Report To The Gambling Commission On Issues Associated With The Problem Gambling Levy

Final Report

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Executive Summary

This review has been completed to inform the Commission on the structure and content of the problem gambling levy calculations and related funding of services by the Ministry of Health (MoH).

The levy calculation contains four factors for review A, B, C and D. We have not been able to review the numbers for factor A (which carries a 10% weighting) as this comprises player expenditure computed by the Inland Revenue Department (IRD) on a confidential basis. Numbers used by the Department of Internal Affairs (DIA) for Factor A in the illustrative calculations provided to the Commission have been taken from alternative published sources. In a similar fashion Factor D represents projected player expenditure based on the same IRD numbers and growth factor assessed using the same source information for prior years. As such we have not been provided with detailed figures to assess factor D. We understand the Commission will be provided with final levy numbers based on the true figures for factors A and D.

The primary focus of the review has been in respect of factors B and C. Factor B comprises the presentation numbers used to determine access to services. This is the most significant factor having a 90% weighting in the calculation of the levy. Sector C comprises the Ministry of Health (MoH) funding profile for services and is the factor that drives the total value of the levy.

Our review has confirmed that the levy computation is based on a number of necessary estimates and compromises. These estimates have been assessed on the best available information but indicate a need to develop much better information over the next three years. Examples are the exclusion of additional problem gambling modes from the presentation data calculations and the likely substantial underestimation of the full scale of problem gambling.

We have not confirmed the accuracy of the data sources used in the calculations but the consistent compilation of presentation data over several years is a positive factor. In contrast the future funding profile has a high degree of uncertainty associated with it in terms of the ability of the MoH to establish suitable provider resources and ensure services are sufficient to address unmet need.

Our summary findings are as follows:

Weightings - Factors W1 and W2

- The allocation of levy proportions between presentations and gambling expenditure should be amended to an 80/20 split compared to the 90/10 split currently used. This is necessary to reflect a wider view of problem gambling

Presentations Data - Factor B

- We believe the basis for computing the presentation data substantially understates the size of problem gambling. There is strong anecdotal evidence that only a small proportion of all problem gamblers are accessing services. There is also evidence that problem gamblers are using other services such as drug and alcohol and mental health. Information resources need to be developed over the next three years to better assess the problem gambling proportions attributable to each gambling mode and the levels of service usage. In the absence of this improved data the present information is the best available.
- **Funding Amount - Factor C**
- The funding plan represents a significant compromise based on constrained overall funding levels. These levels have been calculated on a top down basis to fit a predetermined level of funding rather than funding the programme on the basis of need to determine the level of service required and then establishing appropriate funding levels.
- We believe the funding levels between public and personal health are mismatched and understated based on the likely increase in the number of problem gamblers who will present to intervention services once the public health programme is implemented. The most significant

impact is likely to occur in the third year when the social marketing and media campaign starts. We are unable to quantify the amount of the under funding

- The MoH will not be able to meet the annualised cost of contracts taken over from the PGPA on 1 July as a result of increases in contract volume levels part way through the 2003-04 year. As a result some contracts will be discontinued and others restricted to lower amounts until such time as additional funding can be allocated. Whilst the MoH will manage this issue in the most effective way it suggests that the initial funding amount is understated
- The level of administration and development expenditure is very high in relation to the total funding amount. The proportion is 12% of funding in each year and up to 19% if research costs are included. We also believe the costs include a full allocation of MoH overheads and as such do not represent the marginal cost of undertaking this new area of funding. This approach is inconsistent with the approach the MoH adopts when funding new activities in providers. In our view the costs should be reduced to recognise these factors with the resulting balance allocated to intervention services
- The proportion of service funding allocated to generic public health services is not consistent with the presentation statistics for problem gamblers. Whilst we acknowledge a growing body of evidence for Maori, Pacific, Asian and youth problem gambling we note that 56% of problem gamblers are European and yet the generic funding is 35% of total public health funding in year one dropping to 25% of funding by year three. If funding is reallocated we suggest this imbalance is considered in setting the new amounts
- We believe there is an imbalance of funding between public and personal health (intervention) services. We note there is little flexibility to move funding within the plan and any significant changes would require consultation by the MoH. There is also no ability to transfer funding from public health to the personal health services as this is precluded by the NDOC funding requirements which quarantine funding for public health. This suggests that an injection of new funding would be required to address the under funding issues identified in this report
- The MoH has completed a gap analysis to identify new service requirements. It is uncertain whether there is sufficient Provider capacity and this is likely to result in delays in establishing or extending services. This may indicate a need to defer some expenditure in the funding plan
- There is an inherent difficulty in ring fencing problem gambling funding due to the co-morbidities that many gamblers suffer from. On balance we believe this is likely to favour the problem gambling funding position as these people are accessing other services such as mental health and drug and alcohol in resolving their problems.
- In conclusion we recommend that any increase or reallocation in funding amounts should favour intervention services as the first priority to ensure these services can cope with the increased demand that will arise when the public health campaign commences

Expenditure Forecast - Factor D

- The expenditure projections developed by the Department of Internal Affairs (DIA) contain growth projections that are bwer than that experienced in recent years. The use of lower growth rates increases the levy rate and the potential for collection of more than the projected levy amount over the three-year period, assuming expenditure growth maintains its previous path. We recommend the Commission advises Ministers that the rate of collection of the levy should be monitored and adjusted during the three year term if found to be greatly excessive. We note that there is an ability to take into account any under or over collection in the next levy period.
- Legislative changes in areas such as smoke free and lotteries will potentially impact on levy collections and funding requirements. This will require consideration within the three-year levy period and an early review may be required.

Other considerations

- The recovery of transitional costs by the MoH is addressed in the Commission's report and a separate legal opinion
- Changes will be required to provider reporting requirements to improve future data for levy calculation purposes. We understand the MoH will review this matter
- Service providers should be subject to periodic audit to ensure data accuracy
- The Commission should be periodically briefed by the MoH on levy matters over the next three years in order to provide informed advice on future levy calculations. This will require an ongoing relationship with the MoH that is not presently contemplated by the legislation
- We have raised with the MoH whether they intend to apply the Eligibility Direction in contracting with providers for services. This is their practice with almost all other heath contracts. If they do this will result in a number of current service users no longer qualifying for access, as they are non-residents. While this approach is consistent with other health services we note that problem gambling services are in effect funded by eligible and non-eligible gamblers. The MoH should consider this issue further as a number of patients in this category will be part way through treatment programmes on 1 July and other treatment channels may be required for the long term.

1. Background

1.1 Basis for this review

The Executive Director of the Gambling Commission (the Commission) has requested this report. It is intended to inform the Commission on key elements of the computation of the Problem Gambling Levy and the services the Ministry of Health propose to purchase to alleviate the impact of problem gambling at a population and individual level. It also supports the Commission's consultation process and recommendation to Ministers.

1.2 Scope and limitations

A calculation basis has been set for the problem gambling levy incorporating weighted factors for the level of gambling expenditure in the four gambling sectors and the number of presentations to problem gambling services. The levy calculation is specified in Section 320 of the Gambling Act as:

((AxW1) +(BxW2)) x C divided by D.

Where:

Factor	Basis of calculation
A	The estimated current player expenditure in a sector divided by overall current player expenditure. These figures are computed by the IRD
B	The customer presentations to problem gambling services that can be attributed to gambling in a sector divided by total customer presentations to problem gambling services. In setting B, the MoH has adopted the figures from the Problem Gambling Purchasing Agency (PGPA) for the period October 2002 to September 2003.
C	The funding requirement for the period and reflects an MoH estimate of costs to the government of implementing its strategy.
D	The forecast player expenditure in a given sector for the levy period. The MoH has taken the advice of the Department of Internal Affairs on these figures
W1 and W2	Weights, the sum of which is 1. Cabinet has agreed that W1 should be 0.1 and W2 should be 0.9 i.e. the weighting is biased towards presentations in setting the levy rate for each sector to reflect the focus on managing harm. Although Cabinet has agreed the weightings, these have not yet been set in regulations.

This report provides an objective assessment of the data and information supporting the MoH figures for each component, especially B and C. With respect to B the advice considers whether the customer presentation figures, and the method for attributing presentations to particular sectors, are robust. In relation to C, the advice addresses whether the projected requirements and the costing of the proposed programmes are reasonable. The majority of data for factor A is not available being subject to IRD privacy requirements. The Lotteries information is in accordance with page 32 of the Lotteries Commission 2003 Annual Report. In addition information for factor D on future projections has not been made available to us. We understand that IRD expenditure figures and DIA growth estimates are based on recent history and likely future trends have been used to determine the amounts for D.

The Commission's role is to advise Ministers on the total amount and rate of the levy for a three year period. The Commission does not have an ongoing role in ensuring services for the treatment and control of problem gambling are adequate but must form a preliminary view in advising on the total amount of the levy. The MoH does not have reporting obligations to the Commission and it is recommended that it be required to provide ongoing updates (possibly on a six monthly basis) in order that the Commission can advise Ministers regarding future levy amounts.

This review is predicated on the accuracy of the information provided to the Commission from MoH and other sources and no independent assessment of accuracy of base data has been made. The review has also been completed in a very limited period of time and as such there are a number of

areas for potential review that have not been completed. These have been identified in the Executive Summary and in each section of this report.

2. Customer Presentations to Problem Gambling Services (Factor B)

2.1 Whether the customer presentation figures are robust

2.1.1 Context

In relation to B, customer presentations to problem gambling services have been compiled by Problem Gambling Purchasing Agency (PGPA), the agency contracted to the Problem Gambling Committee and responsible for problem gambling funding prior to the MoH taking control from 1 July 2004. This data has been published in a document entitled "Problem Gambling Counselling in New Zealand 2003".

The key questions addressed in considering this data have been:

- What data underpins the PGPA figures?
- What was the method used by the PGPA for attributing presentations to a particular sector e.g. what happens if an individual identifies him or herself as having a problem with a number of forms of gambling?
- How the presentation is attributed if an individual seeks problem gambling services for one form of gambling e.g. casino gambling, but indicates that their gambling problem started in relation to another form e.g. racing?
- What constitutes a "presentation" for PGPA purposes e.g. if the same individual seeks problem gambling assistance over a prolonged period, is this a single presentation, or is each visit to a treatment provider a presentation?
- How was the data obtained? Are there any reporting obligations in relation to problem gambling presentations and if not, how the data is gathered, and from whom?
- Have the figures been tested by the MoH?

2.1.2 Review of the data source

The PGPA data has been collected, analysed and published on a planned basis for six years. As the data was never intended for the computation of levies it is not be entirely suitable for purpose although it does represent the best data, and possibly the only data, available at the present time. The accuracy of the data has never been tested by audit although the annual review of the data and its interpretation has provided additional assurance as to its accuracy when compared to other studies. John Hannifin of the PGPA has also informed us that they have never experienced any significant issues with the data such as loss or corruption of data.

The design of the PGPA data and reporting systems has provided information to assist in the planning and management of problem counselling services with a particular focus on identifying the numbers of new problem gamblers accessing these services in each year. The report for 2003 is the first time that aggregate numbers for new and continuing users of the services have been published. This has been achieved by adding the new gambler statistics to the number of clients brought forward at the beginning of the period and the number of earlier problem gamblers returning to use the service again during the year.

The statistics are based on the number of problem gamblers. As such each gambler is classed as a presentation without consideration for the differing consumption of services that may exist between different gamblers. In this manner there is an assumption that on average a gambler with a primary problem mode of Lotto will consume the same level of services as a problem gambler with non-casino gaming machines as their primary problem gambling mode. This may well be the

case although we conclude that the data used for the levy does not directly relate to the consumption of services.

The fact that one client might attend for treatment/assistance three times and another for twenty treatments would have a significant impact on the cost of providing that service. Whilst the PGPA dataset is capable of analysing more detailed levels of service access the presence of several treatment options and programmes all using differing levels of resources could result in less rather than more accuracy in assessing service use.

We understand the MoH will review data requirements and develop a more appropriate basis for data collection in future. In the meantime we concur with the use of the existing data for the current levy calculation in the absence of better information.

2.1.3 Review of the collection and use of the data

The data contained in the PGPA report is compiled in two parts:

- Telephone help line services - this data is not included in the levy calculation figures
- Face to face counselling - this data is used as the basis for the levy figures

The data is collected from all problem gambling service providers contracted to the PGPA. Many people do not seek help at all and there is strong anecdotal evidence to support a much higher level of problem gambling than is recognised in the PGPA figures. Organisations presenting to the Commission at the recent consultation hearing expressed concerns that the figures for youth and Asian problem gambling are likely to be understated. An independent study conducted by Auckland University[1] and another commissioned by Manukau City Council[2] lend support for the contention that Maori and Asian problem gambling numbers are understated.

Data for the telephone help line services is not captured at the same level of detail or using the same software based systems as the face to face counselling data. The help line data is also excluded from the data used for computing the presentation figures for levy purposes. The help line service is regarded as a channel for the face to face services with some 20% of callers subsequently accessing a face to face service. The exclusion of the help line figures from the levy calculation therefore has the effect of understating the total number of problem gamblers but may not significantly affect the proportion (i.e. %) of gamblers in each problem gambling mode. This matter is considered in further detail below.

Prior to November 2003 where callers lived and their names were recorded manually and it is possible that some errors may have been made. The PGPA have not been able to estimate the potential impact of this issue on the data. The data presented appears to have a high degree of consistency over time and the analysis in the document adequately explains the changing patterns of gambling problems with comprehensive analysis of the figures.

Face to face service data is more comprehensive and is based on a wider range of questions allowing a greater depth of analysis in areas such as historical spending patterns prior to seeking counselling and subsequent improvements. The process is managed using a tool known as the South Oaks Gambling Screen adapted to the specific needs of problem gamblers. We have not sighted or evaluated this tool. Each service provider is supplied with computer software with which to manage the client interviews and capture the necessary data. As previously noted this data is not subject to audit verification.

Data is collected using criteria that include client details for age, gender, ethnicity, address and their primary mode of problem gambling. Additional problem gambling modes are also established.

[1] Asian Language School Student And Primary Care Patient Responses To A Screening Tool Detecting Concerns About Risky Lifestyle Behaviours by Felicity Goodyear-Smith MBChB MGP FRNZCGP, and Associate Professor Bruce Arroll MBChB PhD FRNZCGP, Department of General Practice & Primary Health Care, and Samson Tse PhD, Centre for Gambling Studies, School of Population Health, University of Auckland
[2] Social Impacts Of Gambling In Manukau City by Jenny Rankine and David Haigh

There is a high level of consistency in the measured percentages for primary problem gambling modes between the help line and face to face services.

The PGPA statistics also identify that 31.8% of service users are not problem gamblers but are seeking help to address a problem with a family member's gambling. The family member of these callers do not all subsequently seek help and as such the numbers of problem gamblers are understated as these clients are not included in the presentation statistics used for computing the levy. The levy numbers are based on the figures in the table set out on page 44 of the PGPA publication.

Table 1: All clients primary mode data used in the levy calculation (indicating split for levy)

Gambling mode	Primary Mode (All clients)	Number of clients	NCGM	Casino	Track	Lotto	Excl
Non casino gambling machines	76.5%	2223	2223				
Casino gambling machines	10.6%	308		308			
Track	5.3%	154			154		
Casino tables	4.2%	122		122			
Other	1.5%	44					44
Sports betting	0.9%	26			26		
Lotto/Keno/Scratchies	0.6%	17				17	
Housie	0.4%	12					12
Total	100.0%	2906					
Number and levy split	2,906		2223	430	180	17	56

Source: page 44 of "Problem Gambling Counselling in New Zealand 2003" published by the Problem Gambling Committee

We have considered the potential impact of including help line figures and additional modes of gambling in the presentation figures used for the levy calculation.

The strong consistency in percentages between the data from the help line and the face to face services suggests the data collection processes of the two sources are consistent (see table 2 below). This combined with the fact that some 20% of these gamblers are reflected in the face to face service statistics leads us to conclude that inclusion of help line in presentation statistics would not increase the accuracy of the levy calculation. In fact the duplication of gamblers between the two statistics would require careful analysis to ensure that reporting of gambling modes is consistent between the two datasets notwithstanding the apparent similarities between them.

The additional mode data in the table provides an interesting perspective with regard to gaming machines indicating problem gamblers with non-casino gambling machines as their primary mode also frequent casinos. Including a factor for secondary modes could be statistically significant. Only some 20% of problem gamblers report additional modes of problem gambling and as such a lower weighting would be required if included in the levy calculations. The DIA excluded the data from the levy calculations on the basis of the low level of reporting and the secondary nature of this problem gambling leading to difficulty in establishing a suitable weighting. We concur with their view but believe the MoH should consider this factor in developing their reporting systems to better inform future levy calculations by including the additional factors.

The PGPA report does not include data for "all clients" so the analysis below uses the "new client" data tables on page 12 of the PGPA report.

Table 2: New client data (i.e. not all gamblers) used to illustrate the additional factors

Gambling mode	Helpline Primary Mode	Face to Face Primary Mode	Face to Face Additional Mode
Non casino gambling machines	83.90%	76.70%	11.00%
Casino gambling machines	7.70%	9.90%	35.20%
Track	3.80%	4.70%	13.50%
Casino tables	2.40%	4.60%	5.70%
Sports betting	1.00%	0.90%	3.70%
Other and multiple	0.70%	2.10%	6.90%
Lotto/Keno/Scratchies	0.30%	0.80%	21.50%
Housie	0.10%	0.40%	2.50%
Total	100.00%	100.00%	100.00%
N	2,199	2,044	437

Source: page 12 of "Problem Gambling Counselling in New Zealand 2003" published by the Problem Gambling Committee

2.2 How presentations have been allocated to the four sectors

The allocation of the presentation data to the four gambling sectors has been made on the basis of the data in table 1 above. The legislation does not provide for "Housie" and "Other" categories to be subject to the levy and so the computation of the levy is based on the remaining categories comprising 98% of the total. The proportions of these remaining categories are consequently increased to return the total of these figures to 100%. In other respects the existing basis of collection and interpretation of the data within the appropriate sector categories helps ensure that the presentations are computed in the most appropriate way for levy purposes.

Over time there will be changes in gambling behaviour brought about by legislative measures such as the smoke free changes and the lotteries changes due to come into force on 1 July this year. It is not possible to estimate the impact of these changes but they reinforce the need to use up to date information to assess the levy amounts. The legislation provides for the Commission to advise Ministers on the most appropriate levy for a three-year period. This does not preclude the possibility of earlier consideration of the strategy, the levy or the levy rates as this is provided for under Section 322 of the Gambling Act 2003 which permits the MoH to undertake a review.

We also note that the MoH are currently using out of date figures in their levy calculation but will be updating their figures in discussion with the DIA so that they agree with the numbers contained in this report. We have not sighted their final calculations.

2.3 Recommendations

- **We believe the basis for computing the presentation data substantially understates the size of problem gambling. There is strong anecdotal evidence that a small proportion of all problem gamblers are accessing services. There is also evidence that problem gamblers are using other services such as drug and alcohol and mental health. Information resources need to be developed over the next three years to better assess the problem gambling proportions attributable to each gambling mode and the levels of service usage. In the absence of this improved data the present information is the best available.**

3 Calculation of the Funding Requirement (Factor C)

3.1 The programmes the Ministry of Health intends to fund

Funding for problem gambling services will be drawn from the Consolidated Fund and then replaced through the collection of the levy by the IRD. This will ensure that the funding of services is not affected by variations in the collection of the levy. However it does remove the direct linkage between the levy and the funding of services. Whilst the Commission does not have any authority over the funding programme planned by the MoH we recommend a system of six monthly reporting is instituted that allows the Commission to assess the success of the funding programme in the context of future levy calculations.

The MoH has provided a conceptual paper in addition to the information published in the strategic plan. When read in conjunction these two documents illustrate the MoH calculation of the levy and the programmes that it intends to fund. This programme has a dual focus of direct intervention and a public health focus. As this focus is very different from the intervention approach currently used to address problem gambling the MoH have made a number of assumptions based on existing public heath programmes in other areas in constructing its proposed programme. The basis for MoH planned expenditure has been reviewed to ascertain what is proposed and whether it is likely to be within the scope of section 317 of the Act which specifies the required content of the problem gambling strategy.

In October 2001 Cabinet agreed in principal to funding for problem gambling services of up to $9.8m in 2002-03, $15m in 2003-04, and $20m in 2004-05 [POL Min (01) 29/3; CAB Min (01) 34/5]. This was based on the expectation that the MoH assumed funding responsibility for problem gambling services from 1 July 2003. As a result of the delays in implementation of this strategy cabinet has approved increased funding allocations in support of the figures in the table below which are taken from the strategic plan in the MoH consultation document.

The MoH have advised that they will take a business as usual approach for the 2004-05 year and use this time to identify required service changes. They believe the additional funding allocated for 2004-05 of some $3 million will be spent but will not start to contract for new services until final cabinet approval is given for the funding in August. Their primary focus at present is in managing the handover of the operational role from the PGPA.

In reviewing the funding and costs below we have not been supplied with detailed analyses supporting these amounts but have met with officials. It is our considered view that these amounts are based on a "top down" approach to estimating costs informed in part by the existing contract figures for contracts to be taken over from the PGPA on 1 July 2004. We do not believe the funding amounts will be adequate to meet likely demand for intervention services. This matter is subject to detailed comment in the subsequent sections of this report with conclusions highlighted in table 3 for quick reference.

Table 3: MoH funding plan from the consultation document with review conclusions

	2004/05	2005/06	2006/07	Increase 2006-07 on 2004-05	Conclusion
Public Health	**$**	**$**	**$**		
Generic services funding	1,598,000	1,608,000	1,905,000	16.00%	The proportion to total expenditure is too low given Europeans are 56% of all problem gamblers
Mäori services funding	826,000	1,094,000	1,400,000	41.00%	The progressive increase is likely to be required but is high when compared with other service funding in this constrained budget
Pacific services funding	764,000	764,000	910,000	16.00%	The increase is proportional to generic services. Many existing PGPA special projects will not be funded
Asian services funding	546,000	542,000	600,000	9.00%	This is a large budget given the small percentage of Asian problem gamblers and the constrained budget
Workforce training	50,000	100,000	200,000	75.00%	This is thought to be reasonable given the large increase in health promotion.
Resources	40,000	150,000	200,000	80.00%	This is a large allocation given the constrained nature of the budget and previous PGPA management costs
Social marketing media campaign	40,000	550,000	1,500,000	97.00%	A large allocation given the constrained nature of the budget and low intervention services funding
Behaviour change indicators	30,000	100,000	200,000	85.00%	This allocation is large given the budget constraints and other work completed in complementary areas
National co-ordination services	200,000	220,000	200,000	0.00%	We are unable to determine whether this is a duplication of other overheads
Sub total	**4,094,000**	**5,128,000**	**7,115,000**	**42.00%**	
Total operational budget	401,688	384,813	384,813	-4.00%	This operational budget is high given past experience with PGPA management and the similar amount for intervention services
Total	**4,495,688**	**5,512,813**	**7,499,813**	**40.00%**	This is a large increase and is designed with a public health promotion focus. It is hard to justify the increase in the light of relatively small growth in intervention services particularly in the final year
Intervention Services					
Help line	1,400,000	1,400,000	1,400,000	0.00%	The absence of an increase represents uncertainty as to the future funding path. We understand a contingency has been made elsewhere for potential increases. This is a single provider contract
Brief and early intervention	3,530,000	4,660,000	4,870,000	28.00%	It is appropriate that new funding concentrates on problem gambling before an acute intervention is required. The increase appears inadequate to match the likely increase in demand arising from the public health campaign especially given the 2006 launch of the social marketing programme
Psychosocial interventions and support	3,800,000	4,520,000	4,330,000	12.00%	The increase in funding in the second year is not matched by a further increase in the third year. This is intended to relate to a peaking in demand for services. Given the social marketing campaign does not commence until the third year we believe this reflects funding constraints that will result in significant under funding issues in the third year
PG information system	220,000	200,000	200,000	-10.00%	This is a large sum for administering the 40 current contracts on an annual basis. There should be a one off cost to establish the system and then a much smaller annual cost in subsequent years
Screening	194,000	223,000	223,000	13.00%	The development of a reliable screening tool is highly desirable. It will place greater demands on the intervention services that do not appear to have been allowed for in the funding levels. It is doubtful that this

	2004/05	2005/06	2006/07	Increase 2006-07 on 2004-05	Conclusion
					level of expenditure is required in each of the three years
Training/audit	464,000	620,000	600,000	23.00%	This largely represents an internal cost of the MoH assessing and developing the training requirements for providers and does not include any significant element in funding training activities for providers. This amount appears excessive given the lack of increase in provider funding
Sub total	**9,608,000**	**11,623,000**	**11,623,000**	**17.00%**	
Total operational budget	382,938	366,063	366,063	-5.00%	This operational budget is high given past experience with PGPA management and the amount also provided for the public health budget
Total	**9,990,938**	**11,989,063**	**11,989,063**	**17.00%**	
Total spend					
Public health services	4,094,312	5,128,687	7,115,187	42.00%	
Intervention services	9,617,063	11,633,938	11,633,938	17.00%	
Research contracts	1,000,000	1,000,000	1,000,000	0.00%	
Public health operating	401,688	384,813	384,813	-4.00%	
Mental health operating	382,937	366,062	366,062	-5.00%	
Sub total	**15,496,001**	**18,513,501**	**20,500,001**	**24.00%**	
Cost recouping	483,666	483,666	483,666	0.00%	Subject to a legal opinion. Detailed information not provided for review
Total planned expenditure	**15,979,666**	**18,997,166**	**20,983,666**	**24.00%**	
Cabinet approved funding	**15,980,000**	**18,997,000**	**20,984,000**	**24.00%**	

Source: MoH Strategic Plan for Preventing and Minimising Gambling Harm

3.2 How the projected requirements were determined

3.2.1 General comments

The planning process to determine the funding requirements was undertaken by the MoH in two separate parts with service planning and public health planning proceeding separately and then being linked once the initial review had been completed. This required a number of compromises, as the total funding plan exceeded the maximum amount available. A further reduction in planned expenditure was also required when cabinet confirmed the funding amount at a lower level than previously anticipated. We have not been privy to the details of these discussions or details of the higher funding amounts.

The MoH funding plan summarised in table 3 represents their firm intentions for the three-year period. The MoH would need to consult again if there was any significant move away from the intentions signalled in that plan. We believe this is problematic given our conclusion that the overall amount of the funding and the allocation between areas is inappropriate.

3.2.2 Individual Intervention Services

MoH planning for intervention provider funding is based on two components being the rollover of current contracts and contracting with new providers to address service coverage gaps. The MoH will concentrate their immediate efforts on a business as usual approach and in growing the fledgling services that have yet to reach operational maturity. Funding for special projects commenced by the PGPA will be constrained and take a lower priority compared to core services. In part this issue reflects the impact of annualising contract increases during the 2003-04 year, which have resulted in full year expenditure projections exceeding the allocated funding.

The PGPA manages 40 contracts and a summary of the providers and their services is included in Appendix 2. We have not been provided with contract values. Given the annualised cost issue above and the differing focus of the MoH to the PGPA we anticipate that a number of targeted contracts and projects will be discontinued . In our view the approach being adopted by the MoH will provide a more co-ordinated set of services than existed under PGPA management which tended to focus on developing small contracts with limited coverage but specific aims.

We have reviewed the overall allocation of funding and believe there is a mismatch between funding for intervention services and public health initiatives. The increase in funding for intervention services over the three-year period is 21% compared to a 67% increase in public health initiatives. Whilst the increased emphasis on prevention is intentional we note two key issues:

- **Timing:** The social marketing and media campaign is designed to modify gambling behaviour but will not commence until 2006. We anticipate that the desired behaviour changes will not be achieved in less than 2-3 years but that awareness will be increased and greater pressure placed on intervention services
- **Funding adequacy:** Funding for intervention services is increased in the second funding year but reduced in 2006 at the point where the social marketing and media campaign with be advertising the availability of help line and other intervention services. Waiting lists are likely to be required to manage within service capacity

The interaction of these two issues indicates that the funding in the third year is constrained and implies that intervention services have been reduced in order to fund the social marketing and media campaign.

We also note that funding for the help line service funding remains static without a volume or price increment over the three year period. This is merely a presentation issue as the service is operated by a single provider and the funding requirements for the service have not yet been determined. The MoH intend to fund this service to higher levels dependent on a future assessment of requirements. Given this additional funding would come from another funding line item this tends to reinforce our view that the overall funding numbers are inadequate.

The MoH has not yet completed an assessment of the ability of current providers to expand their services to meet the increased levels of spend as indicated by the funding programme. We understand they are using the current contracting round to start this assessment process in discussion with providers. The expanded service requirements are likely to require increases in the number of trained staff and/or establishment of new service locations. There may also be a need to contract for new providers to cover some service and locality gaps. The time required to complete this work is likely to result in some delays in the programme and this could indicate the need to defer some planned expenditure.

New providers, especially if they service Maori, Pacific and Asian communities need support with funding to cover the cost of establishing appropriate governance and administrative infrastructures as well as funding service provision. In the Health sector it is acknowledged that servicing deprived communities costs more. It is therefore reasonable to assume that this will hold true for problem

gambling services. The MoH has suggested that they will make allowance for such costs where required.

3.2.3 Health Promotion Services

The MoH has used the cost of similar programmes such as “Like minds like mine” as a basis for costing the health promotion programme. This appears to be a reasonable approach given the experience of the MoH in developing this programme.

The funding profile is not supported by a detailed implementation plan to assist us in evaluating the programme. As previously noted the planning process for the public health programme was completed in isolation from the personal health plan and then matched to ensure the appropriate linkages. We believe this process has not resulted in the most appropriate overall programme as the two plans were significantly affected by a constrained level of funding and compromises were required. In our view this has favoured the public health plan which we regard as oversized in comparison to the personal health plan. This has restricted the funding of intervention services to levels that we believe are likely to be inadequate.

We are also concerned that the proportion of service funding allocated to generic public health services is not consistent with the presentation statistics for problem gamblers. Whilst we acknowledge a growing body of evidence for Maori, Pacific, Asian and youth problem gambling we note that 56% of problem gamblers are European and yet the generic funding is 35% of total public health funding in year one dropping to 25% of funding by year three. If any funding is reallocated or additional funding secured we suggest this imbalance be addressed.

There is no ability to transfer funding from public health to the personal health intervention services as this is precluded by the NDOC funding requirements which quarantine funding for public health.

The social marketing and media campaign receives the most significant increase in funding over the three-year period with the highest increase occurring in the third year. The MoH intends for this programme to support long-term changes in attitudes towards gambling, thereby reducing the demand for intervention services. The likelihood is that increased expenditure on intervention services will be required whilst these changes are taking place. It is also our view that the level of funding for intervention services was reduced in the third year to fund the social marketing and media campaign.

3.2.4 Administration and Development Costs

The MoH intend to deduct an administration fee from the gambling levy. We have not been provided with any detailed information with which to assess this amount.

We also note the Ministry intend to deduct their administration costs for the three preceding years from the gambling levy. The recovery of transitional costs by the MoH is addressed in the Commission's report and a separate legal opinion.

In the table below we have isolated those components from the MoH funding table that do not comprise the purchase of public health or intervention services from providers. These elements represent a mixture of administrative overhead and development costs.

We anticipate that most of these costs comprise MoH internal costs for contract management, project management and research staff. Some work would also represent contracted out services in areas such as the completion of provider capability reviews and problem gambling surveys. To provide a frame of reference for Commissioners in reviewing these matters we approximate that:

- A provider capability assessment would cost approximately $50-60,000

- The analysis and publication of problem gambling statistics such as those published by the PGPA would require one full time analyst, management time and publication costs totalling $70-80,000

Costs such as these would be an integral part of the training and audit budget ($464-620,000) and the PG information system ($200-220,000).

Table 4: Costs that are not related to provider funding

Area	2004-05	2005-06	2006-07
	$	$	$
Workforce training	50,000	100,000	200,000
Resources	40,000	150,000	200,000
Behaviour change indicators	30,000	100,000	200,000
National co-ordination services	200,000	220,000	200,000
PG information system	220,000	200,000	200,000
Screening	194,000	223,000	223,000
Training/audit	464,000	620,000	600,000
Public health operating	401,688	384,813	384,813
Mental health operating	382,937	366,062	366,062
Total	1,982,625	2,363,875	2,573,875
Total expenditure from funding table 3	15,979,666	18,997,166	20,983,666
Percentage of total spend	12%	12%	12%

Source: MoH Strategic Plan for Preventing and Minimising Gambling Harm

The percentage that these costs bear in each year to total costs is illustrated at the base of the table. There is a consistent allocation of 12% in each year. We believe this does not reflect the nature of development and establishment activities that are not usually repeated in each year. We believe appropriate levels of costs would be substantially less than these amounts. We note that in comparison the Regional Health Authorities total overheads in relation to managed funding in the 1990's were less than 2% of funds managed. We also note that in addition to these amounts a further $1,000,000 per annum has been allocated to research and this is discussed further in 3.2.6 section below. The value of administration and research costs combined represents up to 19% of annual funding.

The allocation of the level of costs planned by the MoH significantly reduces the funding available for intervention and other services. In our view this is inappropriate regardless of whether the planned activities are otherwise thought to be necessary. The overall level of funding is constrained and in our opinion the administration and development costs have not been reduced in order to share this burden.

3.2.5 Ability to Implement New Programmes

The time required to implement programmes is often longer than expected. With a start date for the new contracting environment of 1 July 2004 we anticipate it is unlikely that new programmes or providers will be operating effectively before I January 2005. There will be several reasons for this:

- The need to identify the increased services to be purchased and where these will be located
- Known shortages of trained competent staff
- The probable need to establish and develop providers particularly where the increased need lies with Maori, Pacific or Asian communities

As a result of these factors there is there for a strong probability that a portion of the increased funding will not be spent in 2004-05.

3.2.6 Research and Evaluation

A proportion of total funding has been targeted towards research. Whilst we have identified a number of areas in this report where improved information is required we note that for the most part these relate to data collection, which is a normal provider reporting function. We concur with the need for further research but we believe that a large body of information already exists and that future research should be carefully targeted to ensure it is both necessary and does not replicate existing bodies of work.

In the first instance the research work should be targeted towards evaluating the effectiveness of the current and planned programmes.

3.3 Recommendations

- **The funding plan represents a significant compromise based on constrained overall funding levels. These levels have been calculated on a top down basis to fit a predetermined level of funding rather than funding the programme on the basis of need to determine the level of service required and then establishing appropriate funding levels.**
- **We believe the funding levels between public and personal health are mismatched and understated based on the likely increase in the number of problem gamblers who will present to intervention services once the public health programme is implemented. The most significant impact is likely to occur in the third year when the social marketing and media campaign starts. We are unable to quantify the amount of the under funding**
- **The MoH will not be able to meet the annualised cost of contracts taken over from the PGPA on 1 July as a result of increases in contract volume levels part way through the 2003-04 year. As a result some contracts will be discontinued and others restricted to lower amounts until such time as additional funding can be allocated. Whilst the MoH will manage this issue in the most effective way it suggests that the initial funding amount is understated**
- **The level of administration and development expenditure is too high in relation to the total funding amount. The proportion is 12% of funding in each year and up to 19% if research costs are included. We also believe the costs include a full allocation of MoH overheads and as such do not represent the marginal cost of undertaking this new area of funding. This approach is inconsistent with the approach the MoH adopts when funding new activities in providers. In our view the costs should be reduced to recognise these factors with the resulting balance allocated to intervention services**
- **The proportion of service funding allocated to generic public health services is not consistent with the presentation statistics for problem gamblers. Whilst we acknowledge a growing body of evidence for Maori, Pacific, Asian and youth problem gambling we note that 56% of problem gamblers are European and yet the generic funding is 35% of total public health funding in year one dropping to 25% of funding by year three. If funding is reallocated we suggest this imbalance is considered in setting the new amounts**
- **We believe there is an imbalance of funding between public and personal health (intervention) services. We note there is little flexibility to move funding within the plan and any significant changes would require consultation by the MoH. There is also no ability to transfer funding from public health to the personal health services as this is precluded by the NDOC funding requirements which quarantine funding for public health. This suggests that an injection of new funding would be required to address the under funding issues identified in this report**
- **The MoH has completed a gap analysis to identify new service requirements. It is uncertain whether there is sufficient Provider capacity and this is likely to result in**

delays in establishing or extending services. This may indicate a need to defer some expenditure in the funding plan

- **There is an inherent difficulty in ring fencing problem gambling funding due to the co-morbidities that many gamblers suffer from. On balance we believe this is likely to favour the problem gambling funding position as these people are accessing other services such as mental health and drug and alcohol in resolving their problems.**
- **In conclusion we recommend that any increase or reallocation in funding amounts should favour intervention services as the first priority to ensure these services can cope with the increased demand that will arise when the public health campaign commences**

4. Expenditure Projections (Factor D)

4.1 Discussion of issues

As previously noted we have not been provided with detailed information regarding the projections as a consequence of the privacy requirements relating to the underlying IRD data.

The expenditure projections developed by the Department of Internal Affairs (DIA) use IRD expenditure data as the base to which sector-based growth factors are then applied. We note that most of the growth projections are lower than the rate of growth experienced in recent years (e.g. non-casino gaming at 9.65% compared to over 20%). This has been explained as the result of changes in expected trends. The use of low growth expenditure projections increases the levy rate as it is the denominator in the calculation. As such the there is potential for collection of more than the projected levy amount over the three years assuming expenditure growth maintains its previous path.

4.2 Recommendations

- **We recommend the Commission advises Ministers that the rate of collection of the levy should be monitored and adjusted during the three year term if found to be greatly excessive. We note that there is an ability to take into account any under or over collection in setting future levies.**

- **Legislative changes in areas such as smoke free and lotteries will potentially impact on levy collections and funding requirements. This will require consideration within the three-year levy period and an early review may be required.**

5. The Proportions Used in the Calculation (Factors W1 and W2)

5.1 Discussion of issues

The sum of these weights is 1. Cabinet agreed that W1 should be 10% and W2 should be 90% thus providing a significant weighting towards presentations in setting the levy rate for each sector to reflect a focus on managing harm. Although Cabinet has agreed the weightings, they have not yet been set in regulations.

We have considered the weightings and their impact on the levy calculation. We believe that the focus on managing harm is appropriate and that greater weighting should be applied to presentations than gambling expenditure. We also believe that managing harm and the planned public health programme have a wider focus than those persons presenting to acute services. As such we recommend a greater weighting be given to the expenditure category to reflect this broader view. In the absence of scientific data we believe that the 80/20 split originally

recommended by the MoH would better recognise this focus. In our opinion the current 90/10 split provides insufficient recognition of this factor.

5.2 Recommendations

- **The allocation of levy proportions between presentations and gambling expenditure should be amended to an 80/20 split compared to the 90/10 split currently used. This is necessary to reflect a wider view of problem gambling**

Appendix 1 - Current PGPA Providers

PGC Contract Register: at 24 June 2004 (40 contracts)

Contract 99/2003-2004 Odyssey Trust (Auckland)

- Contribution for additional help for clients with gambling problems in a residential treatment service; report on results for the service.
- Clients are not individually funded for residential treatment, Odyssey have agreed to admit, as appropriate, clients with a primary problem of pathological gambling.

Contract 100/2003-2004 Helpline

- National Telephone problem gambling Helpline.
- Dedicated Helplines with separate numbers for Maori, Pacific, Youth and Budgeting.
- Integrated care follow-up system for counselling clients.
- Production and distribution of printed materials.
- Media - advertising and promotion of services.
- Development of standards of best practice for Problem Gambling Helplines.
- Trial of 24 hour phone service.
- National Problem Gambling Issues Newsletter (4 Issues).

Contract 101/2003-2004 Salvation Army Oasis

- National counselling services
- Health Promotion Services Waikato
- Early Intervention Screening Project in Social Service(s) in agreed areas
- Management of grant in support of Gamblers Anonymous national service
- Variation 1 - Contract 124/2003-2004 Salvation Army Oasis January 04
- Social work services to work with families with gambling problems detected through screening of Salvation Army Social Service Agencies in South Auckland and Christchurch

Contract 102/2003-2004 Problem Gambling Foundation

- National Counselling services.
- Health Promotion Services Auckland.
- Services for Asian communities in Auckland and Christchurch.
- Territorial Authorities Project- education and information on gambling issues
- Management of Resource development and distribution contract (this schedule is overseen by Consortium of PGC contracted Providers).
- Women gaming machine problem gamblers project (in liaison with Hauora Waikato). To investigate pathways to problem gambling experienced by women and to develop a clinical response to women problem gamblers.
- Further development and distribution of resources on problem gambling for the school health curriculum.
- Publishing and distribution of the Youth Problem Gambling Strategy developed under the 2002/2003 contract.
- International Gambling Conference September 2003.

Variation 1 PGF Contract 121/2003-2004 February 2004

- Extension of Asian services to Waikato; development of a national strategic plan to minimise problem gambling among Asian people
- Re-orientation of Health Promotion workers to be based in Auckland, Wellington and Christchurch (rather than all based in Auckland) and to include an emphasis on Youth programs. (Youth program to be undertaken in conjunction with Te Rangihaeata Oranga in Hawkes Bay)
- Re-orient the Youth Project to include youth in non-school settings
- Developing and delivering program for Offenders in the Justice System with an emphasis on re-integration into the Community
- Development of a Website based resource bank as part of the national resource contract

Contract 103/2003-2004 Hauora Waikato (Tainui)
- Counselling and Health Promotion Services Waikato and South Auckland
- Early Intervention Screening Project in Health/Social Services in Waikato
- Wahine gaming machine problem gamblers project
- Administrative services for the National Maori Trust

Contract 104/2003-2004 Ngati Porou Hauora
- Health Promotion and counselling services on the East Coast including Gisborne.

Contract 105/2003-2004 Te Rangihaeata Oranga/Monica Stockdale
- Counselling Services Hawkes Bay - including counselling services from Taha Maori Perspective.
- Health Promotion Services Hawkes Bay.
- Development of models used in counselling Maori.

Contract 106/2003-2004 Te Runanga O Kirikiriroa (Hamilton)
- Delivery of Waikato community action project on problem gambling delivered in collaboration with Pacific People's Addiction Services.

Contract 107/2003-2004 Tui Ora Ltd (Taranaki Iwi)
- Health Promotion services targeted at Maori in the Taranaki; early intervention screening project targeting a social service agency in Taranaki.

Contract 108/2003-2004 Grant Paton-Simpson & Associates Ltd
- The ongoing development and implementation of client database systems for providers contracted to PGC, the analysis of data collected and the production of reports and monitoring including national statistics.

Variation 1 Contract 125/2003-2004 Grant Paton-Simpson & Associates Ltd March 2004
- Additional funds to support additional development of software client management system; implementation in new agencies; counsellor service agencies staff training

Contract 109/2003-2004 Hapai Te Hauora Ltd (Auckland – owned by Wai Health, Tainui and Ngati Whatua)
- Delivery of Manukau community action project on problem gambling delivered in collaboration with Pacificare.
- Management of funding support of community problem gambling initiatives in Manukau including Wahine Tupono (Maori Women's group) and Otara community problem gambling project.

Contract 110/2003-2004 Pacificare Trust (Auckland)
- Problem gambling counselling services for Pacific people in Auckland.
- The Pacific component of the Manukau Community Action Project (in collaboration with Hapai).

Contract 111/2003-2004 Wai Health (Henderson)

- Problem gambling counselling services in Henderson, West Auckland. (Maori focus)

Contract 112/2003-2004 Abacus Training and Counselling Services Ltd

- Consultation and training assistance for the early intervention screening projects being undertaken by Salvation Army Oasis, Hauora Waikato and Tui Ora. Workforce Training; clinical audit. and general training services for new agencies delivering problem gambling services

Contract 113/2003-2004 Community Medical Trust (Manurewa Peoples Centre)

- Delivery of a series of educational support groups for people with gambling problems in the Manurewa area.

Contract 114/2003-2004 Pacific People's Addiction Services (Waikato)

- Contribution to Waikato Community Action Project in association with Kirikiriroa
- Provision of problem gambling counselling services for Pacific People in the Waikato area

Contract 115/2003-2004 Taumata Hauora Trust (Five Wanganui Iwi)

- Project to provide information on problem gambling issues to Maori in the Whanganui region; to scope the nature of gambling problems in the area and to develop a strategy to reduce those gambling problems.

Contract 116/2003-2004 Te Runanga o Toa Rangatira Inc (Porirua/Wellington Iwi)

- Counselling and Health Promotion services throughout Wellington area targeted at Maori

Contract 117/2003-2004 Nga Manga Puriri (Northland Tai Tokerau Iwi)

- Provision of health promotion and counselling services targeted at Maori in Northland including -involving Kuia and Kumata in community education on gambling issues.

Contract 118/2003-2004 Te Kahui Hauora Trust –(Rotorua, Central Nth Island Te Arawa Iwi) January 2004

- A consortium of Te Utihina Manaakitanga Trust (problem gambling counselling); Te Runanga O Ngati Pikiao (early intervention and whanau support) and Te Kahui Hauora Trust (Health Promotion)

Contract 119/2003-2004 Best Care (Whakapai Hauora) Charitable Trust (Rangitane Iwi Palmerston North) February 2004

- Counselling and Health Promotion services Palmerston North area

Contract 120/2003-2004 He Oranga Pounamu (Ngai Tahu South Island-excluding top of the South) February 2004

- Counselling and health promotion service in Otago and Southland,
- Counselling services for Maori in Christchurch; Publication of "Framework for Development of Gambling Services for Maori in Te Rohe O Ngai Tahu". (completion of contract 95/2002-2003)

Contract 121/2003-2004 – PGF Variation 1 (see above-page 2) February 2004

Contract 122/2003-2004 National Pacific Project Niu Development March 2004

- Commencement of delivery of National Strategic Plan and Business plan for pacific peoples developed under a previous contract with PGC; Education and information for Pacific communities delivered through Samoan, Tongan Niu and Cook initiatives. Project based in Auckland and to include start up of community initiatives with Pacific People in Wellington and Christchurch.

Contract 123/2003-2004 Woodlands Trust March 2004

- One series of counselling workshops and associated clinical services

Contract 124/2003-2004 Salvation Army Variation 1 (see above) January 2004

Contract 125/2003-2004 Grant Paton-Simpson Variation 1 (see above) March 2004

Contract 126/2003-2004 Te Herenga Waka o te Ora Whanau (National Maori Reference Group) March 2004

- Review of Developing and delivering program for Offenders in the Justice System with an emphasis on whanau and re-integration into the Community

Letter of Agreement – Auckland University of Technology

- Delivery of “think-tank” and International Conference in May 2004 on behalf of PGC

Contract 127/2003-2004Pacific Education Resources Trust April 2004

- Contribution to the publication of “Problem Gambling: New Zealand perspectives on treatment” edited by Tan & Wurtzburg

Contract 128/2003-2004 Ngati Porou Hauora May 2004

- Screening for problem gamblers in communities in Gisborne and the East Coast. Production of DVD on problem gambling targeting Maori for showing in medical and social service centres

Contract 129/2003-2004 Salvation Army Oasis May 2004

- Enhancement project for Counselling services Canterbury

Contract 130/2003-2004 Problem Gambling Foundation Variation 2 May 2004

- Further development of material for Resource bank including Website a

Contract 131/2003-2004 Hikairoa Associates (Wiremu Manaia) May 2004

- Health promotion project with large Maori Organisation

Contract 132/2003-2004 Abacus Variation May 2004

- Extension of workforce development/training project

Contract 133/2003-2004 Helpline Variation May 2004

- Additional funding for promotion of services; investigate potential of film material for DVD/website resource on problem gambling

Contract 134/2003-2004 Paton-Simpson & Associates Variation 2 June 2004

- Additional funding to allow completion of data analysis on clients to June 30 2004 and to complete adjustments to the CLIC system

Contract 135/2003-2004 Te Herenga Waka o te Ora whanau Contract 2 June 2004

- Funding to allow planned follow-up workforce development hui to the workforce training held at Pakirikiri Marae in Tokomaru Bay in November 2003

Current PGC contracts from previous years – still to be completed: (6)

Contract 46/2000-2001 Christchurch School of Medicine

- Preliminary trials of the treatment effectiveness of psychopharmacological agents. [trial of drug therapy (Naltrexone) for problem gamblers to eliminate the craving for gambling].

Contract 43/2000-2001 Tan & Wurtzburg (Christchurch) - Completed March 2004 - final report to be published in peer reviewed journal

- Research into the effects of parental problem gambling on children (draft of final report presented at recent counselling conference).

Contract 59/2001-2002 Auckland Pacific Islands Cultural Social Services Providers Association Inc

- Re-focus of an earlier contract to provide problem gambling screening of Pacific people at selected pacific health and social service providers. Education on problem gambling issues of Pacific social service providers

Contract 81/2002-2003 Mangere Primary Health Service

- Training of primary health workers on screening for gambling problems and screening and assistance/referral, as appropriate, of all patients of the General Practice groups in the Mangere Health Service with the anticipated screening of up to 3,000 patients.

Contract 58/2002-2003 Ministry of Health

- Gambling questions in the New Zealand Health Survey - to be reported late in 2003 and into 2004. Some information was used to inform the MOH strategic plan 2004-2010

Contract 86/2002-2003 Health Research Council

- Management of PGC's research investments;
  1. Contracts for evaluation of Community Projects, [completed]
  2. Gambling questions in the Dunedin Longitudinal Study,
  3. Evaluation of the Socio-economic Impact of Gambling in New Zealand; [Shore Centre Massey University Auckland]
  4. Why do People Gamble? Environmental including socio-cultural influences on Problem Gambling. [Centre for Gambling Studies Auckland University]