manager | Addictions
Mental Health and Addiction | Ministry of Health
p: 64 4 816 3437 | m: s 9(2)(a) **|e: Richard_Taylor@moh.govt.nz**

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- Document1.docx

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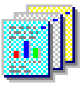

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Minimising Gambling Harm Filing

Status:	Final	**Drawer:**	Sector Liaison
Date:	29/03/2019	**Folder:**	Department of Internal Affairs (DIA)\2019
Title:	MOH Notes for Officials Meeting 29 March re Racing Amendment - MOH views	**File Location:**	
Author:	John Wren	**Unit:**	Ministry of Health Mental Health and Addiction Addictions
Document Type:	Email	**Maintainer(s):**	MHA-Addiction Sean-Paul Kearns
Summary:			
Knowledge Content:	Med		

Hi Richard,
FYI - I have prepared the attached for today, it includes a bit of context about what I said and understood from the last officials meeting.

Note, I have added a couple of new points about the rationale for the risk assessment, provided legislative context for the Ministry's role, and added brand new information from the HPA HLS about online gambling activity from the 2018 HLS - I asked Greg Martin for these yesterday.

MOH Notes 29 March for DIA Officials Meeting Racing Amendment Act.docx

I suggest it will be easy for us to update the attached for Amanda after the meeting. I am quite happy for the attached to go to Amanda now as a heads-up on our current thinking.

Yours

John Wren, PhD | Senior Research Advisor | Addictions - Gambling
Mental Health and Addiction | Ministry of Health
133 Molesworth St, Ministry of Health, Wellington
p: 64 4 816 3938 | m: s 9(2)(a) **|e: john_wren@moh.govt.nz**

2nd Gambling Research and Evaluation Innovation Round for Preventing and Minimising Gambling Harm Request for Proposals Released
The Ministry of Health (Ministry) has released a tender on GETS for the second procurement of a range of innovative gambling research and evaluation services. Find out more, go here:
https://www.health.govt.nz/our-work/mental-health-and-addictions/gambling/gambling-research-and-evaluation/funding-opportunities-gambling-harm-reduction-research-and-evaluation

NZ Population Gambling Survey data now on-line in an interactive web-portal
The web portal is called Kupe: http://kupe.hpa.org.nz/

It includes the HPA Health and Lifestyles (HLS) survey data from 2012, 2014, and 2016.

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Gambling Helpline: 0800 654 655 or text 8006

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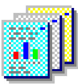

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Minimising Gambling Harm Filing

Status:	Final	**Drawer:**	Sector Liaison
Date:	25/03/2019	**Folder:**	Department of Internal Affairs (DIA)\2019
Title:	Fw: Draft Cabinet papers - Racing Amendment Bill	**File Location:**	
Author:	Richard Taylor	**Unit:**	Ministry of Health Mental Health and Addiction Addictions
Document Type:	Email	**Maintainer(s):**	MHA-Addiction Sean-Paul Kearns
Summary:			
Knowledge Content:	Med		

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----- Forwarded by Richard Taylor/MOH on 25/03/2019 03:01 p.m. -----

From: Georgia Banks <Georgia.Banks@dia.govt.nz>
To: "gary.white@ird.govt.nz" <gary.white@ird.govt.nz>, "michael.lonergan@treasury.govt.nz" <michael.lonergan@treasury.govt.nz>, "clara.rowe@treasury.govt.nz" <clara.rowe@treasury.govt.nz>, "Marie.McAninch@mpi.govt.nz" <Marie.McAninch@mpi.govt.nz>, "David.Berg@ssc.govt.nz" <David.Berg@ssc.govt.nz>, Dave Adams <dave.adams@sportnz.org.nz>, "Richard_Taylor@moh.govt.nz" <Richard_Taylor@moh.govt.nz>, "John_Wren@moh.govt.nz" <John_Wren@moh.govt.nz>,
Date: 21/03/2019 03:08 p.m.
Subject: Draft Cabinet papers - Racing Amendment Bill

Hi there,

Thank you all for attending the meeting of the Officials Group DIA set up for the racing project we are currently undertaking. As you are all aware we are working on the first Racing Amendment Bill and at the meeting we outlined the broad process for this and the likely content of the Bill. Since the meeting we have been working with a number of you in developing briefings and cabinet papers for this Bill.

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Due to the tight timeframes we are working under for this project, we have been unable to follow the normal procedures regarding consultation. Draft Cabinet Papers have now been delivered to the Minister for Racing, and the Minister's Office have subsequently circulated these for Ministerial and coalition consultation. We understand the Minister has asked for feedback from colleagues by 29 March.

For your review, please find attached the three draft Cabinet Papers that have been circulated. We are planning on holding another Officials Group meeting next week, potentially next Friday (29 March). Can you please let me know if you are available on that day. If that date is suitable we will be in touch with a confirmed time for the meeting.

Please note: subsequent to the draft papers being delivered to the Minister, Treasury updated the estimates for money foregone from the repeal of the Betting Levy – I've attached a document outlining the revised figures – these will be updated in the Cabinet papers.

Feel free to contact me if you have any questions.

Thanks,
Georgia

Georgia Banks |Policy Analyst
Policy, Regulation and Communities Branch
Department of Internal Affairs Te Tari Taiwhenua
Direct Dial: 04 382 3491 | Extn: 4491
45 Pipitea Street | PO Box 6011, Wellington 6140 | www.dia.govt.nz

18(d)

18(d)

Changes to forecasted betting levy figures.docx

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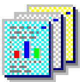

Document Profile

Minimising Gambling Harm Filing

Status:	Final	**Drawer:**	Sector Liaison
Date:	02/04/2019	**Folder:**	Department of Internal Affairs (DIA)\2019
Title:	Fw: Budget sensitive: Racing Reform RIA	**File Location:**	
Author:	Richard Taylor	**Unit:**	Ministry of Health Mental Health and Addiction Addictions
Document Type:	Email		
Summary:			
Knowledge Content:	Med	**Maintainer(s):**	MHA-Addiction Sean-Paul Kearns

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----- Forwarded by Richard Taylor/MOH on 02/04/2019 01:54 p.m. -----

From:	Georgia Banks <Georgia.Banks@dia.govt.nz>
To:	"'John_Wren@moh.govt.nz'" <John_Wren@moh.govt.nz>, "'Richard_Taylor@moh.govt.nz'" <Richard_Taylor@moh.govt.nz>, 'Jen Jamieson' <Jen.Jamieson@mpi.govt.nz>, "'KRAKOSKY, Olivia (AUS)'" <Olivia.Krakosky@mfat.govt.nz>, "'nicola.young@mfat.govt.nz'" <nicola.young@mfat.govt.nz>, 'David Berg' <David.Berg@ssc.govt.nz>, "Dave Adams" <dave.adams@sportnz.org.nz>, "'gary.white@ird.govt.nz'" <gary.white@ird.govt.nz>, "'michael.lonergan@treasury.govt.nz'" <michael.lonergan@treasury.govt.nz>, "'clara.rowe@treasury.govt.nz'" <clara.rowe@treasury.govt.nz>,
Date:	02/04/2019 11:52 a.m.
Subject:	Budget sensitive: Racing Reform RIA

Kia ora koutou,

Please find attached, for your information, a copy of the RIA for the Racing Reform Bill (formerly referred to as the Racing Amendment Bill) . Due to the budget sensitivity, please do not distribute this any further.

Ngā mihi

Georgia Banks |Policy Analyst

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Policy, Regulation and Communities Branch
Department of Internal Affairs Te Tari Taiwhenua
Direct Dial: 04 382 3491 | Extn: 4491
45 Pipitea Street | PO Box 6011, Wellington 6140 | www.dia.govt.nz

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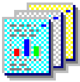

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Minimising Gambling Harm Filing

Status:	Final	**Drawer:**	Sector Liaison
Date:	02/05/2019	**Folder:**	Department of Internal Affairs (DIA)\2019
Title:	Re: Recap	**File Location:**	
Author:	Sean-Paul Kearns	**Unit:**	Ministry of Health Mental Health and Addiction Addictions
Document Type:	Email	**Maintainer(s):**	MHA-Addiction Sean-Paul Kearns
Summary:			
Knowledge Content:	Med		

Thanks Misty

I've cc'd in John and Richard for their info.

s 9(2)(g)(i). More detailed descriptions of the products would be useful, but I'm sure those will be present in the draft papers.

To pull a quote from John's recently published outcomes report: "Research has shown that the most harmful forms of gambling are the continuous type such as pokie machines."
https://www.health.govt.nz/publication/progress-gambling-harm-reduction-2010-2017-outcomes-report-new-zealand-strategy-prevent-and-minimise

Further research including prevalence studies like the Health and Lifestyles Survey and National gambling study can be found on our website, but please feel free to ask if you have a specific question:
https://www.health.govt.nz/our-work/mental-health-and-addictions/gambling/gambling-research-and-evaluation

We look forward to reading the draft papers as they are available.

Cheers,
Sean-Paul

Sean-Paul Kearns
Data Analyst
Addictions
Mental Health and Addiction
Ministry of Health
DDI: 04 816 2035

http://www.health.govt.nz
mailto:Sean-Paul_Kearns@moh.govt.nz

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Notes for DIA Officials Meeting Racing Amendment Act: The Ministry of Health View

MOH Rep: John Wren

Date of Meeting: 29 March 2019

Background – 14 February 2019 Officials Meeting

We note that following points about the risk of harm were raised in general at the previous Officials meeting by Health at the meeting on 14 February.

At the 14 February meeting DIA emphasised that the proposal was for two Bills: (i) Bill 1 - A high level structural overview; (ii) Bill 2 - s 9(2)(f)(iv) [redacted]

The case was mounted by DIA, and understood by Health, that [redacted] There was no discussion about regulatory impact/risk statements. I note that I made it clear that the Ministry view was that the potential for harm was at the medium/high end and that we were concerned that decisions made through the Racing Amendment about online betting would end up pre-conditioning the wider gambling discussion around on-line betting, and the convergence between gambling/gambling and online activity.

Current Racing Amendment Proposal – 29 March – Ministry of Health view

Regarding the current papers developed subsequently to the meeting, and now under consideration (26 March), the points raised by Health at the February meeting still stand, and don't seem to have been recognised in the current proposal – particularly in regard to 'risk of harm'.

We agree with the Treasury approach in the current papers around fiscal risks and benefits, and think it equally applies to the gambling harm. From a Ministry Harm Minimisation perspective (which is legislatively mandated role under the 2003 Gambling Act) the Ministry of Health's view, it is difficult to assess the extent these proposals will increase the risks of harmful gambling without further details about the proposals and regulatory controls that may apply. <u>However, we do have research based insights about the possible impact direction gambling harm associated with the racing amendement, which are</u>:

Firstly, we note:

- The Gambling Act 2003 defines gambling harm as:
  - ‘Harm or distress of any kind arising from, or caused or exacerbated by, a person’s gambling; and
  - Including personal, social, or economic harm suffered –
    1. By the person; or
    2. By the person’s spouse, civil union partnet, de facto partner, family, whānau, or wider community; or
    3. In the workplace; or
    4. By society at large.’

This is a broad approach.

Section 4 of The Gambling Act requires the development of an integrated problem gambling strategy focused on public health. The Act states that the strategy must include:

- measures to promote public health by preventing and minimising the harm from gambling
- services to treat and assist problem gambling and their families/ whānau
- independent scientific research associated with gambling
- evaluation.

This is a comprehensive approach to harm minimisation, which has served well to date (refer Gambling Outcomes Monitoring Report, March 2019).

Based upon the research and policy information available to the Ministry to date:

We believe there is a medium/high probability of increased harm because:

1. the new products will be more publically accessible, legal and advertised (the Gambling 'Availability' hypothesis)
2. new gambling type products are predicted to be introduced and these products are predicted to be at the higher risk end - for example in-race betting and virtual game betting.
3. the risk level will also be influenced by whichever organisation takes over betting operations in the future. For example, the history of companies like bet365 is an aggressive one, this would predict a behaviour in New Zealand that is also likely to be at the higher end.
4. alongside these proposals, we note that SKYCITY have publically announced their intention to be more aggressive in the online betting/casino space.
5. The above two points suggest that gambling activity and associated level of harm in this area will only increase as more competition comes into the market. Once again, this predicts an increase in availability and thus increased harm, and the likelihood of more risky types of gaming/gambling designed to be more attractive to gamblers.
6. unless there is robust regulation about monitoring expenditure at point of purchase, it will be that much more difficult to monitor the level of harm occurring compared to, for example, physical presence at a pokie machine
7. no thought has been given (or at least no information provided) as to what the 'harm minimisation' regime is going to be manged in the bill or briefing documents
8. **Note**, Gambling Harm 'Adaptation' theory, similar to other economic and marketing theories, suggests that the new activity arising from the proposed amendments suggests that that amendments will cause a spike in gambling harm, however over time the market will adapt and a new plateau in gambling activity and associated level of harm will result. However, we cannot predict where the level of harm will settle at. However, we are confident the new level won't be lower.

Attached below, is brand new data from the 2018 Health and Lifestyle Survey gambling module, about self-report of online gambling participation. I have highlighted in Yellow, the two questions most directly relevant to the discussion. I note that this data will help form a baseline for monitoring future gambling harm arising from the proposed Racing Amendment changes.

Unpublished Results from 2018 Health Promotion Agency Health and Life Style Gambling Module. (The results have been loaded into Kupe for testing)

Sum of value	Column Labels											
	Total	Gender		Age					Ethnicity			
Row Labels	Total	Female	Male	15-24 years	25-34 years	35-44 years	45-54 years	55+ years	Maori	Pacific	Asian	Other
g17i G17i: Spent money through a website, on your mobile phone, or on a gaming consol online pokies												
Yes	1.5	0.8	2.3	3.4	2.3	1.7	0.8	0.3	5.5	0.8	0	1.1
No	98.5	99.1	97.7	96.6	97.7	98.3	99.2	99.5	94.5	99.2	99.9	98.8
g19aj G19aj: Playing online poker or other casino games such as blackjack or roulette?												
Yes	0.7	0.4	0.9	0.7	2.2	0.6	0	0.2	2	0.5	0	0.5
No	99.3	99.6	99.1	99.3	97.8	99.4	100	99.8	98	99.1	100	99.5
g19ak G19ak: Placed a sports bet online through an overseas website?												
Yes	0.4	0.2	0.7	0.2	0.7	0.7	0	0.5	0.3	0.2	0.3	0.5
No	99.5	99.8	99.3	99.7	99.3	99.3	100	99.5	99.7	99.5	99.7	99.5
g19al G19al: Other online betting including overseas lotteries?												
Yes	0.1	0.1	0.2	0	0	0.2	0.1	0.2	0.2	0.4	0	0.1
No	99.9	99.9	99.8	99.9	99.9	99.8	99.9	99.8	99.8	99.3	100	99.9
online_gambler Gambled on any activity online (internet game+NZTAB+ sport events online)												
Online gambler	13.2	10	16.5	13.5	17.3	22.5	13	6.8	15.1	11	7.2	14.3
Not online gambler	86.8	90	83.5	86.5	82.7	77.5	87	93.2	84.9	89	92.8	85.7
overseas_online Gambled on any activity on an overseas website												
Yes	2.2	1	3.4	3.7	3.7	2.8	0.9	1	5.8	1	0.3	2
No	97.8	99	96.6	96.3	96.3	97.2	99.1	99	94.2	99	99.7	98
g18i G18i: Often you spent money through a website, on your mobile phone online pokies all adults												
At least weekly	0.2	0.2	0.2	0	0.4	0.7	0	0	1.2	0	0	0
At least monthly	0.1	0	0.2	0.1	0.1	0.5	0	0	0.1	0.5	0	0.1
Less than monthly	1.2	0.6	1.9	3.4	1.8	0.6	0.7	0.3	4.2	0.2	0	1
Did not participate	98.5	99.2	97.7	96.6	97.7	98.3	99.2	99.7	94.5	99.2	100	98.9

Ministry of Health feedback on Racing Cabinet Papers

DIA has outlined an two-staged approach to Ministry officials: : (i) Bill 1 - A high level structural overview; (ii) Bill 2 - s 9(2)(f)(iv)

There are three papers for discussion, all of which focus on Bill 1:
Paper 1: Overview of the New Zealand Racing Industry and identified issues
Paper 2: Policy decisions on transitional governance to drive change
Paper 3: Proposals for immediately increasing revenue for the racing industry

The Ministry's feedback focuses on proposals in Paper 3, however there are some overall observations.

Overall Observations
- Increasing player expenditure will increase gambling harm
- The link between expenditure and gambling harm should be acknowledged explicitly in the papers.

The papers emphasise the commercial/economic case for change. The Ministry notes that the Gambling Act identifies a link between expenditure and harm (specifically the acknowledgement of expenditure as a weighting for determining the Problem Gambling Levy). While the Ministry accepts that DIA intend to deal with regulatory features such as s 9(2)(f)(iv), it feels more explicit acknowledgement of the linkage between expenditure and gambling harm should be incorporated into the papers. In addition, the Ministry has made specific comments regarding the two additional 'products' being recommended to Cabinet (see below under Paper 3).

Paper 1
- The Ministry agrees with Treasury's comments on Paper 1 regarding the lack of analysis of the regulatory and financial implications for the Crown, and in particular the risks relating to gambling harm.

The Ministry understands that this will be dealt with at a later stage (the second of two proposed Bills), however the overall emphasis on increasing revenue raises concerns regarding gambling harm as outlined above.

Paper 2
- Consideration should be given to the governance body including knowledge/experience in preventing and minimising gambling harm.

The Ministry notes that there is no harm minimisation perspective on the Ministerial Advisory Committee (MAC) that is referenced in the papers.

Paper 3
This paper notes two main proposals of concern to the Ministry of Health:
1) Removing the prohibition on in-the-run race betting. This means that people would be able to bet on the outcome of a race multiple times during the race – in 'the heat of the moment'.
2) Reducing restrictions on sports betting. This widens the range of sports on which betting is allowed.

The Ministry's view is summarised as follows:
- The two proposals both aim to increase revenue from gambling, which as noted above, risks increased harm.

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- New products will be more publically accessible and advertised which may widen the pool of gamblers, or encourage current gamblers to spend more. Either of these outcomes increases the risk of harm.
- The risk level will be influenced by the marketing campaign, the design of the products and the spending limits applied to them. Given the overall drive for increase revenue outlined in the paper, the Ministry recommends that – should the proposals be accepted – an explicit reference to a robust regulatory system is made in the paper, to give Ministers and agencies assurance that harm will be minimised and prevented.

In-the-run race betting
The Ministry believes that this proposal would result in a significant increase in gambling harm for individuals. Primarily, this proposal creates the ability for continuous gambling – a known risk factor for gambling harm and one closely associated with harm from pokies (the most harmful form of gambling).

The short duration of races means that individuals (particularly those betting online) would be able to bet significant sums without opportunity for reflection or a well-considered decision making. Research indicates that while the gambler maintains an illusion of control by using an app etc, the reality is that many are betting 'against themselves' (eg, betting on multiple different horses to win) in larger amounts in order to chase losses.

The Ministry notes that in-the-run race betting **online** is banned in Australia. No comment in made in the papers as to whether this would be the case in New Zealand.

Specific notes on the availability of in-the-run race betting are contained below.

Suggested wording for Cabinet paper as sent to DIA

Racing Amendment Bill: Ministry of Health Risk Assessment

Based on information available at this stage, the Ministry of Health assesses that the Bill's proposals represent a medium to high probability of increased gambling harm.

The increased harm arises from the introduction of new betting products and the new avenues for purchase through on-line betting. These developments are highly likely to expand the pool of gamblers, and the design of the products is likely to have features associated with more severe levels of harm.

The Ministry of Health recommends that, should the changes be agreed, an enhanced product regulation process be implemented. Particular consideration should be given to gambling harm prevention and minimisation, including in relation to marketing, product design and the payments system. This could be similar to the process for approval of Lotto NZ products.

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Advice on 'In-the-run' Race Betting in NZ and other Jurisdictions

New Zealand

In-race betting (aka Betting in-running, in-the-run, in-play or live action) is a form of live betting, and involves placing a bet on a horse or dog race while the race is being run. Live betting is predominantly an online activity, but it can also take place in retail outlets or over the phone.
The NZRB is able to offer live betting on sports events, e.g. during a cricket game, but is prevented by the Act from offering bets during a race.

The law in question is section 52(3) of the Racing Act 2003:
"Rules made by the Board under this section must provide that, if there is racing betting on a race, the betting must close before the race starts."
http://www.legislation.govt.nz/act/public/2003/0003/latest/DLM185017.html

https://www.dia.govt.nz/diawebsite.NSF/wpg_URL/Resource-material-Our-Policy-Advice-Areas-Racing-Policy?OpenDocument#intro

Availability offshore

Australia

Offering instant online bets while a sporting event (including racing) is in-play is ***banned*** in Australia over the internet, but is allowed via telephone calls and in TABs.

https://www.legislation.gov.au/Details/C2019C00070

UK

In-play (in-running) betting in all its forms is legal in the UK. Many of the online options presented to New Zealanders for in-running betting are UK based (William Hill, Ladbrokes Coral, bet365)

https://www.gamblingcommission.gov.uk/for-gambling-businesses/Compliance/Sector-specific-compliance/Betting/In-play-betting.aspx

Malta

In-play betting is legal in Malta, in addition to several other online gambling options. Many of these operators are readily accessible to New Zealanders (Unibet, Mr Green).
https://www.mga.org.mt/legislations-regulations/

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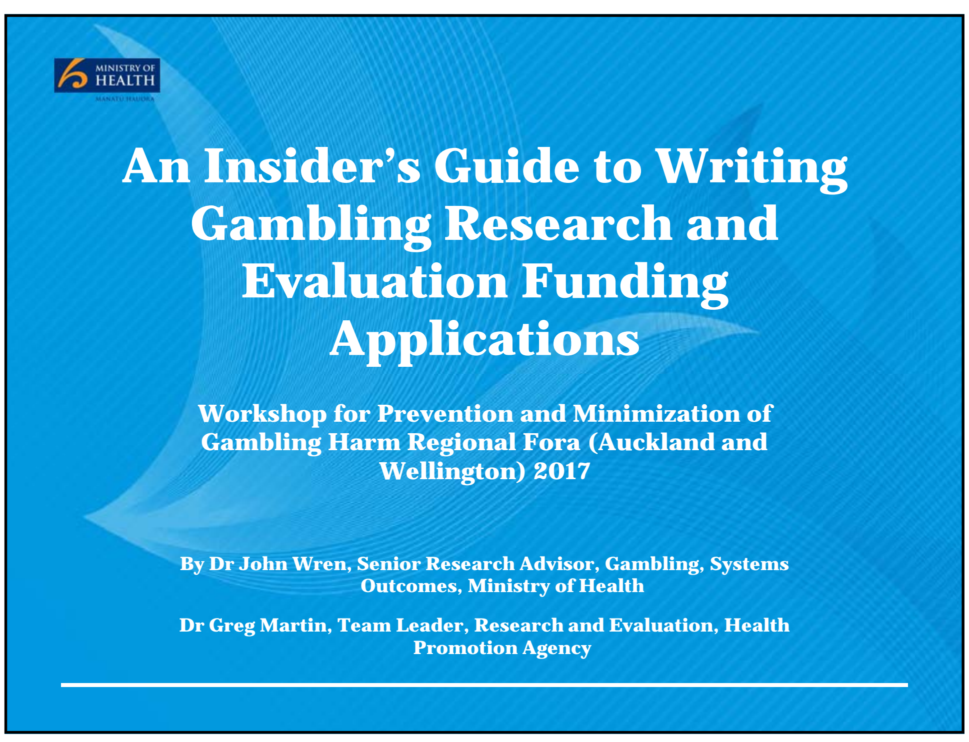
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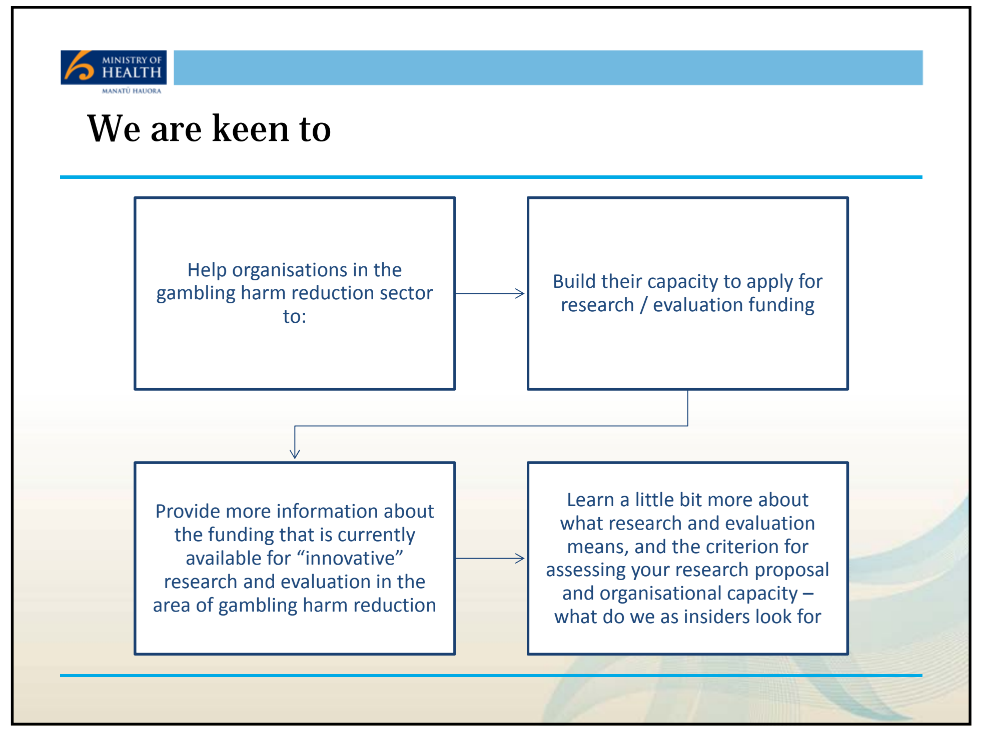
An Insider's Guide to Writing Gambling Research and Evaluation Funding Applications
Workshop for Prevention and Minimization of Gambling Harm Regional Fora (Auckland and Wellington) 2017
By Dr John Wren, Senior Research Advisor, Gambling, Systems Outcomes, Ministry of Health
Dr Greg Martin, Team Leader, Research and Evaluation, Health Promotion Agency


MINISTRY OF HEALTH
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We are keen to
Help organisations in the gambling harm reduction sector to:
Build their capacity to apply for research / evaluation funding
Provide more information about the funding that is currently available for "innovative" research and evaluation in the area of gambling harm reduction
Learn a little bit more about what research and evaluation means, and the criterion for assessing your research proposal and organisational capacity – what do we as insiders look for

MINISTRY OF HEALTH
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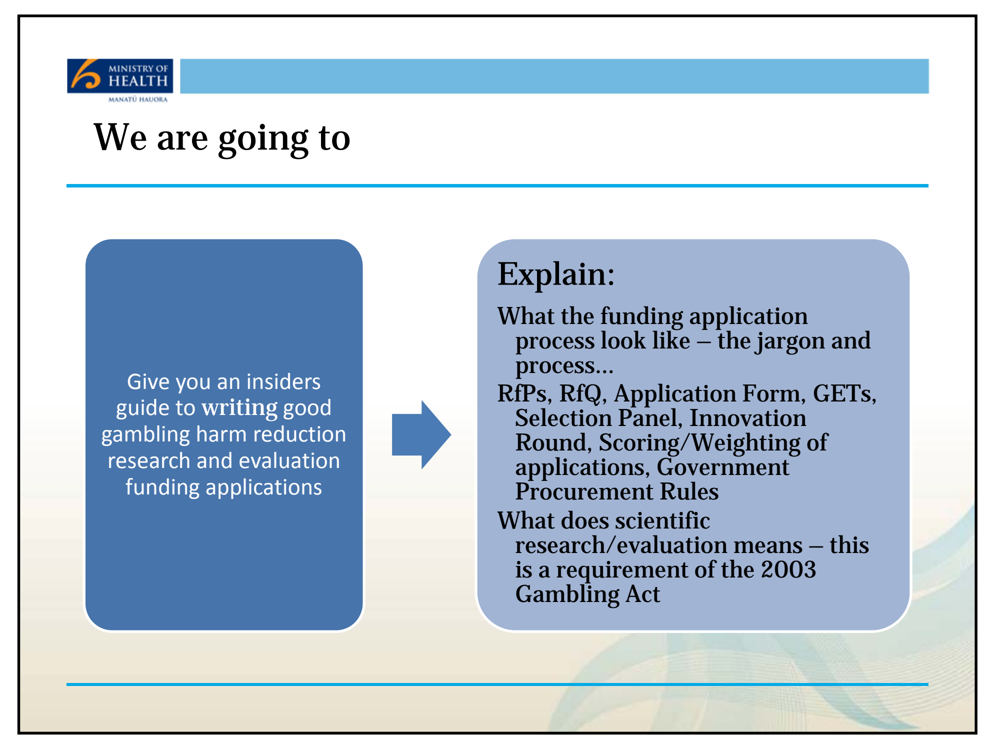
We are keen to
Give you an opportunity to:
• ask us questions
• provide us with a bit of feedback about what research and evaluation activities might be useful to the sector in the coming three years


MINISTRY OF HEALTH
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We are going to
Give you an insiders guide to writing good gambling harm reduction research and evaluation funding applications
Explain:
What the funding application process look like – the jargon and process…
RfPs, RfQ, Application Form, GETs, Selection Panel, Innovation Round, Scoring/Weighting of applications, Government Procurement Rules
What does scientific research/evaluation means – this is a requirement of the 2003 Gambling Act

We are going to

Explain:

- What does Innovation mean
- What to look for in a RfP/RfQ
- What a good application looks like

Provide an opportunity to practice writing key components of a Funding Application

A little bit of context

Reflections on the recent 2017 Innovation Research Round highlighted:

there were more ideas for innovative research and evaluation funding than money available

the funding application process is probably a challenge for many - more might have been funded if the applications had been written better (i.e. clearly covered all aspects of the RfP)

the weighting system used to help select successful proposals needs tweaking to better reflect the innovation and capacity building intent of the innovation round

A little bit of context

improvements could be made to the funding application form to make it clearer to the applicant about what the information being sought was

there may be an opportunity to fund smaller projects to help an organisation grow their capacity and promote awareness of the importance of programme evaluation.

Quick Quiz

1. How much money is available for gambling related research/evaluation activities per year in the current Strategy?
2. What are the two key University based research studies that have been funded by the Ministry for several years that include significant gambling related components?
3. How many Innovation Research Rounds:
    1. have been held in 2017?
    2. in total are due to be held by end of 2018/19?

Quick Quiz

4. Is there a professional standard for evaluation activities in Aotearoa/New Zealand?
   1. If so, what are they?
5. Are there professional research standards / qualifications for "scientific" research in New Zealand?
   1. If so, what are they?

Answers

Q1. How much money is available for gambling harm reduction research/evaluation activities per year in the current Strategy?

ANS: Currently approx. $2.2 million per annum

Q2. What are the two key University based research studies that have been funded by the Ministry for several years that include significant gambling related components?

ANS: *National Gambling Study* and *Pacific Islands Family Study*

Q3. How many Innovation Research Rounds:

1. have been held in 2017? **ANS: 1**
2. in total are due to be held by end of 2018/19? **ANS: 2**

Answers

Q4. Is there a professional standard for evaluation activities in Aotearoa/New Zealand? **ANS: Yes**

If so, what are they? **ANS: Superu/Aotearoa New Zealand Evaluation Association Standard**

http://www.anzea.org.nz/evaluation/evaluation-standards/

Q5. Are there professional research standards / qualifications for doing "scientific" research in New Zealand? If so, what are they?

ANS: Bit of trick question. Historical academic convention recognises a Master's degree as a level appropriate to practice, and Doctoral degree to teach. In practice a minimum of a good Honour's degree is required for an entry level researcher position in academia and government. A Senior position generally requires a Master's degree and appropriate experience over several years.

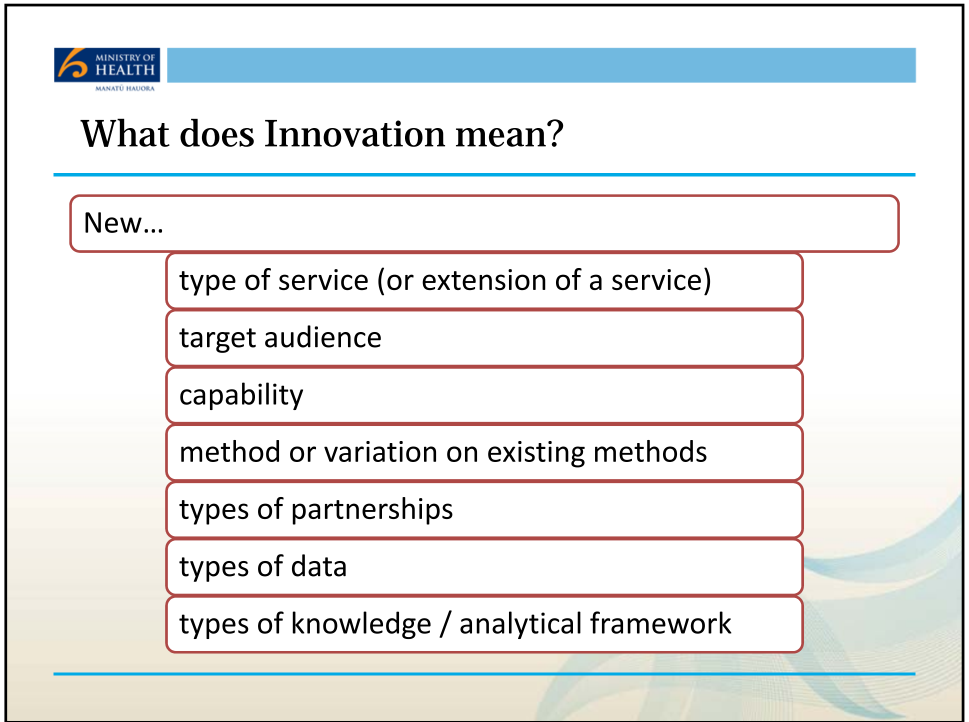
The public process starts with

Issuing a Request for Proposals / Quote (RfP / RfQ) on GETs

- GETS = Government Electronic Tendering System
- GETS provides a standardised and transparent process for bidding for government money for the supply of services
- GETS is open to everybody who registers

RfP - is a general invite to submit ideas to solve a problem / deliver a service –when there is no preferred solution / service design by the funder

RfQ – is an invite to deliver a specific solution/ type of service identified by the funder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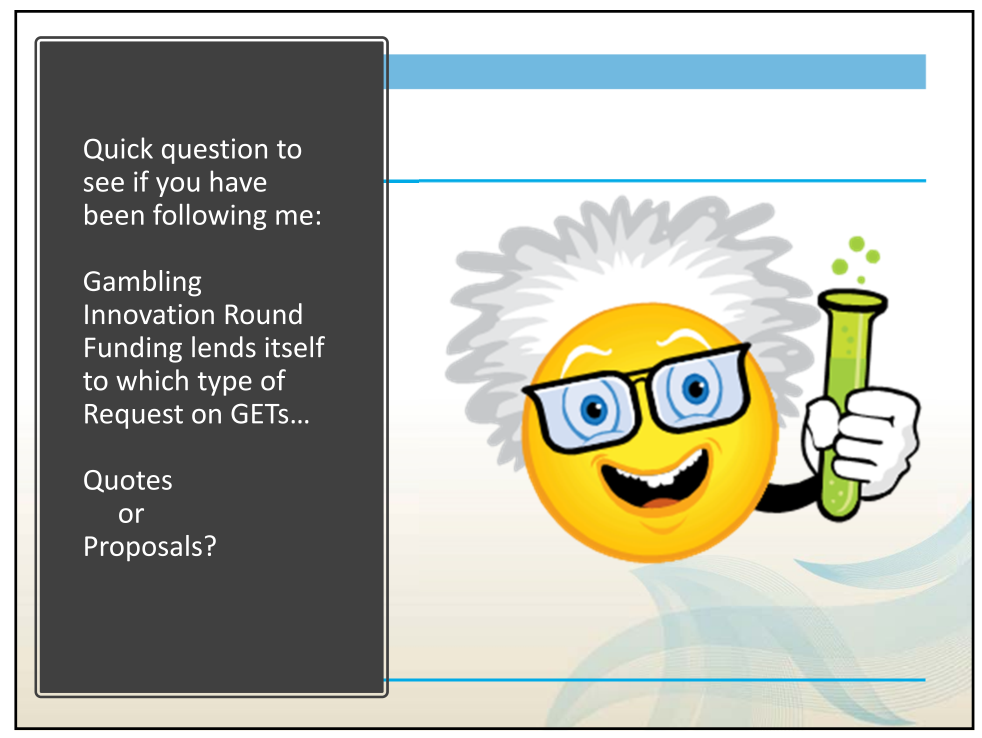
What does Innovation mean?
New…
type of service (or extension of a service)
target audience
capability
method or variation on existing methods
types of partnerships
types of data
types of knowledge / analytical framework


Quick question to see if you have been following me:
Gambling Innovation Round Funding lends itself to which type of Request on GETs…
Quotes
or
Proposals?

Publication of an RfP / RfQ on GETs triggers

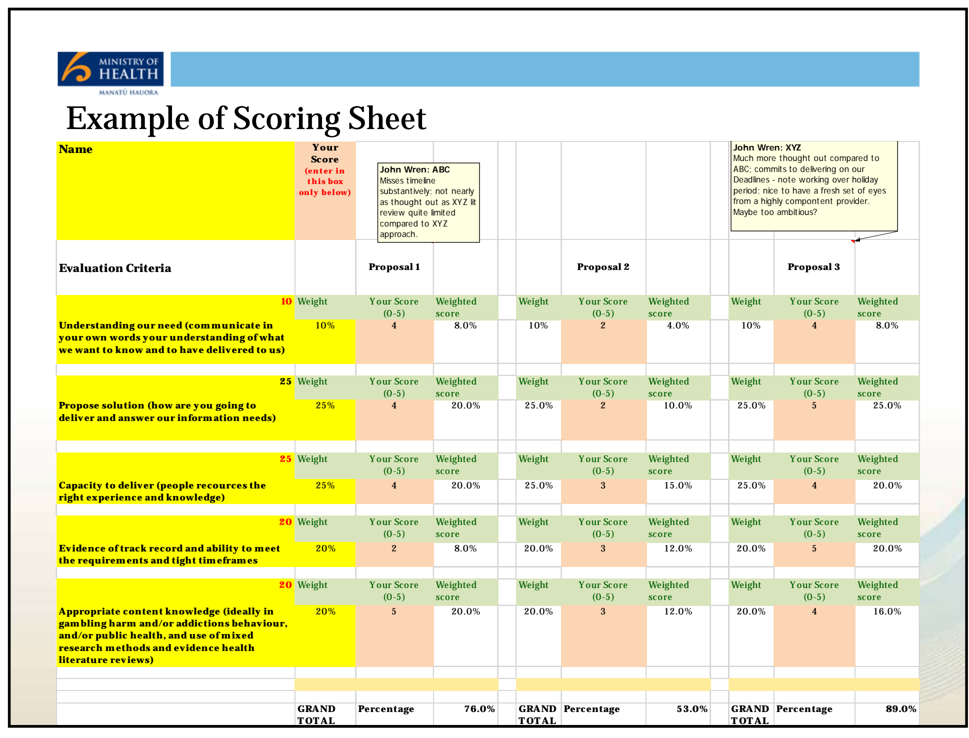
a timeline for…

- opportunity to ask questions
- deadline to submit a proposal – missing the deadline automatically results in rejection of the proposal (unless there are very good reasons)
- a selection panel process to evaluate responses and make a recommendation about which ones to select for funding
- requires the publication on GETS of who the successful bidders are (this can take several months to occur)

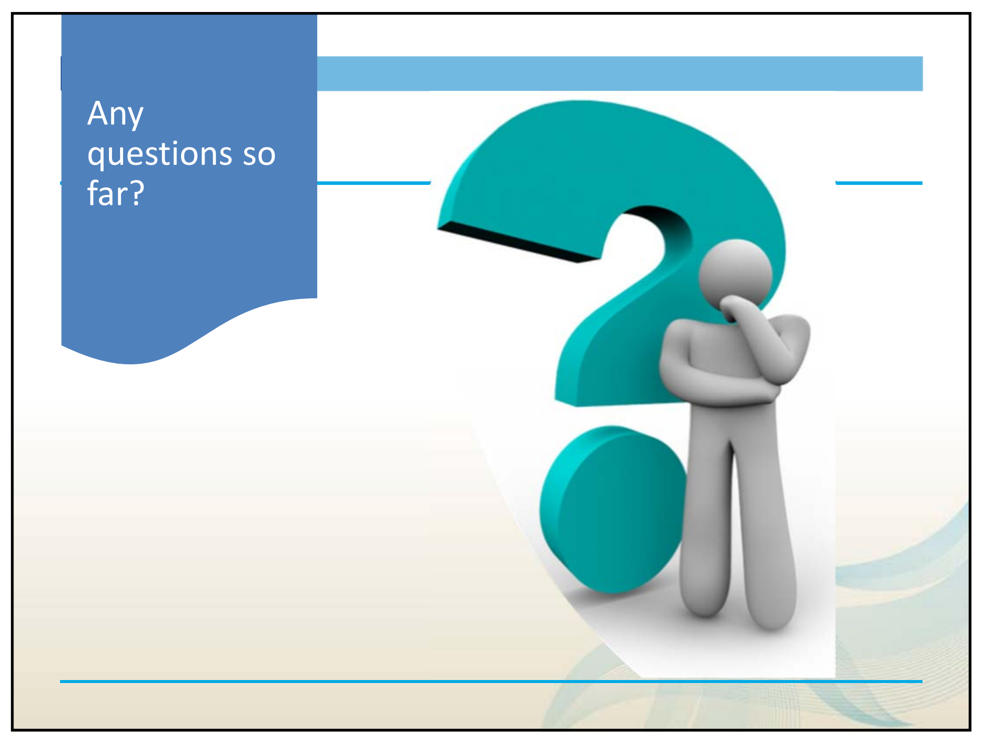
GETs process

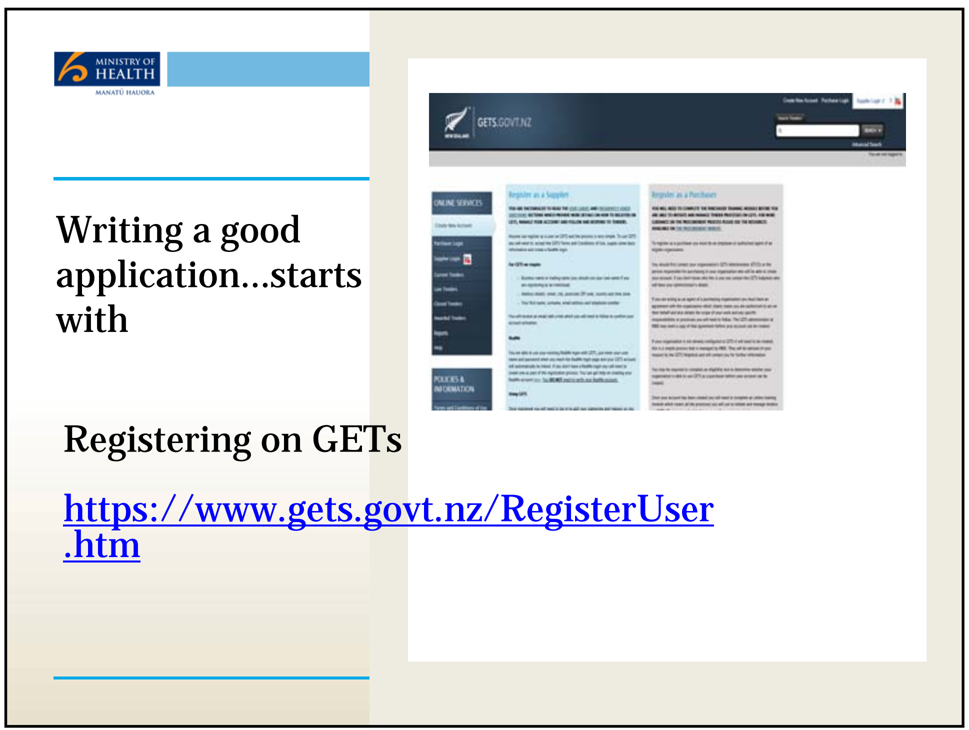
- Requires the use of a Selection Panel, which normally comprises a range of people – including another government agency representative
- Involves the scoring of applications on a range of criteria

  TIP – check the weighting that is published in the RfP for each criterion to get an indication of its importance – spend your effort on the most important items



Name	Your Score (enter in this box only below)								
Evaluation Criteria		**Proposal 1**			**Proposal 2**			**Proposal 3**	
10	Weight	Your Score (0-5)	Weighted score	Weight	Your Score (0-5)	Weighted score	Weight	Your Score (0-5)	Weighted score
Understanding our need (communicate in your own words your understanding of what we want to know and to have delivered to us)	10%	4	8.0%	10%	2	4.0%	10%	4	8.0%
25	Weight	Your Score (0-5)	Weighted score	Weight	Your Score (0-5)	Weighted score	Weight	Your Score (0-5)	Weighted score
Propose solution (how are you going to deliver and answer our information needs)	25%	4	20.0%	25.0%	2	10.0%	25.0%	5	25.0%
25	Weight	Your Score (0-5)	Weighted score	Weight	Your Score (0-5)	Weighted score	Weight	Your Score (0-5)	Weighted score
Capacity to deliver (people recources the right experience and knowledge)	25%	4	20.0%	25.0%	3	15.0%	25.0%	4	20.0%
20	Weight	Your Score (0-5)	Weighted score	Weight	Your Score (0-5)	Weighted score	Weight	Your Score (0-5)	Weighted score
Evidence of track record and ability to meet the requirements and tight timeframes	20%	2	8.0%	20.0%	3	12.0%	20.0%	5	20.0%
20	Weight	Your Score (0-5)	Weighted score	Weight	Your Score (0-5)	Weighted score	Weight	Your Score (0-5)	Weighted score
Appropriate content knowledge (ideally in gambling harm and/or addictions behaviour, and/or public health, and use of mixed research methods and evidence health literature reviews)	20%	5	20.0%	20.0%	3	12.0%	20.0%	4	16.0%
	GRAND TOTAL	Percentage	76.0%	GRAND TOTAL	Percentage	53.0%	GRAND TOTAL	Percentage	89.0%

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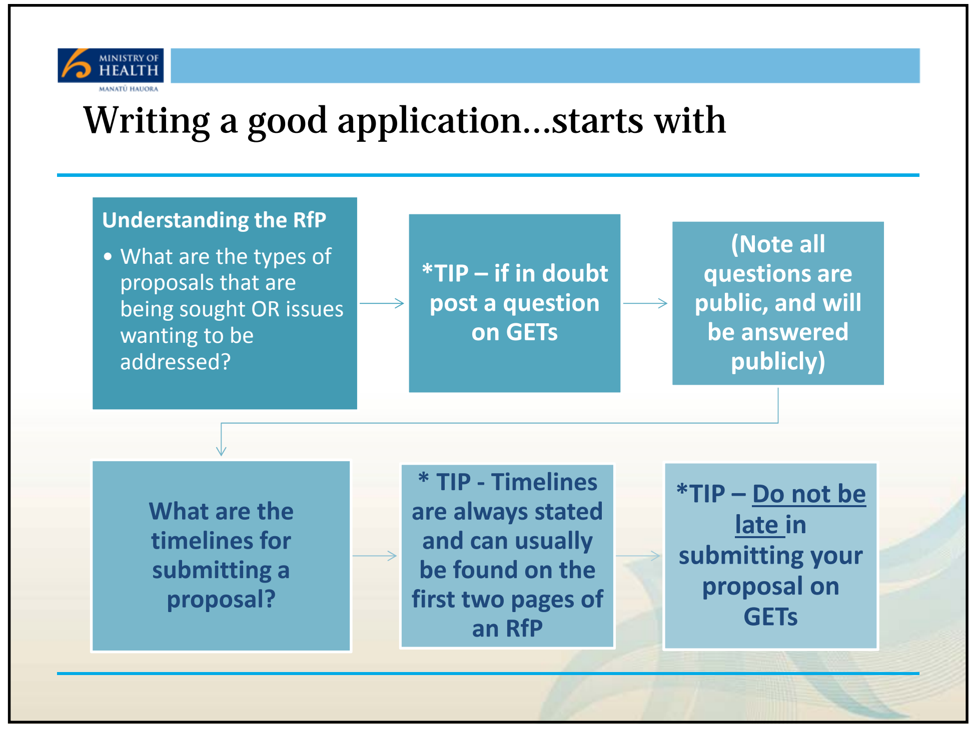
Writing a good application…starts with
Registering on GETs
https://www.gets.govt.nz/RegisterUser.htm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Writing a good application…starts with
Understanding the RfP
• What are the types of proposals that are being sought OR issues wanting to be addressed?
*TIP – if in doubt post a question on GETs
(Note all questions are public, and will be answered publicly)
What are the timelines for submitting a proposal?
* TIP - Timelines are always stated and can usually be found on the first two pages of an RfP
*TIP – Do not be late in submitting your proposal on GETs

Writing a good application…starts with

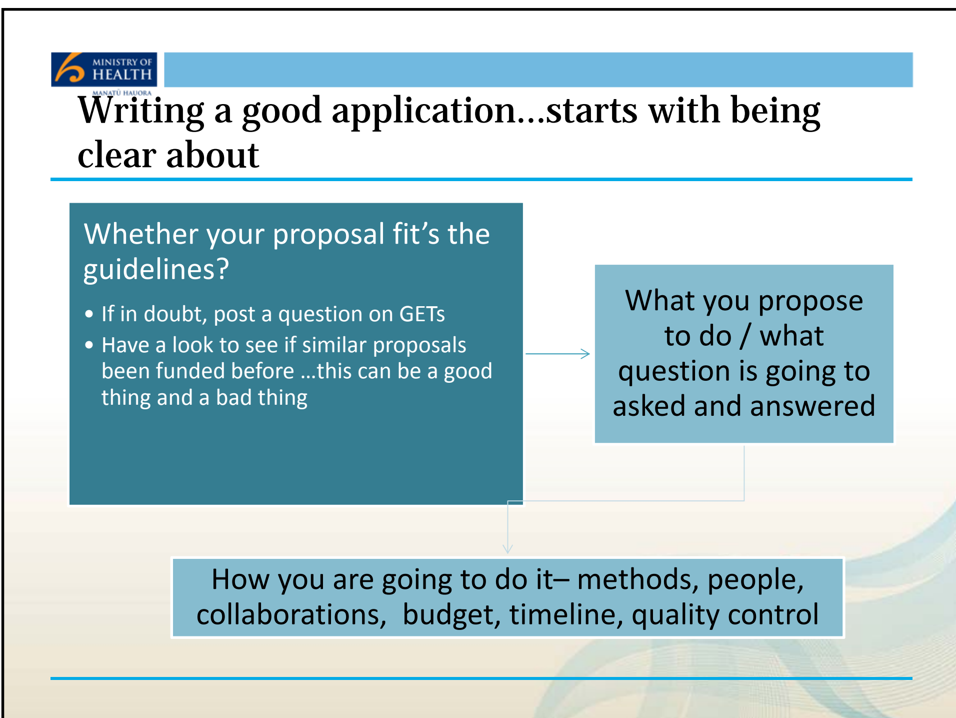
Understanding the RfP

- Does the Request align with your organisation's aims/objectives / interests

***Tip – writing a good application takes time and effort, the chances of success are small – anywhere from 10 to 25 percent chance of being funded. How committed is the organisation?**

*** Tip – Pitch your application to show commitment, and confidence – but don't take anything for granted**

Writing a good application…starts with being clear about



For example is your proposal…

- Research into a new aspect of gambling behaviour / harm reduction in NZ?
- Evaluation of an existing programme's effectiveness?
- Trial and evaluation of a new programme?
- Test of a new product / or service or service redesign?
- Development of new research / evaluation capability?
- Something else…

Tip – use a meaningful title that says straight up what the research/evaluation proposal is about

Think about…

- Allowing time to talk to potential partners – early is better …it can take time to build trust, negotiate contributions, reach agreement, exchange formal letters of support/commitment
- Does the organisation have the resources to deliver the project
  - how can you prove / demonstrate your capability and capacity?
  - note – demonstrating a minimum level of research skills generally requires a minimum of Honours / Masters degree in a research orientated subject area
- Would partnering with a specialist improve your chances?
- What are the timeframes for delivery / budget limits?
  – can you conform to these?

Think about…

What other considerations might be important…

- Intellectual property ownership
  – who owns what, how is it to be used now and in the future?
- Publication of results
  – joint publication, informing the other partner?
- Quality control decisions
  – whose quality, who decides?
- Dispute resolutions process
  – what is the process?
- Payment of invoices
  – has your organisation got the financial resources if delays in payment occur

Think about…

- Getting your proposal proof read and edited before submitting (Tip: typos, spelling mistakes, and poor grammar don't inspire confidence)
- If unsuccessful – ask for feedback on how the application could have been improved
- Don't give up – try again. Sometimes a funding decision is a close call. Typically, only 10 to 25% of applications are successful.

What are the key things to address in this example?

RfP

What we need

Superu manages a Ministerial Fund for social sector research. As part of this fund, government ministers have asked Superu to commission a supplier to carry out new research with customers of government-funded social services.

The research will investigate the customer experience of at least 100 at-risk families in South Auckland to determine:

- What works in their interactions with Government and the government-funded social services they receive?
- What can government build upon to meet the needs of at-risk families?
- What is not working?
- The research should provide answers to these research questions, identify new insights, and describe the stories and experiences of customers.

Why is this an RfP and not an RfQ?

What do you think these are proposing to do?

- The gambling-homeless link: An exploratory study of the New Zealand context
- Research project XYZ recognizes the power of positive affirmation and the use of digital communication by way of the smart phone technology ability to awhi (support) people whom may have complex health, social, economic, cultural and self-esteem issues due to a range of factors in their life.
- Stage 1: addresses and involves a development project for a mobile-phone application (XYZ) intervention for preventing and minimising harm among people who gamble and Stage 2: addresses a national trial of an internet/smart technology-based system for preventing and minimising gambling harm.
- Research is not only reliance on problem gambling screening scores e.g. proxy indices of harm, changes in prevalence rates but goes broader into recreational regular gamblers - thus mapping the full spectrum of gamblers.

Two Examples of Model Proposals for Funding

A response to an RfP

Model Example AUT-PGF PCOMs Evaluation.pdf

A response to an RfQ

Model Example Allen + Clarke Response Form.pdf

Note – both responses have the same format and general style of response although they were to different organisations, for different types of requests and topic areas

Checklist for completing funding application

Checklist for completing Gambling Research Funding Application.docx

Exercise – an opportunity to practice

Context – you have been tasked with preparing a bid for Gambling Research Funding in the 2018 Innovation Round. The Round is publically tendered and competitive.

Your task is to concisely outline what your proposal is, and why it is important. You have a maximum of two pages to present a compelling overview of your proposal.

- What is the research/evaluation question?
- How are you going to answer it – what are your methods?
- What are the key deliverables, timeline and budget?
- What quality assurance can you provide?
- Are there any problems you foresee with delivering the service?

TIP – Use the Check List as Guide and Refer to the Model Responses

Exercise – an opportunity to practice

Greg and I will come around and work with you

Don't hesitate to ask questions

INTRODUCTION TO KEY GAMBLING HARM REDUCTION TERMS, CONCEPTS, THEORY AND ISSUES IN NEW ZEALAND

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THIS DOCUMENT INTRODUCES KEY PUBLIC HEALTH GAMBLING HARM REDUCTION TERMS, CONCEPTS, THEORY AND ISSUES

THE AIM IS TO PROVIDE AN INTRODUCTION FOR NEW PEOPLE TO THE TOPIC

This document aims to introduce some of the key terms, concepts, theory and issues informing the New Zealand Ministry of Health approach to minimising gambling harm, and typically used in the research literature.

The headings of each section are intended to provide a clear guide about the topic covered in each section. In some instances, a frequently asked question format is used to approach the topic. In other instances just a key word or phrase is used to signal the topic.

Each section aims to help new people to the field of gambling harm reduction understand the meaning, history and usage of the topic of interest, and as such it will serve as a useful induction tool and an easily accessible reference point for the gambling harm reduction workforce.

As an introductory guide, this document does not cover all the possible terms, concepts and issues debated in the research literature or in policy. The focus is upon those terms and concepts that are currently common in much of the gambling harm reduction literature, particularly in New Zealand.

It is expected that this document will be periodically reviewed and updated. The reader is invited to submit questions for possible inclusion in future editions. To submit a topic for possible inclusion in future updates, please email it to gamblingharm@moh.govt.nz

THE PARTS AND SECTIONS ARE INTENDED TO BE READ ALONE

The document is divided into three main parts comprising:

1. Terms and Concepts– for example: risk, harm, harm reduction, gambling severity, problem gambler
2. Theories – for example medical model, spectrum of intervention
3. Issues – for example convergence of gambling and gaming

In each part there are a number of sections that address a variety of topics.

Each section is written so that it can be read alone, so that the busy reader can dip into the topic that they want to learn more about, without having to read the entire document.

This approach means that if reading the document as a whole, it will appear to have overlaps in the content. Overlap in content often signals the existence of inter-relationships between the topic and other topics and between terms, concepts and theory.

In this document a:

- 'term/concept' is a name for a fact or concept that relates to a single fact or idea and attempts to define it or explain it in a rational way based upon evidence. For example gambling harm, or healthy gambling.
- 'theory' or 'model' is a set of generalised ideas that explain a phenomena of interest. A theory using a set of rules and facts aims to join together a group of concepts into a

coherent framework that explains a behaviour or phenomena of interest. For example, an explanation for risky gambling behaviour or why there are fluctuations in the incidence and prevalence of gambling harm in the population overtime.

- 'issue' is a general topic of interest and discussion.

Topics covered include:

- What is gambling harm and harm reduction?
- What is the medical model of problem gambling, and how is it different from a public health approach?
- How is problem gambling defined and measured in New Zealand, and internationally?
- What does 'healthy gambling' mean, and where did the concept come from? What evidence is there for the concept?
- What is the Problem Gambling Severity Index (PGSI)?
- What is the level of gambling harm in New Zealand?
- Why does there appear to be differences between some of the reported estimates of the incidence and prevalence of problem gambling in New Zealand, and associated levels of harm?

PART 1 – KEY TERMS AND CONCEPTS

In this part some common terms and concepts used in the field of gambling harm reduction are outlined. A term is defined as is a name for a single fact/concept that relates to a single fact or idea and attempts to define/explain it in a rational way based upon evidence. For example harm reduction, or healthy gambling.

HARM REDUCTION –THE TERM

The term 'harm reduction' was used by Korn and Shaffer (1999) to describe a broad set of interventions running from broad general population level activities at the no/healthy gambling end of their Gambling and Health Pyramid, to the specific individual level interventions at the unhealthy end where interventions are typically intense and clinically orientated (Korn & Shaffer, 1990:330 in Rodgers et al, 2015:22).

HARM REDUCTION – THE CONCEPT: THE IMPORTANCE OF KORN & SHAFFER (1999)

Early researchers such as Volberg (1994) called for a public health approach to gambling harm reduction, however it was Korn and Shaffer (1999) who provided the first full articulation of what such an approach would look like. Their work, which extended into the early 2000s, provided the foundation for the population/public health approach seen in many health orientated problem gambling harm minimisation strategies in Canada, Australia and New Zealand since.

Key aspects to problem gambling harm reduction articulated by Korn and Shaffer (1999) include the following key concepts and terminology:

- spectrum of gambling and health
- harm reduction
- healthy gambling
- primary and secondary prevention
- secondary harm.

HEALTHY GAMBLING

The term 'healthy gambling' was used by Korn and Shaffer (1999) in their Spectrum of Gambling Health to broadly link public health interventions to their Spectrum of Gambling Behaviour. The idea that gambling can be healthy is a problematic concept for a range of gambling harm reduction researchers and public harm minimisation advocates.

Implicit in the concept of healthy gambling is the possibility of there being individual level and social level benefits derived from gambling activities that have no or little harm of consequence associated with the gambling behaviour. For example, benefits could include individual recreation, social connectedness, and monetary benefits from gambling revenue for the government, community groups, and gambling businesses (Korn & Shaffer, 1990. in Rodgers et al, 2015:23).

An important implication of this is that there is inherently an individual and social trade-off and point of balance between what constitutes healthy/unhealthy gambling and associated levels of harm to the gambler, their family, friends and social groups. What constitutes the tipping point between healthy/unhealthy behaviour and associated harm has become a source of debate between the public health advocates (for examples, see Browne et al (2017), Blaszczynski et al (2004), and Dickson-Gillespie et al (2008)) and gambling industry promoters respectively.

Criticisms of the idea of 'healthy gambling' include that the concept does not recognise the addictive nature of gambling behaviour, and in this context, even low level gambling behaviour has increased risk of developing more harmful levels of gambling behaviour. There is an emerging body of New Zealand and international research evidence indicating that 'relapse' is a continual risk for those recovering from significant harmful gambling behaviour (Abbott et al 2018). For those in this category, there is no such thing as 'healthy gambling'.

The concept also lends itself to blaming the individual gambler for their 'unhealthy' gambling behaviour, and to the idea of 'responsible gambling', which is commonly known as the Reno Model.

Another issue is that commonly used measures such as the Problem Gambling Severity Index (PGSI) (which is widely used in New Zealand) and the South Oaks Gambling Screen (SOGS), do not explicitly use the concept of 'healthy' gambling (Rodgers et al, 2015:23-24). These measures are commonly used to identify individuals who gamble and to accurately categorise their gambling behaviour into specific groups with associated indicative levels of harm. The measures are also used to produce estimates of the total number of gamblers in each behavioural group and associated harm in the population of interest (for example the whole population and/or specific ethnic, age, and regional groups).

PREVENTION PARADOX

The idea of the 'prevention paradox' was first raised by Rose (Rose 1985 ; Rose 1992) in the epidemiological[1] context of tobacco disease harm and control. Rose's proposition was that the greatest harm at the population level occurred at the lower thresholds of harm because this was the most common level of harm (prevalent) experienced in the population. This means that while at the individual level the harm experience might be small or moderate, cumulatively the impact upon the health of the population was large. In-addition, for many diseases, low or moderate levels of harm are typically signifiers of the likely occurrence of a much higher level of harm latter in time. Consequently, the most gain from harm minimisation activities (i.e. prevention benefit) can be had by targeting interventions at the low and moderate risk levels rather than at the few individuals who are already experiencing high levels of harm. The focus upon interventions targeting population groups experiencing low to moderate risk/harm in order to gain the most benefit, rather than focussing upon the very few individuals with the highest level of harm, is the prevention paradox. It

[1] Epidemiology is defined by the World Health Organisation (WHO) as the study of the distribution and determinants of health-related states or events (including disease), and the application of this study to the control of diseases and other health problems. Source: *www.who.int/topics/epidemiology/en/*

is a paradox because in many ways it is counter intuitive to the focus on individuals with the most harm and need for treatment.

The question has been recently raised in the gambling research literature as to whether the 'prevention paradox' and the growth of activities targeting interventions at those who display low or moderate risk of harm is justified. It has been argued that analogies with tobacco and alcohol are overstated and that a strong a focus on interventions aimed at the low end or risky behaviour represents an 'overreach of policy and regulation' because the evidence for harm at these levels, and the idea of there being a continuum of gambling harm is not established yet to the same degree of evidence for tobacco and alcohol related harm (Delfabbro and King 2017). In many ways, the perspective put forward by Delfabbro and King (2017) represents a continuation of the debate between adoption of either a bio-medical approach or a public health approach to gambling harm minimisation, and the conceptual and methodological difficulties common in many developing fields of scientific research. The cautions raised by Delfabbro and King (2017) have a lot of validity, however, rather than limiting public health orientated action, it has been argued that the merits of the public health approach remain and the points raised demonstrate the need for ongoing independent scientific research effort that addresses the issues in a range of ways (Abbott 2017b ; Browne and Rockloff 2017).

CONTINUOUS AND NON-CONTINUOUS TYPES OF GAMBLING ACTIVITY

The terms continuous and non-continuous gambling are used to differentiate between two main types of gambling activity that research suggests are associated with different risk levels for harm occurring (Abbott et al 2014a ; Abbott et al 2014b).

Continuous gambling activities are characterised by providing the opportunity for a continuous, repeated cycle of placing a stake, playing, determination of a win or loss, and the ability to collect and reuse winnings. Examples include non-casino gambling machines (NCGMs), casino table games, betting on horse or dog races, and scratchy cards. These types of activities have been shown to be associated with higher risk levels of gambling harm.

Non-continuous gambling forms contrast with continuous forms in that there is a delay of many hours or days between placing a stake or buying a ticket and the determination of a win or loss. The most common examples are Lotto and raffles. Because the gambling behaviour is non-continuous, the risk of harm occurring is lower.

INEQUALITY, DISPARITY AND INEQUITY IN GAMBLING HARM

Where there are differences in health experience between population groups, for example on average females live longer than males, these are usually referred to in the health literature as a 'health inequality'. Where the differences are large, they are referred to as a health 'disparity'. The presence of a health disparity may indicate the existence of a health 'inequity'. The concept of inequity is often associated with 'fairness'. The presence of an inequity may not indicate 'unfairness', depending upon the cause of the inequity and the size of the disparity. In health, an

inequity is deemed to exist where the presence of the disparity is attributed to social, cultural and economic factors rather than bio-medical factors.

Well recognised inequalities in health, including gambling, often occur between groups because of a range of socio-economic, cultural and biological factors. The most common factors are:

- Sex
- Age
- Social deprivation
- Ethnicity
- Education

A number of gambling research studies have demonstrated the presence of inequalities and inequities in gambling harm 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).

The following tables and figures illustrate some examples of gambling harm inequality and probable in-equity between the ethnic groups, given the size of some of the differences. Using odds ratios[2], Table 1 shows the results of analysis of the responses to the 2016 Health and Lifestyle Survey (HLS) by a range of gambling predictors (the top heading line) and population groups of interest (e.g. Ethnicity, Gender, Social Deprivation in the vertical heading line). The brown arrows in the table show the direction of comparison between the groups. The numbers reported are statistically significant at a range of levels. Time series analysis of several years of HLS results shows that these inequalities have persisted for some time (Thimasarn-Anwar et al 2017).

For example, the odds ratios in Table 1 shows when comparing the Asian group to European/Other group, the number reported for 'predictors of moderate-risk/problem gambling' indicates that the Asian experience is 9.5 times higher than European/Other. Māori are second at 4.7 times higher. Statistically these differences are significant. In contrast risks for the Pacific group risk in this category of predictors is estimated to be 2.4 times higher compared to European/Other. It is interesting to note that in terms of overall gambling service utilisation, the table indicates that there is substantive underutilisation of services by the Pacific and Asian groups. This is shown by looking at the numbers in the column 'predicators for those who contact gambling problem services', where the numbers are significantly lower for these two population groups given the levels of gambling harm occurring in these two population groups.

[2] An odds ratio is a statistical measure of association between an exposure and an outcome. In this case between gambling behaviour, harm, and the other variables of interest – such as service utilisaton. The odds ratio provides an estimate of the size of the outcome for a given amount of exposure to the event causing the outcome. It is one way that enables researchers to statistically make direct comparisons between population groups.

Table 1: Examples of Gambling Inequalities in the New Zealand Population: Odds Ratios (HLS 2016)

Substantive inequality between ethnic groups

Ethnicity	Predictors of low risk gambling	Predictors of moderate-risk/problem gambling	Predictors of any level of risky gambling	Predictor for participants who agreed on the statement of someone close gambling more than intended
Māori	1.93*	4.7***	2.61***	2.84***
Pacific	3.54***	2.4	3.21***	1.96**
Asian	2.07	9.5*	3.24*	0.26**
European/Other	Reference	Reference	Reference	Reference

Ethnicity	Predictors of being impacted by someone else's gambling	Predictors of going without because of someone's gambling in the household	Predictors for those who contact gambling problem services	Predictors for respondents who have seen/heard a gambling harm advertisement
Māori	2.15***	3.48***	3.14**	0.99
Pacific	0.88	1.33	1.21	0.62**
Asian	0.7	0.63	0.31	0.31***
European/Other	Reference	Reference	Reference	Reference

Under-utilisation at a level indicating an inequity and disparity given harm levels in top row

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Figure 1 shows data illustrating significant inequality, disparity and inequity between New Zealand populations groups by socio-economic status as measured by the social deprivation index. The figure shows the distribution over a number of years of the location of Class 4 Electronic Gambling Machines (EGMs or pokies) between different socio-economic population groups. In the figure approximately 50% of all EGMs (which research has shown is the source of the highest risk of harmful gambling activity) are in the most socio-economically deprived areas (i.e. poorest areas of the country). Economically, these are the groups who least can afford the financial losses from gambling and experience the health harm arising from the risky gambling activity.

Inequities between Māori and non-Māori and between Pacific peoples and non-Pacific peoples have been present for a long time in New Zealand. Inequities between socio-economic groups are also not new. Evidence from the New Zealand Burden of Diseases, Injuries and Risk Factors Study[3] has shown that while absolute levels of health inequity and inequity have reduced in population groups' overtime, the relative levels of inequality and inequity between population groups remains.

Figure 22, using data from the New Zealand Health and Lifestyle Survey (HLS) illustrates that this also appears to be the case for gambling harm. When comparing the 2010 HLS results for each ethnic group, and comparing them to the latter results for 2012, 2014, 2016 years, we can see that for each group (Māori in particular), there has been a reduction in the absolute level of harm (refer to red circle for an example of the comparison), however when comparing each group over time, the

[3] Ministry of Health. 2016. *Health Loss in New Zealand 1990–2013: A report from the New Zealand Burden of Diseases, Injuries and Risk Factors Study*. Wellington: Ministry of Health.

existence of relative inequality between the ethnic groups remains (refer to the green circle for the comparison).

Figure 1: Examples of Inequality in New Zealand Population by Deprivation: Class 4 venues. Source DIA

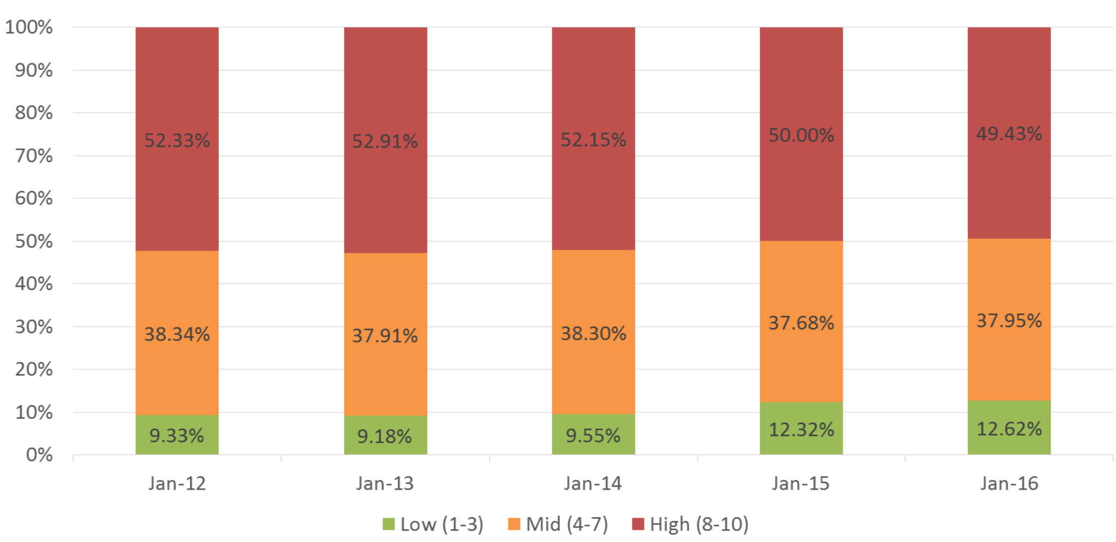
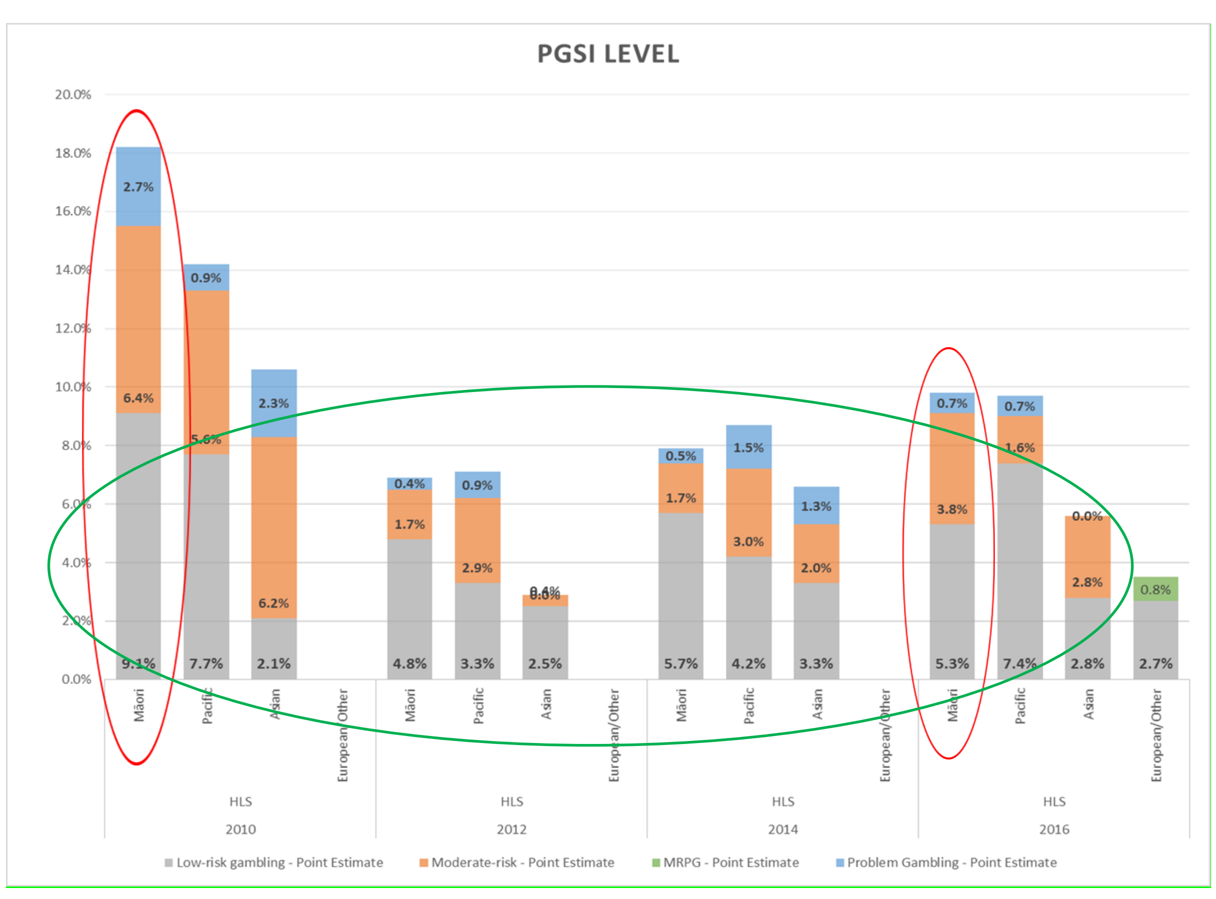


Figure 2: Absolute and Relatives Inequalities Overtime between NZ Ethnic Groups in Gambling Harm Experience, 2010-2016



POPULATION BURDEN OF GAMBLING HARM

The population burden of gambling harm originates in the idea that a person's health occurs not only at the individual bio-medical level, it is also heavily impacted by a network of social and economic relationships. The population approach steps back from looking at the individual, to looking at groups of people to find a wider set of common associations with the experience of health. The approach rejects the idea of the isolated totally independent and free individual, rather individuals operate within a network of relationships that heavily impacts upon their health condition and their experience of what health and wellness means.

The approach has highlighted the presence of 'health inequalities' between population groups, and where the differences are large and substantively associated with specific social situations (for example poverty) the inequalities are typically described as representing 'health inequities' as they are caused by factors other than bio-medical explanations. The approach has led to research across a broad range of public health issues, highlighting that effective policy and service interventions are those designed with an understanding of the social, cultural, economic characteristics of the target population.

Because of the broader approach of the population perspective to thinking about health and harm, the burden of harm associated with a health issue takes on a different dimension both in terms of scale and complexity from the more focussed individual model.

Recently Browne et al (2017) at Central Queensland University and Auckland University of Technology combined the PGSI with methodologies from welfare economics and public health epidemiology to produce Quality Adjusted Life Years (QALYs) estimates of the New Zealand population burden of gambling harm. While the approach is new to the field of gambling, it is not new to other areas of public health research. This approach is likely to be seen as controversial by some due to both:

- its extension of the burden of harm beyond the traditional strict medical model set out in the DSM IV criterion
- the use of welfare economics principles, and the weights applied by the researchers to various health harms (conditions) associated with PGSI 1+ levels of gambling behaviour to calculate the QALYs.

The underlying epidemiology methodological approach used by Browne et al (2017) is well established and used by the World Health Organisation to produce the Global Burden of Disease estimates (Murray and Lopez 2017). The welfare economics approach and QALYs have also been used in other health/social sector fields such as injury prevention and family violence prevention. The appropriateness of such use in the New Zealand context has been discussed from an economics perspective by Guria and Yeabsley (2014). Both these authors are well respected researchers with NZIER for many years, and have a detailed understanding of the application of economic social trade-off methods, and the QALY concept in health decision-making.

Although the Browne et al (2017) approach is currently novel in the problem gambling research field, it is expected that through the normal course of research development the approach is likely to spread, and be subjected to checking and refinements over time by other researchers internationally. The Ministry will watch these developments with interest.

See the section 'Alternative estimate of level of harm occurring in the New Zealand population' for a brief summary of the key findings of the research, and a web link to access the report.

SOCIAL COST OF GAMBLING HARM – AN ECONOMICS APPROACH

Inherent in the concept of 'healthy gambling' suggested by Korn and Shaffer (1999) is the idea of there is an economic and social trade-off between the benefit and harm accruing from gambling activity and that a dollar figure can be placed on this. In 2009 the Australian Productivity Commission reported an analysis that suggested in 2008/09 in Australia there were:

- large tax and consumer benefits from gambling, lying in the range between $12.1 and $15.8 billion
- large social costs associated with gambling, lying in the range of $4.7 to $8.4 billion
- indication that overall large net social benefits from gambling of $3.7 to $11.1 billion (Commission. 2010).

Recently, Sapere Research Group (Rook et al 2018) have noted that from an economics perspective that those in the most economically deprived areas of New Zealand bare a disproportionate level of economic harm from gambling both in terms of the losses they incur from gambling expenditure, and the lower level of economic return to their communities from gambling proceeds.

The use of the social trade-off approach is controversial in health economics and public health policy decision-making. Wren and Barrell (2010) have reviewed, explained and discussed the use of such economic methods in policy terms in the New Zealand public health policy space. Guria and Yeabsley (2014) have also discussed the use of such methods in more economic technical detail.

CANADIAN PROBLEM GAMBLING INDEX (CPGI) AND ITS ASSOCIATED PROBLEM GAMBLING SEVERITY INDEX (PGSI)

Beginning in 1997 the Canadian Problem Gambling Index (CPGI) and its sub-component the Problem Gambling Severity Index (PGSI) were developed by Ferris and Wynne (2001) in response to a Canadian inter-provincial government initiative to measure problem gambling across Canada. The key result of the initiative was publication in 2001 of the CPGI, which included a subset of questions that have come to form the PGSI.

The questions developed were informed by the Southern Oaks Gambling Screen and the DSM IV criterion about gambling behaviour and associated harm. The final set of questions, responses and scoring of them were designed to be suitable for use in general population surveys.

Through extensive testing at the time, and since by a range of researchers in different populations, the questions have been shown to be highly valid, reliable, sensitive and specific in identifying a range of gambling behaviours and associated levels of harm.

The full set of 31 questions in the CPGI aims to measure:

- respondents level of involvement in gambling
- the degree to which the behaviour reported represented a risk of harm occurring
- general types of harm occurring associated with the behaviour
- the demographic characteristics of respondents.

The PGSI component of the CPGI consists of nine questions focussed upon assessing the degree to which the self-reported gambling behaviour represents a problem in terms of a continuum of behaviour and frequency of harm that can be categorised as representing:

- Non-gambling
- Non-problem gambling
- Low risk gambling
- Moderate risk gambling
- Problem gambling

Figure 3: Illustration of the Problem Gambling Severity Index Questions, Responses and Scoring

When you think of the past 12 months, have you bet more than you could really afford to lose?

0 Never 1 Sometimes 2 Most of the time 3 Almost always

Still thinking about the last 12 months, have you needed to gamble with larger amounts of money to get the same feeling of excitement?

0 Never 1 Sometimes 2 Most of the time 3 Almost always

When you gambled, did you go back another day to try to win back the money you lost?

0 Never 1 Sometimes 2 Most of the time 3 Almost always

Have you borrowed money or sold anything to get money to gamble?

0 Never 1 Sometimes 2 Most of the time 3 Almost always

Have you felt that you might have a problem with gambling?

0 Never 1 Sometimes 2 Most of the time 3 Almost always

Has gambling caused you any health problems, including stress or anxiety?

0 Never 1 Sometimes 2 Most of the time 3 Almost always

Have people criticized your betting or told you that you had a gambling problem, regardless of whether or not you thought it was true?

0 Never 1 Sometimes 2 Most of the time 3 Almost always

Has your gambling caused any financial problems for you or your household?

0 Never 1 Sometimes 2 Most of the time 3 Almost always

Have you felt guilty about the way you gamble or what happens when you gamble?

0 Never 1 Sometimes 2 Most of the time 3 Almost always

Total your score. The higher your score, the greater the risk that your gambling is a problem.

Score of 0: Non-problem gambling.
Score of 1 or 2: Low level of problems with few or no identified negative consequences.
Score of 3 to 7: Moderate level of problems leading to some negative consequences.
Score of 8 or more: Problem gambling with negative consequences and a possible loss of control.

Ferris, J., & Wynne, H. (2001). The Canadian problem gambling index: Final report. Submitted for the Canadian Centre on Substance Abuse.

Source: https://www.problemgambling.ca/EN/Documents/ProblemGamblingSeverityIndex.pdf

(Accessed: 4 August, 2017)

Whether a behaviour represents a risk depends upon the responses to the questions and associated scores. In answer to each question, respondents are able to respond with either 'Never', 'Sometimes', 'Most of the time' and 'Almost always'. These responses represent a continuum of frequency of both behaviour and experience of harm. Each of these answers is associated with a score ranging from 0, 1, 2 and 3 respectively. The scores are added up to give a total score, which can range from 0 to 27. Four categories of score were established associated with levels of gambling behaviour and associated frequency (risk) of harm. The scores associated with different levels of behaviour and risk are:

- 0 = 'Non-problem'
- 1-2 = 'Low risk'
- 3-7 = 'Moderate risk'
- 8+ = Problem (Ferris & Wynne, 2001:37-38).

It should be noted that the category of 'Low risk' does not mean no harm, just that the number and frequency of harm self-reported by the respondent as occurring is most often described as 'sometimes', in contrast to the higher levels of frequency represented by 'Most of the time' and Almost always' (Ferris & Wynne, 2001: Table 15). Ferris & Wynne go on to comment that in public health/health promotion terms, the categories of 'Low' and 'Moderate risk' represent a practical

division in terms of what to DO with the groups once identified….(and represent) possible targets for prevention (primary, secondary, and tertiary) (Ferris & Wynne, 2001:35).

Harm in the PGSI is described in terms of the frequency of:

- the gambler experiencing feelings of guilt
- the gambling behaviour causes financial problems to the individual and / or family and affected others
- others criticising the gambling behaviour being observed
- the gambler experiencing health problems, including anxiety and stress.

In more recent years, public health research reporting of the PGSI categories in survey results has extended to include the number of respondents who scored 0, and to report the prevalence estimates for each of the gambling behaviour categories (Centre. 2011). This approach has a lot of merit as it gives a sense of the size of a range gambling behaviours in a population, and recognises that even low levels of gambling behaviour are associated with harm to them, their family and wider associates.

Other researchers have also recommended using cut-off scores of 3+ or 4+ to describe 'problem gambling' for population health intervention purposes. This approach, aligns well with Rose's approach to population health promotion (Rose 1985 ; Rose 1992). For similar discussions, see Centre. (2011), Rodgers et al (2015), and Walker et al (2010).

PART 2: KEY THEORIES / MODELS OF GAMBLING BEHAVIOUR, HARM AND INTERVENTION

A 'theory' or 'model' is a set of generalised ideas that explain a phenomena of interest. A theory using a set of rules and facts aims to join together a group of concepts into a coherent framework that explains a behaviour or phenomena of interest. For example, an explanation for risky gambling behaviour or why there are fluctuations in the incidence and prevalence of gambling harm in the population overtime.

AVAILABILITY THEORY - AN EXPLANATION FOR CHANGING LEVELS OF GAMBLING ACTIVITY IN THE POPULATION

Proponents of Availability Theory suggest that increased availability (i.e. increased exposure) to gambling activities leads to increased levels of gambling behaviour and associated harm (Abbott 2017a). One of the earliest articulations of this view was by Volberg (1994).

There is some evidence for the theory. Research has shown that when a new gambling product is introduced to the market, levels of gambling activity increase. However, evidence also suggests that after a period of time – for example six months – gambling activity levels decline back to levels similar to those preceding the launch of the product. This suggests that there are other influences of gambling behaviour at work in the social environment (Abbott 2017a). Abbott also argues that since the 1980s the history of gambling in New Zealand exhibits features of both availability and adaptation theory.

ADAPTATION THEORY – AN EXPLANATION FOR CHANGING LEVELS OF GAMBLING ACTIVITY IN THE POPULATION

Adaption Theorists argue that gambling behaviour is influenced by a range of other factors than just the level of access (i.e., availability/exposure) to gambling activities (Abbott 2017a). Furthermore, gambling behaviour is amenable to change by the use of a range public (population) health orientated interventions (Abbott 2006).

Abbott has argued that since the 1980s, the history of gambling in New Zealand exhibits features of both availability and adaptation theory.

MENTAL HEALTH MEDICAL MODEL OF GAMBLING BEHAVIOUR

Research based thinking about gambling stems from two streams of thought that are often described as the mental health 'medical model' and the 'population/public health' model respectively (Rodgers et al 2015).

The mental health medical model of gambling became prominent through the work of the American Psychiatric Association (APA), and its 1980 publication of the third edition of its Diagnostic and Statistical Model of Mental Disorders (DSM III). It is called the medical model, because the model

sees 'mental disorders' as a 'subset of medical disorders', and uses medical disease classification techniques to identify and group a wide range of individual behaviours and mental states of wellbeing (Mayes and Horwitz 2005).

In DSM III, the APA for the first time formally recognised 'pathological gambling as a disorder of impulse control' (Lesieur and Rosenthal 1991). DSM III described pathological gambling as a clinically significant behavioral/psychological disorder that could be clinically diagnosed using defined criteria. With the inclusion of the diagnosis of 'pathological gambling in the DSM, the issue of gambling received greater prominence in the health sector and broader research community.

The success and influence of the DSM III approach (and subsequent editions) lies substantively in (i) providing a clinically orientated common language and standard criteria for the classification of mental disorders, and (ii) its basis in reviews of the published research literature that is recognised as authoritative by psychiatrists, associated clinicians and mental health treatment providers. Since the publication of DSM III, the medically orientated approach to diagnosis and treatment of mental health and a wide range of behaviours has become widely accepted in the western world. For many practicing psychiatrists and professional mental health workers, the DSM is the dominant reference point for their practice.

Since gambling's initial inclusion in DSM III, the criteria for what defines 'pathological gambling' has evolved over time and has been subjected to a number of criticisms by researchers. In response to the criticisms of the original criteria, and with a review of the growing body of new research in the 1980s on gambling diagnosis and treatment, the criteria have been revised in DSM IV (Lesieur and Rosenthal 1991) and DSM V (Reilly and Smith 2014). With DSM V, two key changes were introduced. Gambling was reclassified as an addiction, and the threshold for diagnosis of a gambling disorder was reduced from a requirement for five out of nine factors being present to four out of nine (Reilly and Smith 2014) .

PUBLIC HEALTH CRITICISMS OF THE MEDICAL MODEL

While the strength of the DSM approach is its basis in a broad range of medical orientated research, this has not prevented the DSM criteria from being controversial. Beginning in the late 1990s, a growing body of public health orientated research has criticised the mental health medical model for ignoring the social and economic context in which problem gambling arises, inherently blaming the individual for their addiction, and for treatment interventions that don't take into account the importance of family and friends in problem identification, care and recovery. In addition, the approach has been criticised for leading to a focus on the identification and quantification of harm only in terms of the individual gambler (Messerlian et al 2004).

POPULATION/PUBLIC HEALTH MODEL OF GAMBLING BEHAVIOUR

In contrast to the medical approach, the population/public health approach to gambling is a relatively new field of research and activity that began to emerge in the 1990s.

In 1993 the Canadian Public Health Association (CPHA) formally recognised that gambling was a public health issue. Resolution No 14 summarised the evidence base and called for a health impact assessment of regulated gambling in Canada (Canadian Public Health Association. 1993). This was

followed in 1999 by a new resolution on video lottery terminals (Canadian Public Health Associaton. 1999). These resolutions set out the parameters for discussion of problem gambling from a public health perspective and were important in raising awareness of the issue amongst public health researchers and practitioners.

Following on from the CPHA activity, the first comprehensive public health approach to problem gambling was first described by Korn and Shaffer (1999). The Korn and Shaffer framework (see sections on Spectrum of Gambling Behaviour and Harm respectively), also known as harm reduction, acknowledges the importance of the mental health model, but argues that gambling has wider health dimensions to it that must also be acknowledged and incorporated into a holistic understanding and response to preventing and minimising gambling harm. The original Korn and Shaffer approach currently informs the Ministry of Health's *New Zealand Strategy to Prevent and Minimise Gambling Harm 2016/17 to 2018/19.*[4]

Rodgers et al (2015) suggest other important early public health orientated research were papers by:

- Volberg (1994) linked gambling to the availability of gambling opportunities, and importantly set out a number of other aspects problem gambling prevention, including:
  - presenting the concept of the continuum of gambling behaviour with pathological gambling at the most extreme end
  - describing characteristics distinguishing pathological gamblers from other gamblers in the population
  - identifying particularly at risk groups
  - observed that childhood exposure to gambling was a predictor of later behaviours.
- Volberg and Abbott (1994) on the results of the New Zealand National Gambling Survey, which presented prevalence estimates of problem gambling in the New Zealand population
- Gaboury and Ladouceur (1993) on gambling prevention in five Quebec schools
- Orford (1994) on gambling by young men and the importance of family and friends in addiction prevention.

RESPONSIBLE GAMBLING (THE RENO MODEL) – A STRATEGIC FRAMEWORK FOR REGULATION

The Responsible Gambling model sets out a framework that its proponents argue comprise 'a set of science based strategic principles and guidelines for developing, implementing, and maintaining responsible gambling activities'. The framework is also known as the Reno model due to its original development at a meeting by the original authors in Reno, Nevada (Blaszczynski et al 2004) .

The framework was developed as a counter to regulatory policies seen as derived from 'anecdotally-based socio-political influences', and as a response to a lack of conceptual clarity about what gambling harm is, how to measure it, and development of consensus about what to do about minimising gambling harm (Blaszczynski et al 2004). By following the framework, the intent was to inform the development of more 'scientifically informed policies' focussed on preventing and minimising gambling harm in general, and harm from 'excessive gambling behaviour in particular' (Blaszczynski et al 2004 ; Ladouceur et al 2016).

[4] http://www.health.govt.nz/publication/strategy-prevent-and-minimise-gambling-harm-2016-17-2018-19

The framework has been influential in shaping regulatory responses in a number of jurisdictions as it calls for 'industry operators, health service and other welfare providers, interested community groups, consumers and governments and their related agencies' to work together to implement 'responsible' harm minimisation activities (Blaszczynski et al 2004).

Key features of the model are that the key stakeholders (including gambling industry, clinicians and harm minimisation advocates, and regulators) will:

- commit to reducing the incidence and ultimately the prevalence of gambling-related harms
- work collaboratively, and inform and evaluate public policy aimed at reducing the incidence of gambling-related harms
- collaboratively identify short and long-term priorities for an action plan to address within a recognized time frame
- use scientific research to guide the development of public policies
- the action plan will be monitored and evaluated using scientific methods (Blaszczynski et al 2004).

In-addition, in 2016, the key proponents of the Reno model have argued that research evidence suggests that 'best practice' for 'responsible gambling' activity should include the following activities:

- promote and enable self-exclusion by problem gamblers
- the development of gambling behaviour algorithms that can identify sentinel events
- introduction of gambler limits
- introduction of 'responsible' gambling machine features
- employee training (Ladouceur et al 2017).

All these features of the Reno framework and activities can be seen in the New Zealand regulatory approach to gambling harm minimisation set out in the Gambling Act 2003, the process the Ministry follows for developing its three year service plans, and the activities in the Ministry Service Plans in recent years.

While the Reno Model has been influential in terms of shaping regulatory frameworks in a number of jurisdictions internationally, it has been subject to criticism, and the original regulatory tensions identified by the authors remain in spite of the general acceptance of the framework by regulators. The main criticisms of the Reno Model are that the framework emphasises individual responsibility for harm and harm reduction, focuses harm minimisation activities on clinical treatment, and provides 'justifications for compromised responsible gambling regulation' (Hancock and Smith 2017). Hancock and Smith (2017) have proposed that a revised Reno Model should be adopted that places a stronger emphasis on 'consumer protection', which includes the adoption of public health principles, consumer protection, duty-of-care, and ideas of regulatory responsibility (Abbott 2017b). In terms of tensions, these relate to ongoing debate around how to define and measure gambling harm, and then achieving consensus on what to do. These tensions are readily apparent in the New Zealand policy debate about where the focus of gambling harm prevention should be, and in the debate about the applicability of the prevention paradox to gambling harm reduction (Browne and Rockloff 2017 ; Delfabbro and King 2017).

The current Ministry approach includes elements of the Hancock and Smith (2017) extension of the Reno Model. Elements include the explicit adoption of a strong public health approach, clear delineation of regulatory responsibility, acceptance by government agency officials and professional

harm minimisation service providers of a of duty-of-care and growing focus on the consumer. The idea of care also extends to many gambling providers in New Zealand – particularly those in community venues.

SPECTRUM OF GAMBLING BEHAVIOUR: KORN AND SHAFFER (1999)

Korn and Shaffer (1999) set out a 'spectrum of gambling' (see Figure 4 page 23) that combines a mix of the medical model and public health ideas about gambling harm that runs through the following states: No gambling; Infrequent (light) gambling; Frequent (heavy) gambling; Problem Gambling; Pathological Gambling (Korn & Shaffer, 1999:308 in Rodgers et al, 2015:21).

- 'Problem gambling' was described in the context of DSM IV as a level of behaviour that represented meaningful problems associated with social costs and involving public health and welfare, but which where sub-clinical problems' at the individual level of behaviour.
- Pathological gambling was described in the context of DSM IV as behaviours that were clinically significant at the individual level.
- The other states of harm recognised that harm was not localised to just the gambler, but also affected significant others including family/whānau, friends and the workplace.

It is important to note that the terms 'problem gambling' and pathological gambling' have their basis in the widely accepted DSM IV criteria. Over time, the distinctions between the two categories have become a point of debate about where to focus harm minimisation efforts, and how to most accurately report the level of health harm occurring in the wider population arising from individual gambling activities. In the last 5 to 7 years, a number of public health researchers have argued that lower levels of gambling behaviour and associated harm does not mean no risk and no harm of concern. Rather, low levels of harm do impact upon family/whānau function and health, and more harmful behaviours develop out of the lower levels of behaviour. Recently, public health researchers have begun to argue that the harm occurring at all the lower levels when added up cumulatively, represents a level of harm at the social level that is much higher than that just reported at the severe problem gambling level (Browne et al 2017). Consequently, they argue, harm reduction should actively target early interventions at the population group comprising the infrequent and frequent gambling groups as well as the 'problem gambling' group. It is important to note that these interventions at the lower level of harm will take a different form to those at the severe end of gambling activity and harm.

The concept of the 'spectrum of gambling behaviour' is closely associated with the idea of the 'spectrum of gambling and health' – see next section.

SPECTRUM OF GAMBLING AND HEALTH/HARM

Closely following the spectrum of gambling behaviour, Korn and Shaffer (1999) described a 'spectrum of gambling and health', which aligned standard public health interventions terminology such as 'primary' and 'secondary' prevention, and 'brief' and 'intensive' treatment with three categories of gambling behaviour comprising the terms: (i) 'no gambling', (ii) 'healthy gambling', and (iii) 'unhealthy gambling'. These three categories were depicted as a pyramid with 'no gambling' at

the base and ‘unhealthy gambling’ at the top tip (Korn & Shaffer, 1990:330 in Rodgers et al, 2015:22).

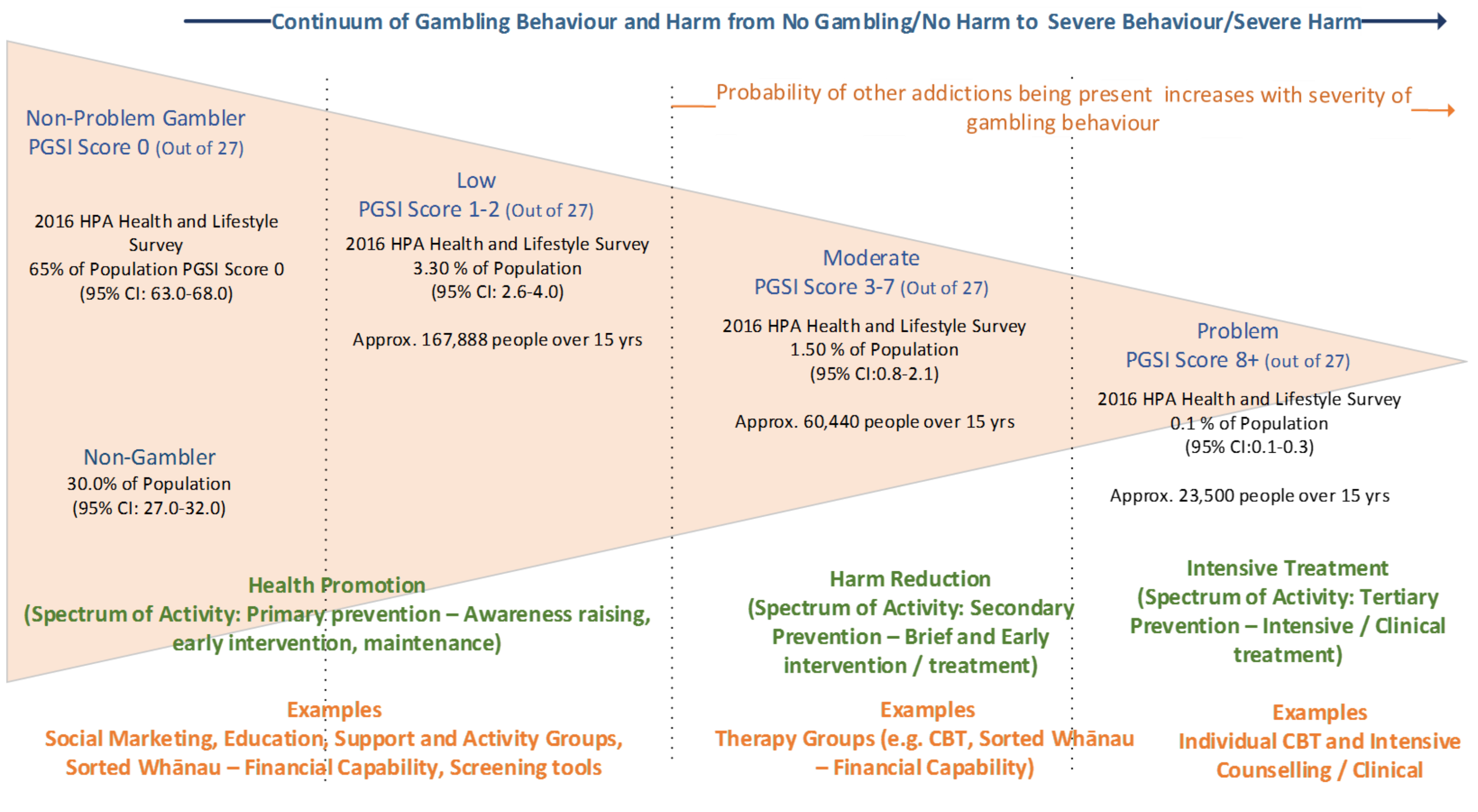
Associated with these three categories were the notions of ‘gambling problems’ that were named ‘none’, ‘mild’, ‘moderate’ and ‘severe’ gambling problems. The mild, moderate and severe problems were associated with the beginning and end points of the ‘unhealthy’ tip of the pyramid.

What each of these groups of gambling problems meant though were not fully set out by Korn and Shaffer (1999). They did note though that gambling not only impacted upon the individual as described in the DSM III, it also impacted upon the immediate family, friends and wider society through damaging work relationships and social groups impacted by the behaviour and associated harm. This type of harm was described as secondary harm.

Korn and Shaffer (1999) recommended the development of a brief screening survey capable of identifying probable harmful gambling behaviours, associated levels of harm, and discriminating between levels of gambling behaviour and associated harm. The Canadian Problem Gambling Index (CPGI), and its subsidiary the Problem Gambling Severity Index (PGSI) were subsequently developed through a rigorous research program by Ferris and Wynne (2001) to provide a valid measure of gambling behaviour and associated harm (Walker et al 2010).

The following figure adapts the original Korn and Shaffer (1999) spectrum of gambling behaviour, and populates it with 2012 estimates of the common categories of gambling behaviour described using the PGSI scoring, and overlays examples of public health intervention.

Figure 4: Continuum of Gambling Behaviour, Harm, and Intervention



Source: Adapted from Korn & Shaffer (1999). Wren, J. New Zealand Ministry of Health. 20 March 2018

DYNAMIC CAUSAL LOOP MODEL FOR GAMBLING BEHAVIOUR – A NEW INNOVATION

A relatively recent innovation in public health service planning is the use of dynamic systems loop models to understand the directional influence of key causes of public health issues, and points for effective intervention (including treatment) (Homer and Hirsch 2006 ; Trochim et al 2006).

Dynamic systems loops models have been developed in recognition that traditional linear models of public health systems and individual behaviour such as the Korn & Schaffer model, do not well reflect the dynamic nature of public health issues that occur in complex socio-economic systems. In addition, traditional linear models are rarely helpful for service planning and policy decision-making in terms of understanding the directional nature and size effect between cause and effect (including the influence of time) or where effective points for intervention might occur and what change the intervention will have on the system in terms of change in activity and time.

The model on the following page (Figure 5) has been developed by the author of this guide to illustrate a research based system level model of the cause and effect relationships influencing gambling behaviour in New Zealand, and where the various points available for public health intervention (including clinical treatment) are (Figure 6). The model aims to recognise the social and individual dynamics influencing gambling behaviour. Through the use of arrows and symbols – refer to the legend – the aim is to better illustrate the direction of various causes, the direction of influence on behaviour in terms of increasing or decreasing gambling behaviour and harm, the influence of time, and where public health interventions (including treatment) can be used to minimise harmful gambling behaviour at the population and individual level in the system.

Figure 5: Gambling Behaviour Dynamic Systems Loop Model

Gambling Addiction and Harm Loop

Financial Capability (Sorted Whānau)

Perceived probability of Financial benefit

Enjoyment benefit

Education about alternatives / addictions

Screening

Presence of other Addiction co-morbidity / Mood & Anxiety Disorder

HP Advertising / Regulation

Individual Propensity towards Gambling Activity & Ease of Access

R+

Advertising and New Product enticement

Experience of Harm or benefit to individual, family/whanau / significant others *(PGSI Score)*

Participation in Gambling Activity

Probability of harm

Regulation

Type of gambling activity

HP Education / Advertising

Treatment Loop

Evidence based customer focussed service design

Access to attractive services

Awareness raising of services

Gambler's Propensity to Seek Support / Treatment

B+

Support / Treatment Provided

Upskilling of workforce Promotion of service standards

Early & Clinical Orientated Interventions

→	Influencers of gambling behaviour
-	Variables move in opposite direction to each other
+	Variables move in same direction to each other

Source: Wren, J. New Zealand Ministry of Health, March 2018.

Figure 6: Points of Intervention Gambling Harm Minimisation in a Dynamic Systems Loop Model

Gambling Addiction and Harm Loop

Financial Capability (Sorted Whānau)

Perceived probability of Financial benefit

Enjoyment benefit

Education about alternatives / addictions

Screening

Presence of other Addiction co-morbidity / Mood & Anxiety Disorder

HP Advertising / Regulation

Individual Propensity towards Gambling Activity & Ease of Access

R+

Advertising and New Product enticement

Experience of Harm or benefit to individual, family/whanau / significant others (PGSI Score)

Participation in Gambling Activity

Probability of harm

Regulation

Type of gambling activity

HP Education / Advertising

Treatment Loop

Evidence based customer focussed service design

Access to attractive services

Awareness raising of services

Gambler's Propensity to Seek Support / Treatment

B+

Support / Treatment Provided

Upskilling of workforce Promotion of service standards

Early & Clinical Orientated Interventions

→	Influencers of gambling behaviour
-	Variables move in opposite direction to each other
+	Variables move in same direction to each other

Source: Wren, J. New Zealand Ministry of Health, March 2018.

HOW IS GAMBLING HARM DEFINED IN NEW ZEALAND POLICY?

In the New Zealand policy and regulatory context gambling harm is legally defined in the New Zealand Gambling Act 2003 as:

> 'Harm or distress of any kind caused or exacerbated by a person's gambling and includes personal, social or economic harm suffered by the person, their spouse, partner, family, whānau and wider community, or in their workplace or society at large.'

This definition aligns with the broad public health approach to thinking about harm, where harm involves anything that leads to negative health and social wellbeing (including economic) impacts upon the individual, and or their family/whānau and or others in the community such as an employer.

The broadness of the definition also means there are many different ways of measuring the harm occurring at the individual and social level respectively. This can lead to some confusion about the level of harm being talked about or reported in any given document, and whether the measure being used is appropriate for the type or level of harm that is being reported.

This broad definition can also lead to policy debate about which harm is more significant and where should harm reduction activities be focussed. For example, the mental health medical model focusses on the individual level of gambling behaviour and harm – 'the problem gambler'. Gambling harm is defined by the PGSI score and associated DSM IV criteria. A consequence of this approach is that interventions tend to be limited to this relatively small group of people, and interventions are clinically orientated.

In contrast, population/public health researchers argue that harm is also experienced by the gambler's family/whānau and other social groups connected to the gambler – for example an employer. Harm in this context can be measured in a number of ways. A recent innovation in the gambling research literature to reporting the population burden of gambling associated harm is the use of Quality Adjusted Life Years (QALYs) by Browne et al (2017) using New Zealand data. This approach is novel in

Measuring Types of Harm

Problem Gambling Severity Index (PGSI) – a commonly used method to measure harm to the individual and in the population

The most common method widely used method in a number of countries to measure harm to the individual and in the population as a whole is the PGSI score (see section on PGSI).

Harm in the PGSI is described in terms of the frequency of:

- the gambler experiencing feelings of guilt
- the gambling behaviour causes financial problems to the individual and / or family and affected others
- others criticising the gambling behaviour being observed
- the gambler experiencing health problems, including anxiety and stress.

The more frequent these experiences are reported using the scale, the higher the level of harm occurring to the individual, and in the population when the individual scores are pooled together.

See the section on 'What is the Canadian Problem Gambling Index (CPGI) and its associated Problem Gambling Severity Index (PGSI)' for more detail.

Recently Browne et al (2017) have used the Quality Adjusted Life Years (QALYs) method to quantify gambling harm at the population level in New Zealand.

the international gambling research literature, however it is a well-established approach in the communicable diseases literature. The population health approach to harm leads to an emphasis upon adopting a broader range of activities targeting the full spectrum of gambling behaviour and associated harm.

HOW GOOD IS THE CPGI AND PGSI IN IDENTIFYING AND CLASSIFYING A RANGE OF GAMBLING BEHAVIOURS AND ASSOCIATED HARM?

The CPGI and the PGSI component is substantively based on psychiatric/psychological clinical diagnostic criteria, which includes both behavioural and harm characteristics. Testing of the PGSI suggests that both factors work together in the same measure to reliably produce clinical based estimates of individual level risk and associated harm from the persons gambling activity. Numerous research studies have demonstrated the utility of the PGSI to distinguish between different levels of gambling behaviour and to measure the presence of problem gambling (defined in clinical orientated terms as those with a score of 8+) in a population (Centre. 2011 ; Rodgers et al 2015 ; Walker et al 2010).

It should be noted though that a clinical level assessment of harm does not automatically equate to the population level of harm associated with the individual level gambling behaviour. Social levels of harm are those that are additional to the individual level and arise from harm to family/whānau and others in the community – such as employers – whose health and wellbeing are negatively impacted by the gambling behaviour. It is for this reason that other measures using QALYs by Browne et al (2017) at Central Queensland University and Auckland University of Technology (AUT) have been recently promoted.

Because of the research robustness of the PGSI and its free availability and ease of use, it has become a popular survey tool used by public health researchers around the world and government agencies in Canada, Australia and New Zealand who are tasked with measuring the incidence and prevalence of problem gambling in their populations. However, recent reviews of the use of PGSI in public health literature have observed that the combination of behaviour and harm characteristics in the PGSI has posed some understanding and communication issues for public health researchers and policy decision-makers (Centre. 2011 ; Rodgers et al 2015 ; Walker et al 2010).

CRITICISMS OF THE PGSI

Over the last 10 years, a number of criticisms of the PGSI have been raised and debated (Centre. 2011 ; Rodgers et al 2015 ; Walker et al 2010).

One significant issue is the language used in the questions to assess the harm experienced by the respondent is quite general and lacks sufficient specificity to provide a hard measure of the extent of population level harm occurring. This problem extends to appropriateness of the cut-off scores presented by Ferris & Wynne (2001), and in particular whether the emphasis on the 'problem gambler' category is appropriate from a holistic public health perspective.

In recent years, a number of robust studies have suggested that for public health prevention/harm minimisation purposes, score thresholds of 3 or 4+ should be adopted as better representations of

the scale of gambling behaviour and associated harm occurring and for a strong public health/harm reduction response (for discussion of the research see Walker et al (2010), Centre. (2011), Devlin and Walton (2012), Rodgers et al (2015)). This issue has led to arguments for new methods to report the population level harm arising from problem gambling, or whether alternative measures should be used such as that recently published by Browne et al (2017).

HOW IS PROBLEM GAMBLING BEHAVIOUR AND HARM COMMONLY MEASURED?

A range of measures are to clinically diagnose and categorise a person's gambling behaviour, assess the level of harm occurring to them and their families/whānau, and to estimate the levels of different types of gambling behaviour occurring in the population. For a discussion of the various measures available, the reviews by Centre. (2011) and Walker et al (2010) are recommended. In New Zealand the most commonly used measure at the individual and population level is the PGSI.

WHAT IS THE NEW APPROACH TO QUANTIFYING POPULATION LEVELS OF HARM FROM GAMBLING ACTIVITY: USING THE PGSI TO CALCULATE NEW QALY BURDEN OF HARM ESTIMATES

Recent research by Browne et al (2017) at Central Queensland University and Auckland University of Technology have used the PGSI combined with welfare economics and public health epidemiology methods to produce QALY estimates of the population burden of problem gambling harm. This approach is new and novel to the problem gambling field of research, and is likely to be seen as controversial by some due to both:

- its extension of the burden of harm from beyond the individual to include a wider group of people associated with the gambler
- the welfare economics principles used and the subsequent weights applied by the researchers to various health harms (conditions) associated with all levels of gambling behaviour classed as PGSI 1+.

While the approach is new to the field of gambling, it is not new to other areas of public health research. The underlying epidemiology methodology used by Browne et al (2017) are well established and used by the World Health Organisation to produce the Global Burden of Disease estimates. The welfare economics approach and QALYs have also been used in other health/social sector fields such as injury prevention and family violence prevention. The appropriateness of such use in the New Zealand context has been discussed from an economics perspective by Guria and Yeabsley (2014). Both these authors are well respected researchers with NZIER for many years, and have a detailed understanding of the application of economic social trade-off methods, and the QALY concept in health decision-making.

Through the normal course of research development, the approach by Browne et al (2017) is likely to evolve over time and to be subject to checking and refinements by other researchers internationally. The Ministry will watch these developments with interest.

HOW MUCH RISK GAMBLING BEHAVOUR AND ASSOCIATED HARM IS OCCURING IN THE NEW ZEALAND POPULATION?

WHAT LEVELS OF PGSI HAVE BEEN REPORTED IN NEW ZEALAND IN RECENT YEARS, AND WHICH NUMBER IS THE MOST ACCURATE MEASURE OF PROBLEM GAMBLING BEHAVIOUR AND HARM OCCURRING IN NZ?

A range of problem gambling estimates (based on the PGSI criterion) have been published in New Zealand over the years. Table 2 (page 34) presents the results of a meta-analysis that pools the results of the most recent published survey data[5] on gambling participation in the New Zealand population and associated levels of harm for the main types of population groups.

The best estimate of the current number of 'problem gamblers' (as defined by the PGSI) is between 0.50 and 0.70 percent of the population, which is approximately 23,000 people using the 2014 New Zealand census population. In addition to this number, the various survey results (which are funded by the Ministry of Health Gambling Levy) suggests that there are approximately an additional 60,440 people who can be classified as at 'moderate risk' (i.e. score of 3+ on the PGSI scale), and another 167,888 who are at 'low risk' (i.e. PGSI score of 1+).

The table on page 34 suggests that over the last six to seven years approximately 65 percent to 75 percent of the New Zealand population participates in at least one form gambling activity in a 12 month period and whom do not have a gambling problem. However, between three to five percent of the population who gamble are at low risk, one to two percent are at moderate risk, and approximately 0.5 percent are high risk problem gamblers (defined as those scoring 8+ on the PGSI scale). The table also suggests this level of PGSI defined harm has been relatively stable in the last six to seven years.

The spread of the confidence level associated with each of the estimates presented in the table indicates the variation around the estimates. This variation around the point estimate can give rise to some confusion and debate about what the actual level of problem gambling and its associated harm is in New Zealand. To help address this, the use of statistical meta-analysis has been recommended to help avoid 'the potential for policy confusion based on normal variation in estimates drawn from separate studies' (Devlin & Walton, 2012, pg: 191-192).

Devlin and Walton (2012) undertook a meta-analysis in 2012 to assess the robustness of the PGSI as used in the 2010 Health and Lifestyles Survey and the 2006/07 New Zealand Health Survey, and the prevalence levels reported. The results of the research were published in the internationally respected International Journal of Gambling Studies. The authors found that the PGSI accurately reflected the presence of problem gambling behaviour and associated harm in individuals answering the questions in both the surveys. In addition, the PGSI held true when separately considering men, women, Māori, Pacific and Asian people. Positive associations were evident between the PGSI and gambling behaviour, accessing gambling intervention services, arguing about gambling, the burden of debt due to gambling, and the comorbidity of smoking. In terms of the size of problem gambling, defined as a score of 8+ on the index, a prevalence estimate of 0.53 percent in the population was determined. When considering 36 overseas studies reviewed in the

[5] More recent results from the 2016 HLS survey, and an updated meta-analysis commissioned by the Ministry of Health, will be publically released by June 2018. The results of this work indicate levels of PGSI based harm in the population at the same levels as those reported by Develin & Walton in 2012.

research this figure was adjusted to 0.50 percent by the researchers. This estimate was around 20 percent higher than that established by the largest 2007 National Health Survey, and 25 percent lower than the 2010 study Health and Lifestyles survey (and the more recent surveys). Recently the Ministry has commissioned an update of the Devlin & Walton analysis to cover the period to 2016. The results show that current prevalence estimates of 'problem gamblers' in the population remain at 0.5 percent for the current period to 2016.

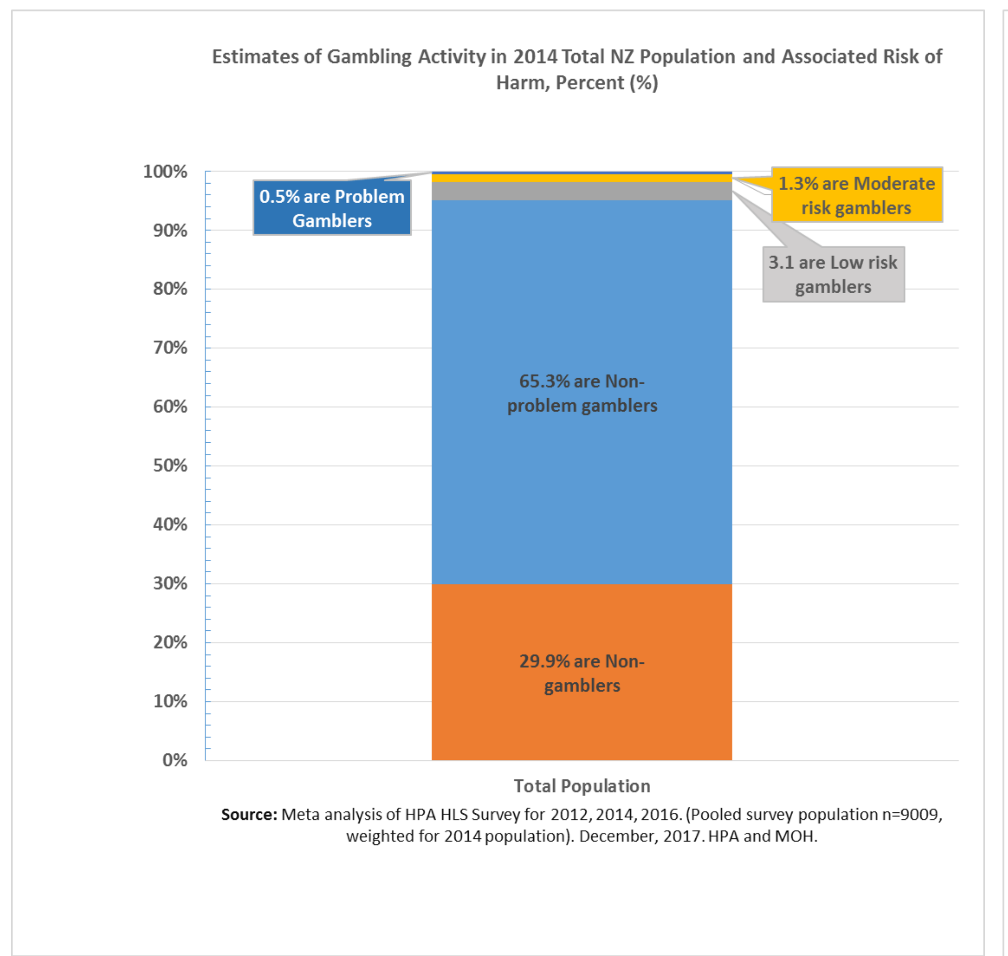
The 2015 National Gambling Study (NGS) results are also consistent with recent Health and Lifestyle survey results (Abbott et al 2018). Survey respondents are people who self-report their gambling behaviour and have experienced the associated levels of harm to themselves or to their family/whānau and affected others from their gambling behaviour.

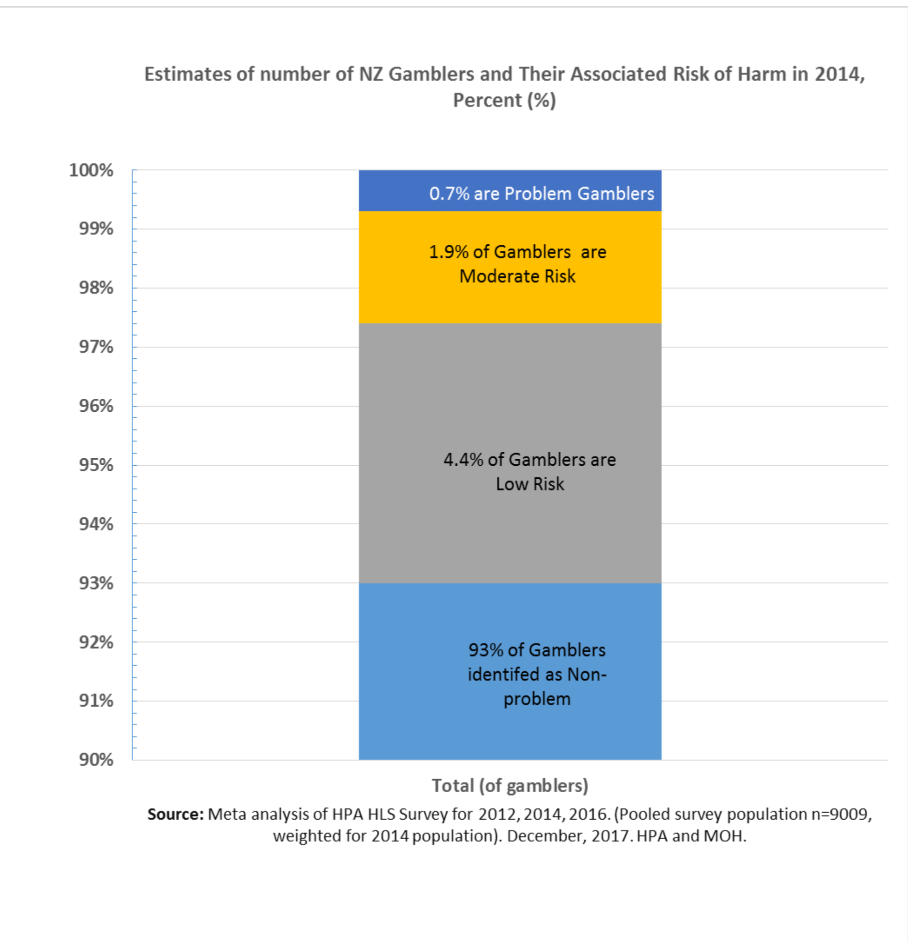
From a public health perspective, targeting moderate and low risk categories of behaviour for prevention is justified both conceptually and a research basis for harm reduction as outlined by Korn and Shaffer (1999), and from the population/public health approach outlined by Rose in the mid-1980s (Rose 1985 ; Rose 1992). Rose's approach predicts that shifting the population distribution of a risk factor prevents more burden of disease/harm than targeting people at high risk. It is this perspective that fundamentally underpins the work of Browne et al (2017). It should be noted this approach differs from the recent movement to broaden the clinical intervention approach by developing an expanding list of high-risk categories for numerous conditions. This broadening has led to what has been called the application of 'pseudo-high-risk' prevention strategies that should not be equated with sound population/public health approaches (Chiolero et al 2015).

ILLUSTRATING LEVELS OF PROBLEM GAMBLING IN THE 2014 NEW ZEALAND POPULATION

The results described above are illustrated in the following two figures, and are based upon the results of new meta-analysis commissioned by the Ministry of Health in November 2017, which comprises the combined the pooled results of the 2012, 2014 and 2016 HLS results (publication of the full 2016 HLS results is expected by June 2018). The new meta-analysis results are comparable with the earlier results that have been publically released.

Figure 7: Meta-analysis Estimates of PGSI scale Problem Gambling in the 2014 NZ population by total population and the gambling population respectively





Source: New Zealand Health Promotion Agency and Ministry of Health. (December, 2017). Meta-analysis of Health and Lifestyle Survey results 2012, 2014, 2016) (Pooled survey population n=9009 weighted for 2014 population). Wellington, New Zealand. Figures prepared by John Wren, Ministry of Health.

POOLED PGSI ESTIMATES OF GAMBLERS AND THEIR RISK OF HARM BY ETHNICITY AND SOCIAL DEPRIVATION IN THE 2014 NEW ZEALAND POPULATION

The following table presents the results of a meta-analysis of the combined 2012, 2014, 2016 Health and Lifestyle Survey results, which was commissioned by the Ministry of Health from the Health Promotion Agency in November 2017. The pooled results represent a survey of 9009 people in the New Zealand population, and the results are weighted for the 2014 population.

The table shows that over the 2012-2016 period, using the PGSI measure of gambling behaviour and associated levels of harm and considering all forms of gambling:

- approximately 65.3% of the population are non-problem gamblers, 3.1% are low risk/harm, 1.3% are moderate risk/harm, and 0.5% are problem gambler/harm who have high levels of risk and harm that is at a level requiring clinical treatment for the behaviour
- males and females are associated with very similar levels of gambling behaviour and harm, although the male rates are higher in all of the risky gambling categories compared to females
- those aged 18-24 years have the highest levels of risky gambling behaviour and associated harm across all the categories of gambling behaviour, followed by those aged 25-44 years, and then 65+
- Māori rates of gambling and associated harm are approximately double those of non-Māori across all the categories of risky gambling behaviour/harm
- Pacific peoples rates of gambling and associated harm are approximately two-thirds higher than non-Pacific people, and are similar to Māori levels of risky gambling behaviour/harm
- the New Zealand Asian population has a much higher level of participation in gambling (rates of non-gambler and non-problem gambler are much lower than the other population groups) compared to all the other population groups, and the levels of risky behaviour and harm is similar to non-Asian.
- as social deprivation increases, there is a trend to increased levels of risky gambling behaviour and associated harm. The trend is most clear in the 'Moderate' and 'Problem Gambler' categories, where the rates of risky behaviour and harm are double for those in the most deprived category compared to those in the least deprived (1.9 compared to 0.1). It is also notable for the 'Problem Gambler' category the level of risky gambling behaviour and associated harm approximately doubles between each deprivation category. This may substantively explain the levels of risky gambling behaviour and harm observed in the Māori and Pacific gambling populations. These results are consistent with a broad range of other research.

Table 2: Results of Meta-analysis of HPA-HLS results 2012, 2014, 2016 of gambling activity and associated risk of harm in the 2014 New Zealand population by PGSI classifications. Point Estimate and 95% Confidence Interval in brackets.

Percent Total Population, Point Estimate (95% Confidence Interval). Pooled sample (n) = 9009)					
PGSI Category / Population Group	**Non-gambler**	**Non-problem gambler**	**Low risk gambler**	**Moderate risk gambler**	**Problem gambler**
Total pop	29.9 (28.3-31.4)	65.3 (63.7-66.8)	3.1 (2.6-3.5)	1.3 (0.9-1.7)	0.5 (0.1-1.3)
Female	30.2 (28.3-32.2)	66.0 (64.0-67.9)	2.8 (2.2-3.4)	0.9 (1.4-2.4)	0.7 (0-1.4)
Male	29.4 (27.3-31.6)	64.5 (62.2-66.8)	3.4 (2.6-4.2)	1.8 (1.1-2.5)	0.9 (0.2-2.7)
Age: 15-17 years	74.8 (66.2-83.5)	24.0 (15.4-32.6)	1.2 (0.0-4.5)	0 (0-1.7)	0 (0-1.7)
Age: 18-24 years	39.6 (34.2-44.9)	54.5 (49.2-59.7)	3.4 (1.8-5.7)	2 (0.5-5.2)	0.6 (0.1-1.7)
Age: 25-44	28.8 (26.4-31.2)	65.2 (62.6-67.8)	3.3 (2.5-4.1)	1.6 (1.1-2.2)	1.1 (0.1-4.0)
Age: 45-64	21.8 (19.7-23.9)	73.2 (71.0-75.4)	3.5 (2.5-4.4)	1.3 (0.8-1.9)	0.2 (0.1-0.5)
Age: 65 plus	27.8 (24.9-30.8)	69.4 (66.4-72.4)	2.2 (1.4-2.9)	0.6 (0.3-1.1)	0 (0-0.1)
Māori	26.7 (23.8-29.7)	64.7 (61.6-67.9)	5.2 (3.8-6.6)	2.7 (1.7-3.7)	0.6 (0.3-1.0)
Non-Māori	30.3 (28.6-32.1)	65.3 (63.6-67.1)	2.7 (2.2-3.3)	1.4 (3.3-1.0)	1.0 (0.4-1.9)
Pacific	36.6 (32.8-40.5)	55.0 (51.0-59.1)	5.1 (3.2-6.9)	2.3 (1.4-3.3)	1.0 (0.4-1.9)
Non-Pacific	29.4 (27.7-31.1)	66.0 (64.3-67.6)	2.9 (2.4-3.4)	1.3 (0.9-1.6)	0.5 (0.1-1.4)
Asian	46.2 (41.3-51.2)	48.0 (43.1-52.9)	3.2 (1.6-5.8)	2.2 (0.6-5.5)	0.5 (0.1-1.5)
Non-Asian	27.4 (25.8-29.1)	67.8 (66.2-69.5)	3.0 (2.5-3.5)	1.2 (0.9-1.5)	0.5 (0.1-1.5)
NZDep: 1- Least deprived	26.0 (22.1-29.8)	71.4 (67.5-75.3)	2.3 (1.1-3.5)	0.2 (0-0.7)	0.1 (0-0.5)
2 -	28.3 (25.1-31.6)	67.2 (63.7-70.7)	3.1 (2.0-4.3)	1.3 (0.4-3.0)	0.1 (0-0.2)
3 -	30.0 (25.9-34.1)	65.6 (61.5-69.7)	2.5 (1.6-3.4)	1.7 (1.0-2.4)	0.2 (0.1-0.6)
4-	34.2 (30.7-37.7)	60.5 (57.0-63.9)	3.4 (2.3-4.5)	1.5 (0.8-2.2)	0.4 (0.1-1.2)
5- most deprived	31.3 (27.9-34.7)	60.9 (57.4-64.3)	4.0 (3.0-4.9)	2.0 (1.2-2.9)	1.9 (0.2-6.9)

Table 3: Results various surveys of percentage of New Zealand population PGSI classifications (Point Estimate and 95% Confidence Interval in brackets)

Source of PGSI Estimates	% Non-Problem Gamblers in Pop	% Low risk gambler	% Moderate risk gambler	% Problem Gambler ****	Sample size	Approx. No. of people in pop classified 'problem gambler'*
HPA/MOH Meta-analysis HLS Survey 2016, 2014, 2012	65.3 (63.7-66.8)	3.1 (2.6-3.5)	1.3 (0.9-1.7)	0.5 (0.1-1.3)	9009	22,800 (over 15 years of age) 55,000 Moderate-risk 125,000 Low risk
Health & Lifestyle Survey 2016 (HLS) (HPA)	65	3.3	1.5	0.1	3,854	6,000 (Over 15 years if age) 55,000 Moderate-risk 125,000 Low-risk
Health & Lifestyle Survey 2014 (HPA)	66.3	2.7	1.2	0.7	2,594	22,800 (Over 15 years of age)
Health & Lifestyle Survey 2012 (HPA)				0.2		8,816 (Over 15 years of age)
Health & Lifestyle Survey 2010 (HPA)	72.6 (69.0-76.1)	5.9 (4.3-7.5)	2.3 (1.3-3.2)	0.7 (0.32-1.32)	1,740	21,755 (Over 15 years of age)
Health Survey 2006/07 (MOH)	60.1 (58.9-61.3)	3.5 (3.1-3.9)	1.3 (1.1-1.5)	0.43 (0.30-0.57)	12,425	17,995 (Over 15 years of age)
Develin and Walton (2012) meta-analysis estimate 2010 HLS & 2006/07 HLS results				0.5 (0.50-0.53)		21,755 (Over 15 years of age)
National Gambling Survey 2014 (AUT)**	70.0 (68.0-72.0)	5.0 (4.1-5.9)	1.5 (1.0-1.9)	0.3 (0.2-0.5)	2,186	
National Gambling Survey 2013 (AUT)**	70.3 (68.6-72.0)	5.6 (4.8-6.5)	1.5 (1.1-1.9)	0.5 (0.3-0.7)	2,633	
National Gambling Survey 2012 (AUT)**	72.5 (71.2-73.9)	4.9 (4.3-5.6)	1.7 (1.4-2.1)	0.6 (0.4-0.9)	4,535	23,504 60,440 as gamblers with Moderate levels of risk (i.e score of 3+) (Low risk = additional 167,888) (over 18 years)

* Note numbers are approximate depending on which population estimate is used as the denominator (ie, 15 or 18 years of age resident, and time point of estimate

**For reports see: http://www.health.govt.nz/our-work/mental-health-and-addictions/problem-gambling/research-and-evaluation/implementation-2007-2010/national-gambling-study and https://www.health.govt.nz/system/files/documents/pages/national-gambling-study-final-report-report-no.5.pdf

QUALITY ADJUSTED LIFE YEARS AS AN ALTERNATIVE ESTIMATE OF THE LEVEL OF HARM OCCURRING IN THE NEW ZEALAND POPULATION, COMPARED TO THE PGSI

Recently Browne et al (2017) at Central Queensland University and Auckland University of Technology combined the PGSI with methodologies from welfare economics and public health epidemiology to produce (Quality Adjusted Life Year) QALYs estimates of the population burden of problem gambling harm. The study was funded by the Ministry of Health.

In contrast to the PGSI method of reporting harm, the authors of the study reported the level of harm occurring in the New Zealand population.

- The study estimates that the total burden of harms occurring to gamblers is greater than common health conditions (such as diabetes and arthritis) and approaches the level of anxiety and depressive disorders.
- Both qualitative and quantitative results suggest that this burden of harm is primarily due to damage to relationships, emotional/psychological distress, disruptions to work/study and financial impacts.
- The most critical result from the research is regarding absolute scale of harms from gambling to the New Zealand population. There was an estimated 161,928 years of life lost to disability as a result of harms from gambling in 2012. Within this number 67,928 years were attributed to gamblers themselves and 94,729 to people who were effected by someone else's gambling. This represents a substantial level of harm compared to other issues. In addition this calculation does not include harms experienced beyond a 12 month period, meaning that it is likely to be conservative.
- Although some of this 'burden of harm' was concentrated in problem gamblers, the results suggested that at a population level the majority of harm is accruing to those who are not necessarily problem gamblers.

The full report can be downloaded for free:

http://www.health.govt.nz/publication/measuring-burden-gambling-harm-new-zealand

See also the section on 'Population burden of gambling harm' for more information about this approach to measuring gambling harm.

WHAT IS THE EVIDENCE FOR EFFECTIVE INTERVENTIONS?

The evidence for effective interventions varies quite widely by type of intervention, type of research method and where the focus of research has been over time.

The strongest evidence for effective intervention is for clinical interventions focussed on the individual whose gambling behaviour is at the most severe end, which is commonly described as 'problem gambling' and associated with a PGSI score of 8+ using the PGSI screening tool for gambling behaviour and associated harm.

There is also good support for cognitive behaviour therapies.

Other support group type activities have a public health role to play in awareness raising, and early intervention where there are low levels of harmful gambling behaviour, and maintenance is required for those who have received intensive intervention.

In the last five years two authoritative reviews of the evidence for effective intervention have been published, which are recommended for reading.

RECOMMENDED SUMMARIES OF EVIDENCE FOR EFFECTIVE GAMBLING INTERVENTION

- Monash University, Problem Gambling Research and Treatment Centre. 2011. Guideline for screening, assessment and treatment in problem gambling. Melbourne: Clayton: Monash University.
- Rodgers B, Suomi A, Davidson T, et al. 2015. Preventive Interventions for Problem Gambling: A Public Health Perspective. Australian National University. Canberra, ACT, Australia.

The Monash University document is the result of review of evidence by authoritative researchers and clinicians. It presents summaries of the strength of the research literature on gambling behaviour assessment and intervention and makes recommendations about which ones are effective and should be used. The review essentially ends up recommending clinical focussed interventions. This largely reflects where the research focus has been over time, and a prioritisation of importance given to particular types of research study.

The Australian National University document is more public health focussed, and provides a wide ranging review of the literature on gambling harm. It is very easy to read, informative, and provides an introduction to key issues, the evolution of thinking about gambling harm and intervention, and the role of public health approaches to gambling harm reduction. As such, it provides a useful compliment to the Monash University report. The report also includes a section on lessons that can be learnt for public health gambling harm reduction activities in the tobacco and alcohol areas.

CHALLENGES TO ADDRESSING GAMBLING IN-EQUITY

The World Health Organization defines equity as a 'fair opportunity for everyone to attain their full health potential regardless of demographic, social, economic or geographic strata'. This definition relates both to health status and to the social determinants of health. Inequities are inequalities that are judged to be unfair, that is, both unacceptable and avoidable.[6]

Inequities are not random, and they are typically due to structural factors present in the society and local community and are not explainable by bio-medical 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.

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[6] http://www.who.int/gender-equity-rights/understanding/equity-definition/en/, accessed 17 June 2015.

WHAT IS THE NEW ZEALAND NATIONAL GAMBLING STUDY 2012 (NGS)

The New Zealand NGS is nationally representative longitudinal survey of adults aged 18 years and older. The NGS commenced in 2012 with 6,251 participants recruited and initially interviewed face to face. Subsequent interviews were undertaken annually until 2015. The Gambling and Addictions Research Centre (GARC) at Auckland University of Technology (AUT) and the National Research Bureau (NRB) were contracted to undertake this work and deliver data analysis and report writing.

The study is funded by the Ministry of Health via the Gambling Levy, and is one of the research components of the Government S*trategy to Prevent and Minimise Gambling Harm 2016/17 to 2018/19*.

The survey questionnaire included questions on: leisure activities and gambling participation, past gambling and recent gambling behaviour change, problem gambling, life events, attitudes towards gambling, mental health, substance use/misuse, health conditions, social connectedness, level of deprivation, gambling expenditure, and demographics.

Information from the survey has led to six major reports[7] for the Ministry of Health on:

1. gambling participation
2. problem gambling
3. New Zealanders' attitudes towards gambling
4. new cases of gambling and the factors that influence peoples transitions to and from risky levels of gambling
5. gambling participation, gambling harm, and risk factors for the cohort of participants who have remained in the National Gambling Study for two years
6. gambling participation, gambling harm, and risk factors for the cohort of participants who have remained in the National Gambling Study for three years.

CONVERGENCE OF GAMBLING AND GAMING, AND THE BREAKDOWN OF THE TRADITIONAL DIVISION BETWEEN CONTINUOUS AND NON-CONTINUOUS FORMS OF GAMBLING

The boundaries between continuous and non-continuous and simulated and commercial gambling are becoming increasingly blurred, with a resulting increase in exposure to gambling harm (Griffiths et al 2013) . For example, there are now opportunities to play realistic games that look and feel exactly like gambling.

Simulated gambling games mimic the characteristics of gambling games but do not provide an opportunity to stake, win or lose real-world money. The use of internet payment methods makes it easy to use a range of payment methods and to spend money faster.

Commercial electronic gambling has begun to incorporate features more traditionally associated with gaming, such as moving to new levels and increasing interactivity between player and game.

[7] http://www.health.govt.nz/our-work/mental-health-and-addictions/problem-gambling/research-and-evaluation/implementation-2007-2010/national-gambling-studyGriffiths M, King D, Delfabbro P. 2013. *The Technological Convergence of Gambling and Gaming Practices*.

Internationally commercial gambling operators have commenced partnering, merging with and purchasing simulated gambling companies.

Examples of this happening in NZ include Lotto NZ beginning to develop and sell instant gambling products that look like games and have other attractive features to users associated with the high risk electronic gaming machines (continuous). Users are able to 'try' these games on MyLotto.co.nz for free (https://mylotto.co.nz/instant-play/4443). KidsCam research at Otago University has shown that NZ Lotteries advertising is widely seen by children and they have access to Lotteries products.

In 2015 SKYCITY ran for a while a free-to-play online gaming site with virtual gaming machines and table games (https://www.stuff.co.nz/auckland/69416192/skycity-launches-online-gaming-site). Other gambling providers in New Zealand have expressed interest in broadening their gambling products by moving online to increase their competitiveness with overseas markets. Many online gambling website will promote/advertise their main site by hooking people on free-to-play games that appear to be gambling. These free-sites can be advertised freely on New Zealand television because, by definition, no 'gambling is taking place on the site advertised.

The convergence of gambling and gaming and associated increased levels of advertising, and the use of internet based payment systems that make it easier to spend money on gambling products suggests the emergence of new levels of exposure to high risk gambling products in NZ, and the attendant probability of harm.

APPENDIX 1: LIST OF SOME COMMONLY USED ABBREVIATIONS AND TERMS

Abbreviations and Terms	Definition / Explanation
Adaption Theory	Adaption Theorists argue that gambling behaviour is influenced by a wider range of factors other than just the level of access (ie, availability / exposure) to gambling activities (Abbott 2017a). Furthermore, gambling behaviour is amenable to change by the use of a range public (population) health orientated interventions (Abbott 2006). Abbott (2017a) has argued that the history of gambling in New Zealand since the 1980s exhibits features of both association and adaptive behaviour.
Affected Other / Concerned Significant Other (CSO)	Affected others are people closely associated as family/whānau members or employer or community group members with the gambler, and whom are negatively impacted by the gambler's risky gambling behaviour. Affected Other has the same meaning as Concerned Significant Other (CSO).
APA	American Psychological Association (APA) – a literature citation style which is widely used in the social sciences and other fields
APA	American Psychiatric Association – Professional organisation for American psychiatrists
Availability (Exposure) Theory	Proponents of Availability Theory argue that increased availability (i.e increased exposure) to gambling activities leads to increased levels of gambling behaviour and associated harm (Abbott 2017a). There is some evidence for the theory. Research has shown that when a new gambling product is introduced to the market, levels of gambling activity increase. However, evidence also suggests that after a period of time – for example six months – gambling activity levels decline back to levels similar to those preceding the launch of the product. This suggests that there are other influences of behaviour at work. Abbott (2017a) has argued that the history of gambling in New Zealand since the 1980s exhibits features of both association and adaptive behaviour.
BBGS	Brief Bio-Social Gambling Screen. A measure of gambling behaviour.
CAGI	Canadian Adolescent Gambling Inventory. A measure of gambling behaviour for youth.
CBT	Cognitive Behavioural Therapy. A type of intervention aimed at gamblers at the more severe end of the gambling behaviour continuum.
Class 4 gambling venues	In New Zealand, gambling is regulated by the Gambling Act 2003 (the Act). The Act defines four classes of gambling activity – Class 4 gambling are gaming machines in pubs and clubs (outside a casino), which are seen as

	high-risk, high-turnover gambling. Class 4 gambling may only be conducted by a corporate society and only to raise money for an authorised purpose (eg, community and non-commercial).
CPGI	Canadian Problem Gambling Index. A survey developed in Canada in the late 1990s about gambling behaviour and its impact upon the health and well-being of the gambler and their family and others. The survey consists of 31 questions. Responses to a subset of the questions are used to calculate a Problem Gambling Severity Index which is used to categorise the gambling behaviour, and report the incidence and prevalence of gambling in Canada, Australia and New Zealand, and by many other public health researchers internationally.
Continuous and Non-continuous gambling	The terms continuous and non-continuous gambling are used to differentiate between two main types of gambling activity that research suggests are associated with different risk levels for harm occurring (Abbott et al 2014a ; Abbott et al 2014b). Continuous gambling activities are characterised by providing the opportunity for a continuous, repeated cycle of placing a stake, playing, determination of a win or loss, and the ability to collect and reuse winnings. Examples include non-casino gambling machines (NCGMs), casino table games, betting on horse or dog races, and scratchy cards. These types of activities have been shown to be associated with higher risk levels of gambling harm. Non-continuous gambling forms contrast with continuous forms in that there is a delay of many hours or days between placing a stake or buying a ticket and the determination of a win or loss. The most common examples are Lotto & raffles. Because the gambling behaviour is non-continuous, the risk of harm occurring is lower.
Concerned Significant Other (CSO) / Affected Other	Concerned Significant Other's (CSO) are people closely associated as family/whānau members, or employer, or community group members with the gambler and whom are negatively impacted by the gambler's risky gambling behaviour. CSO has the same meaning as 'affected other'.
DIGS	Diagnostic Interview for Gambling Severity. A measure of gambling behaviour.
DSM	Diagnostic and Statistical Manual of Mental Disorders. The premier manual used by practicing psychiatrists and mental health workers to guide their professional practise. There are different versions of the DSM in use. The version is denoted by the use of Roman numerals such as III (for version 3) and IV (for version 4). The latest version is VI (for version 6). Many Ministry of Health's in OECD countries, including New Zealand, recognise DSM-IV for clinical diagnosis and treatment purposes.

	Other versions of the DSM have been developed for a range of population groups. Examples include: • DSM-IV-J = Diagnostic and Statistical Manual of Mental Disorders Version 4, adapted for Juveniles • DSM-IV-MR-J = Diagnostic and Statistical Manual of Mental Disorders Version 4, Multiple Responses, adapted for Juveniles
EGM	Electronic Gambling Machine.
FLAGS	Focal Adult Gambling Screen. A measure of gambling behaviour.
Gambling Harm	'Gambling Harm' as defined as in the New Zealand Gambling Act 2003 is: 'Harm or distress of any kind caused or exacerbated by a person's gambling and includes personal, social or economic harm suffered by the person, their spouse, partner, family, whānau and wider community, or in their workplace or society at large.' This definition aligns with a broad public health approach to thinking about the harm that can arise from gambling. In contrast, a clinical medical mental health model to harm, such as that set out in the DSM IV, describes harm in more tightly defined clinical terms focussed upon the individual's behaviour and a set of negative consequences to them and their family from their gambling behaviour.
GOI	Gambler of Interest
Harm reduction	A public health approach that emphasises undertaking a wide range of interventions aimed at addressing the whole continuum of gambling behaviour.
Healthy gambling	This is a terms associated with gambling behaviours categorised as low risk/low harm.
HRP – Harm reduction programmes	Harm reduction programmes refers to a wide range of public health interventions, some of which are specified in the New Zealand Gambling Act 2003.
Lifetime gambling	The term is another measure of gambling activity in the population, and is a measure of whether the respondent has ever gambled.
Inequalities / Inequities / Disparity	Where there are differences in health experience between population groups, for example on average females live longer than males, these are usually referred to in the health literature as a 'health inequality'. Where the differences are large, they are referred to as a health 'disparity'. The presence of a health disparity may indicate the existence of a health 'inequity'. The concept of inequity is often associated with 'fairness'. The presence of an inequity may not indicate 'unfairness', depending upon the cause of the inequity and the size of the disparity. In health, an inequity is deemed to exist where the presence of the disparity is attributed to social, cultural and economic factors rather than bio-medical ones. New Zealand research has shown that gambling inequalities exist between different categories of population groups in the country.

MAGS	Massachusetts Gambling Screen. A measure of gambling behaviour.
Medical model of gambling	The medical model of gambling focusses upon the individual and uses classical biological terminology and methods to diagnose and categorise a range of gambling behaviours. Harm reduction activities focus upon the use of a range of intensive individual behaviour modification therapies and targets those at the most severe and harmful end of gambling behaviour.
NAGS	National Gambling Survey. This survey is funded by the New Zealand Ministry of Health to provide reliable national estimates of problem gambling in New Zealand. The survey is currently undertaken by the Gambling and Addictions Research Centre at Auckland University of Technology using the CPGI methodology and its PGSI subsidiary.
Pathological gambling	Originally, the term was introduced in DSM III and modified in DSM IV to describe a level of gambling behaviour classified requiring clinical intervention. In DSM V, the term 'gambling disorder' is preferred, and gambling is categorised as an 'addiction'.
PGSI	Problem Gambling Severity Index. A set of nine questions that is part of a longer list of 31 questions in the CPGI. The PGSI is a commonly used as an indicator of the prevalence of problem gambling behaviours and harm in the population. The index is generated by the administration of a standard set of questions through a survey. The responses to the questions are used to generate a ranked score representing both risky behaviour and likely level of harm associated with the behaviours. The PGSI index has been extensively tested for its validity and reliability, and is accepted as robust measure of self-reported individual level of gambling behaviour and associated levels of harm occurring in the population surveyed. The responses to the questions are scored, and the scores are placed with a set of categories that are described as set of types of behaviour that at the most severe end is defined as representing 'problem gambling'.
Prevalence of gambling	Prevalence refers to the number of people with the reported gambling behaviour in the population in a defined time period. A 12 month time period is the commonly used reference period, however other time periods referring to the last 6 months or 1 month have been reported.
Prevention Paradox	The prevention paradox, first articulated by Rose (1985, 1992), argues that the most gain from harm minimisation activities (i.e. prevention benefit) can be had by targeting interventions at the low and moderate risk levels rather than at the few individuals who are already experiencing high levels of harm. It is a paradox, because in many ways it is counter intuitive to the focus on individuals with the most harm and need for treatment. The prevention paradox has been widely applied in areas such as tobacco and

	alcohol control, however its applicability to gambling harm reduction is contentious.
Primary prevention	Primary prevention in public health generally refers to population level activities aimed at stopping a health problem from starting.
Problem gambling	The term 'Problem gambling' can be used in two ways, and both usages are common in the literature: 1. Originally, the term was introduced in DSM III and modified in DSM IV to describe a level of gambling behaviour classified 'sub-clinical', which was one level down from 'pathological' gambling that represented 'clinical' behaviour. 2. In more recent years, the term has been associated with the survey questions and scoring system introduced with the Canadian Problem Gambling Index (CPGI) and derived Problem Gambling Severity Index (PGSI). The PGSI uses a scoring system from 0 to 27 to identify three broad types of gambling behaviours ranging from: a. Low risk (those who score 1-2, in response to the 9 questions b. Moderate risk (those who score 3-7, in response to the 9 questions c. Problem gamblers (those who score 8-27 (commonly shortened to 8+) in response to the 9 questions (Ferris & Wynne, 2001., in Braganza et al, 2010). More recently, there has been the appearance in some of the public health literature of a fourth category: d. Non-gambler, representing those who score 0. (Monash, 2011) Furthermore, a number of robust studies have suggested the suggested changing the cut-off score promoted by Ferris & Wynne of 8+ to 4+ to represent problem gamblers (see reviews by Walker et al, 2010; Monash, 2011; Devlin & Walton, 2012). Recently some public health researchers (for example Browne et al, 2017) have developed new estimates of population levels of harm associated with a wider range of gambling behaviour, which uses well established epidemiological methods. However the approach is novel in the problem gambling research field.
Problem Gambling Severity Index	A subset of nine indicators of gambling behaviour derived from the CPGI.
Public health model of gambling	The public health model of gambling places gambling behaviour within the wider social and economic context. Harm reduction activities vary widely, and aim to address the whole continuum of gambling behaviour including the social and economic context that surrounds gambling behaviour in population groups.

Secondary prevention	Secondary prevention in public health generally refers to activities aimed specific population groups or individuals and to stopping a health problem after it has started.
SOGs	Southern Oaks Gambling screen. A measure of gambling behaviour that is very similar to the CPGI/PGSI. A number of variations of SOGS have been developed over the years.
Spectrum of gambling/Continuum of gambling	This is a theory of gambling behaviour that categorises gambling behaviour as ranging from no/little harm to problem /pathological behaviour associated with severe harm.
Spectrum of gambling and health	This is a theory of gambling behaviour that has observed that the more severe and harmful gambling behaviour is often associated with a number of health issues/addiction behaviours (ie, comorbidities). The strongest health associations are with alcohol, drugs and poor mental health.
Tertiary prevention	Tertiary prevention in public health generally refers to specialist treatment services at treating an individual.

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Out of scope

SECTION 4. **Problem gambling**

Out of scope

4.2 Racing Amendment Bill

Contact: Robyn Shearer, Deputy Director-General Mental Health and Addiction,

Item: *The Ministry is providing feedback to the Department of Internal Affairs on the Cabinet papers relating to the Racing Amendment Bill.*

Three papers were due to be lodged for discussion at the Cabinet Economic Development Committee on 4 April 2019, all of which focus on a high level structural overhaul of the racing industry.

The primary objective of the Bill is to increase revenue for the racing industry. Amongst the suite of proposals, the papers recommend introducing two new wagering products: legalising 'in-the-run' race betting; and allowing betting on a range of new sports (provided those sports enter into an agreement with Sport NZ).

The introduction of new betting products is likely to lead to increased expenditure on gambling by expanding the number of gamblers and/or by encouraging individuals to spend more. In particular, 'in-the-run' race betting and its availability in an on-line setting creates the opportunity for continuous gambling – a form of gambling that is associated with more severe levels of harm.

While it is possible that harm may be reduced by legalising certain types of gambling within the New Zealand context (as New Zealanders may place bets using the Racing Board's products, and not overseas websites), it is reliant on a regulatory regime being applied which is sufficiently robust.

The Ministry has provided extensive feedback through agency consultation, including draft text for inclusion in the Cabinet papers (provided to your office), and made the following recommendations to the Department of Internal Affairs:

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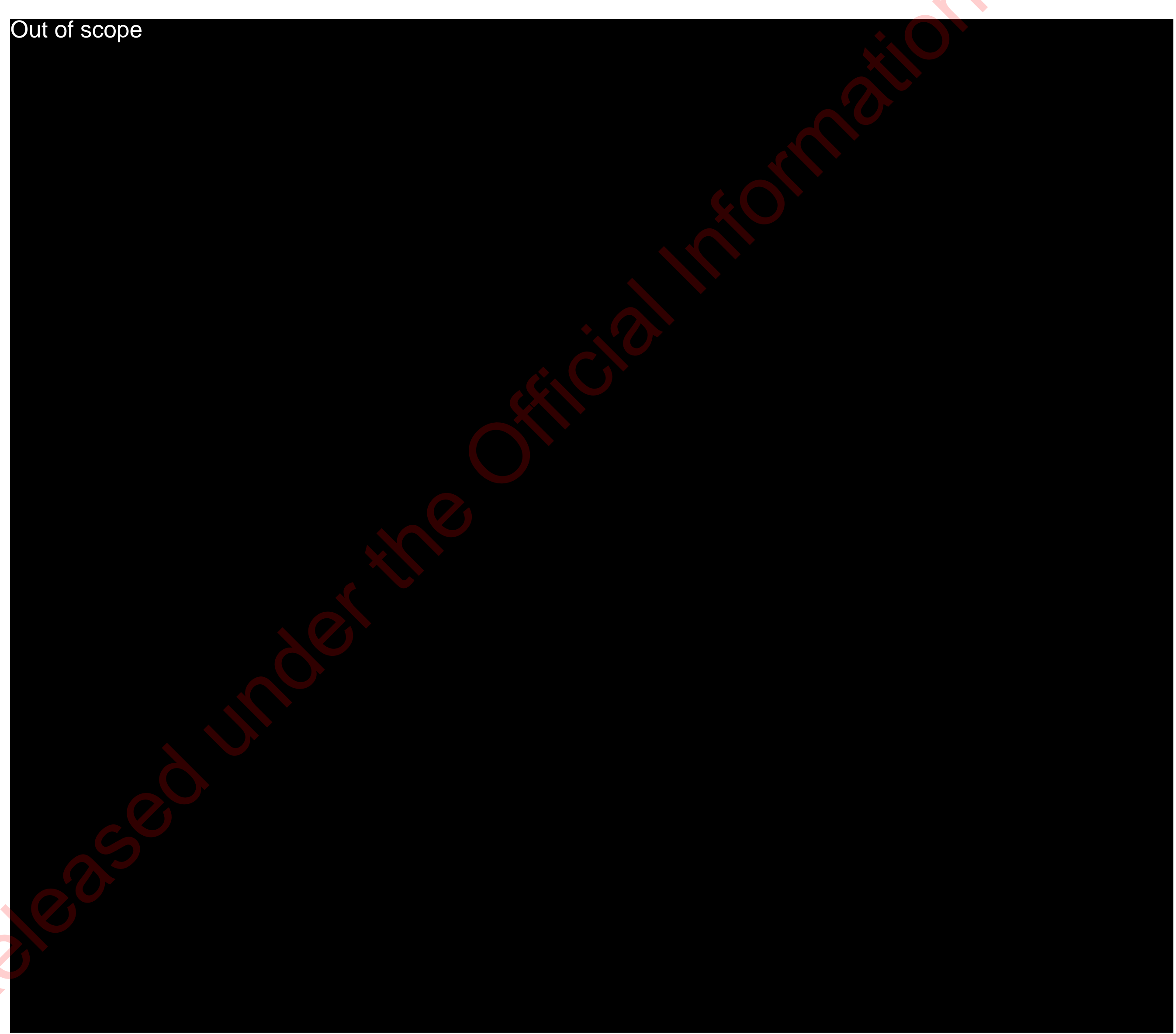
- *consideration should be given to the Racing Industry Transitional Agency, or any other governance body, including knowledge/experience in preventing and minimising gambling harm*
- *the link between increased gambling expenditure and gambling harm should be explicitly acknowledged in the paper*
- *that the two new wagering products – and the introduction of 'in-the-run' race betting in particular – present a medium to high risk of increased gambling harm, and that an appropriately robust regulatory regime should be signalled in the papers to give Ministers, agencies and the public assurance that harm will be prevented and minimised.*

Action: No action required. This information is for noting.



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3.5 Racing Amendment Bill: Ministry of Health advice

Contact: Robyn Shearer, Deputy Director-General Mental Health and Addiction, s 9(2)(a)

Situation: The Ministry is providing feedback to the Department of Internal Affairs on Cabinet papers relating to the Racing Amendment Bill.

There are three papers for discussion at the Cabinet Economic Development Committee lodged on 4 April 2019, all of which focus on a high level structural overview (Bill 1).

The primary objective of the Bill is to increase revenue for the racing industry. Amongst the suite of proposals, the papers recommend introducing two new wagering products: legalising 'in-the-run' race betting, and allowing betting on a range of new sports (provided those sports enter into an agreement with Sport NZ).

The introduction of new betting products is likely to lead to increased expenditure on gambling by expanding the number of gamblers and/or by encouraging individuals to spend more. In particular, 'in-the-run' race betting, and its availability in an online, creates the opportunity for continuous gambling; a form of gambling that is associated with more severe levels of harm.

While it is possible that harm may be reduced by legalising certain types of gambling within the New Zealand context (as New Zealanders may place bets using the Racing Board's products, and not overseas websites), it is reliant on a regulatory regime being applied which is sufficiently robust.

The Ministry has provided extensive feedback through agency consultation, including draft text for inclusion in the Cabinet papers (provided to your office). We have made the following recommendations to the Department of Internal Affairs:

- that consideration should be given to the Racing Industry Transitional Agency, or any other governance body, including knowledge/experience in preventing and minimising gambling harm
- that the link between increased gambling expenditure and gambling harm should be explicitly acknowledged in the paper

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- that the two new wagering products – and the introduction of 'in-the-run' race betting in particular – present a medium to high risk of increased gambling harm, and that an appropriately robust regulatory regime should be signalled in the papers to give Ministers, agencies and the public assurance that harm will be prevented and minimised.

Action: No action required. This information is for noting only.

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Note: Update to Cabinet papers – Review of Racing: Paper 1 and Paper 3

Changes to the forecasted betting levy figures

1. This note is to inform you of changes to the forecasted betting levy figures which have been included in the Cabinet papers:
    - "Review of Racing: Paper 1 – Overview of the New Zealand Racing Industry and identified issues" (Paper No. 1), and
    - "Review of Racing: Paper 3 – Proposals for immediately increasing revenue for the racing industry" (Paper No. 3).
2. Subsequent to the Cabinet papers being circulated to Ministers for consultation, the Treasury informed the Department of Internal Affairs that the forecasted betting levy amounts provided (and were included in the Cabinet papers) are incorrect as they include both the betting levy and the problem gambling levy paid by the New Zealand Racing Board (NZRB).
3. The amount in which Treasury provided referenced a total financial impact of nearly $65 million over the next four financial years (which equalled approximately $16 million per year). However, Treasury has advised that the actual total financial impact is less than this and is actually closer to $57 million over the next four financial years.
4. Table 1 below shows the corrected financial impact of repealing the betting levy over the next four financial years.

Table 1: Financial impact of repealing the betting levy

$000	FY19/20	FY20/21	FY21/22	FY22/23
Approximate impact of repealing the betting levy	14,000	14,000	14,000	15,000

5. The final Cabinet papers will be updated to include these revised figures. As such, please note that the following paragraphs which reference the incorrect amount of betting levy will be updated to reflect this:

<u>Paper No. 1</u>

- Paragraph 51.5 – please note, the amount referenced in this paragraph combines the revenue from the betting levy (approximately $14 million per annum) and the estimated amounts of potential revenue from offshore betting charges ($30 million per annum);
- paragraph 53; and
- paragraph 54.

<u>Paper No. 3</u>

- Paragraph 6;
- paragraph 52;
- paragraph 68;
- paragraph 70; and
- Table 2 following paragraph 72.