Value for Money review of problem gambling services

Ministry of Health

March 2011

Official Supplier of Accounting and Tax Advisory Services

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Section 1 – Executive summary

1.1 Background, and Scope

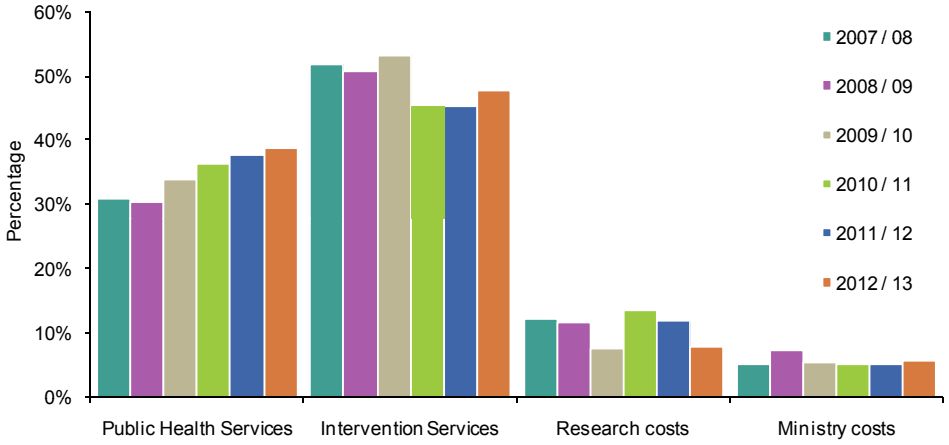
Background - Problem Gambling in New Zealand

Gambling is a popular activity in New Zealand, with national surveys showing that six to eight out of ten people, (aged 15 years and over), gamble at some point during a year. Problem gambling is defined as gambling behaviour that results in any harmful effects to the gambler, his or her family, whānau, significant others, friends and co-workers and through to the wider community.

The Ministry of Health, ("the Ministry"), has been allocated responsibility for funding and coordinating an integrated problem gambling strategy under the Gambling Act 2003. The problem gambling levy, a levy on domestic gambling collected by the Inland Revenue Department, recovers the cost of developing, managing and delivering an integrated problem gambling strategy. In 2010 / 11, funding for problem gambling services was $18.6m. The graph below illustrates how this funding is consumed and variations between 2007 / 08 and 2012 / 13. The total level of spend is independently reviewed as part of the problem gambling levy setting process every three years.

In view of this, it is important to note that the cost of providing problem gambling services in New Zealand is not borne by the tax-payer, but rather is recovered from the gambling industry.

Graph 1: Problem gambling services spend 2007 - 2013



Source: KPMG

Scope of this review

KPMG was commissioned to complete a Value for Money (VfM) review of problem gambling services funded by the Ministry. In 2010 / 11 this funding was $18.6m. Analysis in this report focuses on the economy, efficiency and effectiveness of the use of the total funding, not on the size of the funding pie itself. It considers the value delivered from this spend. $18.6m is the current spend (2010 / 11) and provides an indication of the review scope.

The scope of this review was to:

- Examine the cost-effectiveness of existing services delivered by Ministry-funded problem gambling service providers
- Review international evidence to compare the cost effectiveness of New Zealand-based services with international problem gambling services, and best practice
- Assess whether the current service delivery structure of problem gambling intervention and Public Health services is appropriately structured to achieve maximum health gains
- Provide an indication to Ministers of whether services are being delivered in the most efficient and effective way, both to meet the Government's objectives and to generate the maximum possible benefit for the level of expenditure.

Excluded from this review are the regulatory roles of the Department of Internal Affairs (DIA) and the oversight roles of the Gambling Commission. Also excluded as mentioned above is discussion on the total level of problem gambling spend.

The scope of this review was limited to the review and analysis of secondary sources of data. KPMG was not commissioned to obtain primary data.

1.2 Approach

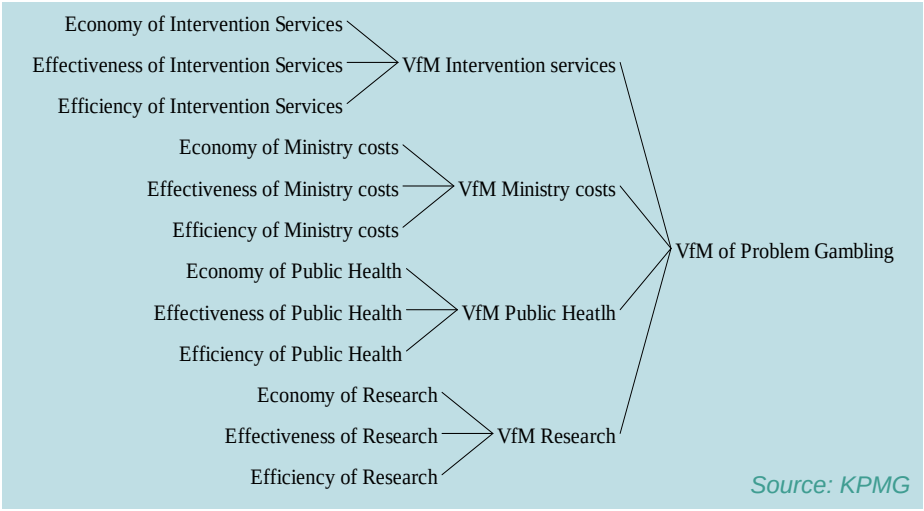
Approach

KPMG has undertaken both a quantitative and qualitative analysis. Our views have been formed from evidence from three sources: hard data on problem gambling services, stakeholder interviews and relevant literature. The data which supports our findings and conclusions has been validated by key stakeholders. We have engaged widely with key stakeholders: the Ministry, representatives from 94% of service providers by funding, international jurisdictions undertaking similar work and with international experts in the field of problem gambling. We have reviewed a wide range of available literature as listed in Appendix B.

KPMG is grateful to this large number of stakeholders, listed in Appendix A, for the time they made available and their open, enthusiastic and professional support.

Our approach, summarised below, is based on a review of the three core drivers, or factors that affect VfM: the Economy of services, the Efficiency of services and the Effectiveness of services; commonly referred to as the '3Es'. The services reviewed are Intervention, Public Health, Research and Ministry costs. Individual drivers of each service were identified and analysed.

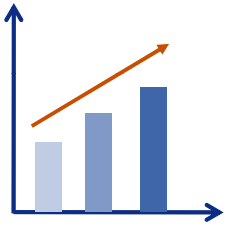
Diagram 1: VfM Driver tree



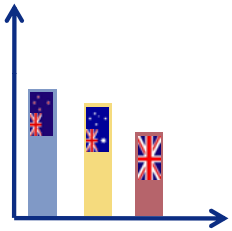
Initially, the impact of each individual driver was assessed in isolation. So, for each driver, holding all other factors in the system constant, (the principle of ceteris paribus), we assessed its impact upon overall VfM. To reach our overall conclusions, the impact of the individual factors were brought together.

Performance assessments were made by applying a set of up to four comparators, depending upon available data as illustrated below.

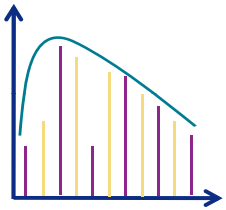
1. Comparison with New Zealand problem gambling services over-time



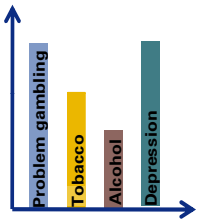
3. Comparison with problem gambling services internationally



2. Comparison with New Zealand problem gambling services across providers



4. Comparison with analogue services



To derive best value from this review, our focus was aligned to the proportionate spend between the four types of service or cost that make up problem gambling strategy. So the majority of our focus was on Intervention Services and Public Health services.

1.3 Overall conclusion

Summary

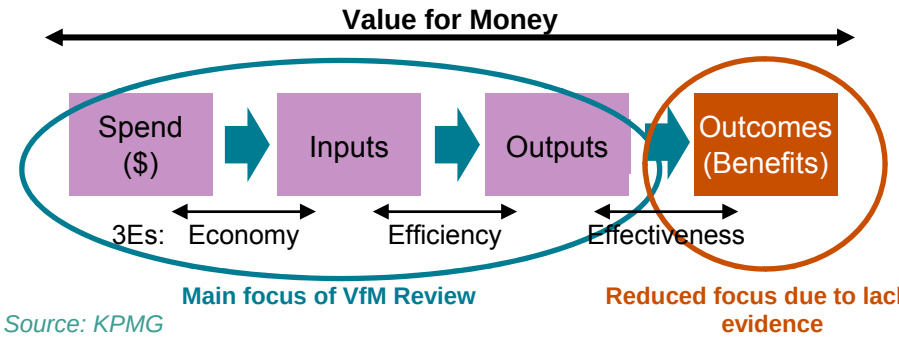
1. VfM Overall	Premature to conclude
2. VfM (Inputs & Outputs focus)	Good
3. Trend	Positive
4. Confidence in conclusions	Medium to High

Conclusion 1: It is premature to assess the overall VfM for Problem Gambling

Overall VfM is exactly what it says; the value received for the money spent. It is simply the ratio of the total costs compared to the total quantified benefits, or value delivered; 'the *bang for the buck*'. So, for 2010 / 11, VfM is the ratio of the cost of $18.6m compared to the quantified benefits. However, sufficient robust evidence does not exist to enable the benefits, or outcomes to be quantified. So, in terms of overall VfM, we have to conclude that it is premature to make this assessment. It is premature because the Ministry has established an outcomes framework and is in the process of undertaking the work required to populate and report on outcomes. This framework is intended to go some way towards providing better information upon which to assess and quantify the ultimate benefits accruing to New Zealand from the implementation of the Ministry's Problem Gambling Strategy.

Due to this lack of hard evidence to quantify the outcomes, the main focus of this review has had to be on inputs and outputs rather than outcomes, as illustrated below.

Diagram 2: Definition of VfM and focus of this review



Source: KPMG

Conclusion 2: VFM, covering our focus on inputs and outputs, is assessed as Good. Many significant strengths were identified. A shorter list of less significant areas for development were also identified. These are summarised in the next slides.

Caveat to Good assessment. Achievement is significantly below target in two important areas. We are unable to conclude if the reason is inappropriate targets or low provider achievement. If targets are appropriate, then achievement would thereby be low in these areas, in which case we would revise our VfM conclusion to Fair/Good.

The two areas where achievement is below target are both important drivers of intervention services VfM. Intervention services consume nearly 50% of costs. The first is Driver 3: Provider face-to-face time (includes telephone contact). The second is Driver 8: The extent that providers achieve intervention contract targets. The assessment of the appropriateness of targets is outside the scope of this review.

Conclusion 3: The trend in VfM is positive

There is fairly strong evidence that the VfM of problem gambling services, covering our main areas of focus, inputs and outputs, has increased significantly over the past three years. For six of the seven drivers, where a trend could be assessed, the trend was positive.

Confidence in conclusions

4. Our confidence in these conclusions is Medium to High given the quality and availability of the supporting evidence.

Large amounts of robust data exist and our conclusions were supported by both the quantitative and qualitative analyses. Throwing the net wide by looking across government sectors and the private sector, 26 potential drivers of problem gambling VfM were identified. Of these, 13 were both appropriate and feasible to apply. It was not feasible to conclude on the remaining 13 drivers due to:

- Insufficient objective data
- Excess effort required to measure the driver relative to the benefits that would have been gained
- Further analysis indicating the driver was not appropriate to this sector.

Numerous strengths exist, as well as some potential areas for development. The top eight strengths and seven potential development areas are summarised over the page.

1.4 Strengths

1. **The preventative approach of Public Health to prevent and minimise harm.** The Public Health approach is important in preventing problems associated with gambling and promoting healthy communities, as well as being an effective way of raising awareness of problem gambling. Positive qualitative feedback was received from all service providers on the Public Health approach and Dr David Korn, (an internationally recognised academic in the problem gambling field), commented that "the Public Health framework is a real strength and reflects both a bold and balanced vision." Note that obtaining evidence to drive the effectiveness of Public Health services is identified as a development area.
2. **Intervention services appear innovative and well designed.** The Ministry's intervention service model recognises that people affected by gambling harm can benefit from a range of services: Brief, Full, Facilitation and Follow-up. The model aims to address not only the gambling behaviour, but also to reduce the impact of harm by facilitating the client's access to other services. The approach also acknowledges the widespread impact of problem gambling on the individual and their family / significant others. The unit cost of intervention services fell between 2008 / 09 and 2009 / 10 by an average of 33%. There have been positive trends and increases in achievement against intervention contract targets with 25% of providers achieving, or exceeding 75% of their targets in 2007 / 08 versus 86% achieving, or exceeding 75% of their targets in 2009 / 10.
3. **Coverage is national and services are targeted to ethnic groups most at risk of harm.** Problem gambling services are delivered in all of the 15 largest cities and towns in New Zealand and also have good geographical reach into smaller towns. Smaller towns are typically served by mobile clinics and the Gambling Helpline, which can deliver services in more than 41 languages, providing services to clients in remote areas. The Ministry has contracted dedicated Maori, Pacific and Asian service providers, in recognition of the high prevalence of problem gambling in these communities.
4. **Awareness campaigns achieve good levels of recall of the key messages.** A key component of the Public Health approach is the awareness campaign, "Kiwi Lives," delivered by the Health Sponsorship Council which aims to "*strengthen New Zealanders' understanding and awareness of, and response to, the far reaching impacts of gambling*." An evaluation into this report concluded that "*the campaign has achieved excellent levels of recall and communication of the desired message*," particularly among the younger age groups and Maori and Pacific people.

   In addition, attendance at problem gambling services within New Zealand is higher than in other countries, on a per capita basis, which is indicative of the greater level of awareness of problem gambling within New Zealand.
5. **A comprehensive dataset exists of problem gambling service usage.** The Ministry administers the Client Information Collection (CLIC) database for recording problem gambling service usage. This database records all demographic information for all clients that attend intervention sessions with a Ministry funded service provider. This comprehensive dataset provides greater visibility of client data and hence greater accountability for performance of service providers against their contractual targets.
6. **The problem gambling levy recognises the gambling industry taking responsibility.** The costs of problem gambling services are recovered through the problem gambling levy and are not funded by the taxpayer. They are fiscally neutral to the government. In this way the levy equals the spend on problem gambling services. The gambling industry viewed the funding model for problem gambling services as a positive recognition of their corporate social responsibilities. Collaboration across key stakeholders in this sector is a foundation to working together to efficiently and effectively help those in need.
7. **Good relations between the Ministry and service providers exist which have led to a significant upward trend in performance over the past three years**. Many service providers spoke of excellent relationships with their contract managers within the Ministry and spoke of the quality of feedback received to improve performance. This feedback has led to a significant improvement in performance against contract over recent years.
8. **VfM has improved significantly in the past three years.** It is particularly evident from the quantitative analysis that, overall there has been a strong positive trend in VfM over the past three years. For seven of the eight drivers where a trend could be assessed, the trend was positive. For example between 2008 / 09 and 2009 / 10:
   - Face-to-face time with clients rose from 26% to 33%
   - Average cost of a single intervention session dropped from $199 to $134 on average
   - Proportion of service providers achieving 75% of targets rose from 44% to 86%.

1.5 Development areas and suggested next steps

1. **Achievement below contract targets for many service providers.** In 2007 / 08, the proportion of providers meeting 75% of their targets was 25%. This rose to 44% in 2008 / 09, and then to 86% in 2009 / 10. While this is an impressive trend, significant opportunities remain for further improvement. **Suggested next step**: The Ministry should continue to obtain and monitor the implementation of individual improvement action plans from providers achieving less than target.

2. **Achievement below target by providers of the proportion of their time spent with clients.** In 2008 / 09, intervention practitioners spent time face-to-face (or on the telephone) with clients for 26% of total time. For 2009 / 10 this rose to 33%. The Ministry's targets for clinical hours approximates to 42% face-to-face time (equal to 15 hours per week). In terms of achievement of contracts this represents 62% and 78% achievement of clinical hours targets. These targets are intended to reflect time spent booking, preparing and documenting sessions and non-attendance by clients. Achievement is significantly below target, suggesting reduced VfM. Alternatively, targets could be inappropriate. It was not possible to determine if this is an achievement issue or a target setting issue. **Suggested next step**: Determine if the proportion of provider time spent with clients is a genuine performance issue or due to inappropriate targets. Take corrective action accordingly.

3. **Lack of clear evidence to support the appropriateness of weightings used to determine the level of Public Health spend.** We were unable to conclude on the appropriateness of the weightings used to support the total level of spend for Public Health services. The weightings that underlie this model are important and small changes can result in a magnified impact on the overall level of spend. Note: The question is in regards to the weightings that support the level of Public Health spend, not the principles used. **Suggested next step**: The Ministry should continue to enhance and document the model used to calculate the level of Public Health funding. For Public Health services, these enhancements could be underpinned by targeted research to quantify causal links between factors within the model and the need for these services.

4. **Limited evidence to support and drive the effectiveness of Public Health funding.** There is currently limited evidence to support the effectiveness of Public Health funding, which reduces our ability to conclude on the VfM of these services. This is an inherent limitation with many Public Health campaigns internationally and with comparable health areas. It may also reflect the comparative infancy of gambling-specific Public Health programmes. It is recognised that this is a highly challenging area with no easy solution.

5. **Apparent confusion over intervention targets, how they are applied and what level represents an appropriate target.** Each service provider has targets set within their contracts for the delivery of intervention sessions. We understand that these targets are set based on the level of utilisation the Ministry expects from purchased FTE. Providers raised concerns over the appropriateness of target levels, particularly for Brief Intervention services and Follow-up services. There is also a lack of clarity as to the nature of the targets in terms of whether they are seen as aspirational or absolute. Without this understanding, we cannot conclusively ascertain whether intervention service delivery performance is poor or whether targets are inappropriate. In 2009 / 10, 43% of service providers did not meet their contracted targets. **Suggested next step**: The appropriateness of intervention targets should be assessed and clear and consistent communication over the nature of the targets should be given to service providers. Root-causes of poor performance should be addressed.

6. **Perceived contract rigidity by providers that may drive sub-optimal behaviours.** Some providers indicated that if they were to focus on meeting contract targets, they might in turn ignore service users' real needs, which would thereby reduce the effectiveness of the services. In addition, providers indicated that activities they deem critical, such as relationship-building with those at risk of harm, are not captured in the data collection system. However, it appears the Ministry may be more flexible than some providers realise. **Suggested next step**: If contracts are considered too rigid, the Ministry needs to communicate and provide appropriate training. An agreed level of flexibility is required in terms of how targets are monitored and performance is assessed.

7. **The desire for greater clarity, communication and reporting from the Ministry to industry on outcomes.** A common theme from discussions with the gambling industry was a desire for a greater level of clarity, communication and reporting from the Ministry on spend and outcomes delivered. Industry seeks better information on how levy expenditure is used. Currently gambling industry stakeholders are unaware of the rationale behind the level of levy funding or the rationale behind increases in the levy over time. **Suggested next step**: Identify industry needs for budgetary clarity. Implement improved audit trail of expenditure against budget.

1.6 Potential information gaps 1.7 Alternative service delivery models

1.6 Potential information gaps

To assess the efficiency, effectiveness and economy of problem gambling services provided, the drivers , or key factors that effect the '3Es' were identified by KPMG. This formed the basis of our analysis. In identifying these drivers, we looked broadly, considering both problem gambling sectors in other jurisdictions as well as generic drivers of VfM applied in different sectors, both private and public. We then sought evidence and data to enable us to draw conclusions on the performance of these drivers. We recognise that all drivers are not explicitly covered in the Ministry's contracting framework for problem gambling, and nor, necessarily, should they be.

Of the total 26 drivers of VfM identified, we were not able to draw conclusions on the performance of 13 due to insufficient objective data, excess effort required to measure the driver relative to the benefits that would have been gained, or further analysis indicating the driver was not appropriate to this sector.

We looked broadly to identify drivers of VfM. Whilst data for these additional drivers would provide a fuller picture, the benefit this provides needs to be weighted against the additional cost or burden of collecting this data. We recommend the Ministry considers all drivers where evidence was unavailable, assesses the significance of these drivers and considers the individual cost benefit of populating drivers.

An additional gap is the lack of clear evidence to support the effectiveness of Public Health services in general. As discussed earlier under potential development areas, this is recognised as a highly challenging area for Public Health work in general.

The Ministry is taking steps to help address this challenge by populating an outcomes framework for monitoring and reporting on the achievement of problem gambling outcomes. This framework was developed as part of the Ministry's Strategic plan 2010 – 2016. The Ministry is about to commence work to populate this framework and then begin reporting on progress using this framework. KPMG sees this outcomes framework as a step in the right direction towards outcomes reporting which will supplement currently available data on outcomes. However, it is recognised that many of the challenges of reporting on outcomes, in particular from Public Health investment, may remain.

1.7 Alternative service delivery models

KPMG was asked to assess whether the current service delivery structure of problem gambling and Public Health services is appropriately structured. An appropriate service delivery model is a fundamental driver of the VfM of problem gambling services. However, the cost of changing the current structure and accompanying risks would be substantial. Therefore a full, robust strategic options analysis would be required before sufficient evidence could be collected, to make the decision on changing this structure.

In this review, given the time available, we have been able to undertake a high level preliminary analysis. We have identified three alternative service delivery models. For each model, an initial review enabled high level advantages and disadvantages to be identified.

The status quo is for 24 providers, predominantly NGOs, to be funded by the Ministry on an FTE basis. The alternative models identified are:

1. Devolution to District Health Boards
2. Consolidation of service providers
3. Output/outcome based at-risk funding of providers.

Section 2 - Introduction

Section 2 – Introduction

2.1 Objective and scope

Objectives

The Ministry has requested that a Value for Money (VfM) review of problem gambling services be undertaken.

KPMG was commissioned to complete this VfM review of problem gambling services. The objectives of this review were to:

- examine the cost-effectiveness of existing services delivered by Ministry-funded problem gambling service providers;
- review international evidence to compare the cost effectiveness of New Zealand-based services with international problem gambling services, and best practice;
- assess whether the current service delivery structure of problem gambling intervention and Public Health services is appropriately structured to achieve maximum health gains.

The review was required to provide Cabinet with an indication of whether services are being delivered in the most efficient and effective way, both to meet the Government's objectives and to generate the maximum possible benefit for the level of expenditure. Options for improving the efficiency, cost effectiveness and sustainability of problem gambling services and their management have been provided, where appropriate.

Scope

The scope of this review includes the spend for problem gambling services (for 2010 / 11 this will be $18.6m). The $18.6m is the current year spend (2010 / 11) and purely an indication of scope. The scope covers all four areas of problem gambling services. These are Public Health services, interventions, research and Ministry costs related to the management of the problem gambling programme.

The review examined available data for the 2007 to 2010 years.

Specifically excluded from the scope of this review are the regulatory roles of the Department of Internal Affairs (DIA) and the oversight roles of the Gambling Commission.

Also excluded is discussion on the appropriateness of the total level of problem gambling spend.

The scope of this review was limited to secondary sources of data. KPMG was not commissioned to obtain primary data

2.2 What is value for money?

Value for Money methodology

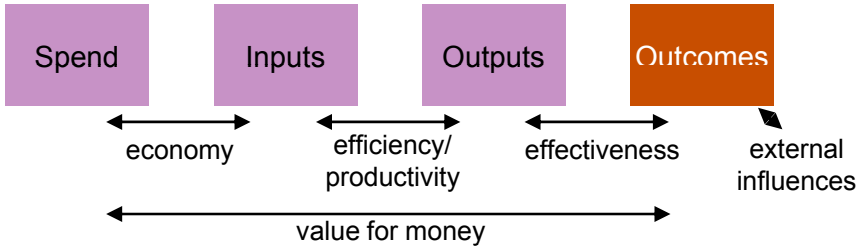
VfM describes the optimal balance of spend and inputs in order to deliver optimal outputs and outcomes. In economists' language, VfM is about maximising the net present value of (government) spending, subject to other non - quantifiable constraints. In plain English, it is about getting "more bang for your buck."

In the context of problem gambling, the Ministry has an obligation to ensure that all programmes that are supported meet a clear VfM test. A key focus of the Ministry's problem gambling strategy is minimising and preventing harm – so ensuring that those who suffer from problem gambling addictions are treated in the most efficient and effective ways and ensuring that the services and programmes which are provided to support the strategy are rigorous, efficient, effective and *"able to stand up to scrutiny"* (Hon Peter Dunne, April 2010).

VfM is about reducing costs whilst simultaneously improving the efficiency and effectiveness of spending. VfM should seek to support service quality whilst lowering unit costs and should help agencies to manage growing public expectations for public services and growing demand, whilst supporting those most in need.

There are three key components of VfM; these are Economy, Efficiency, Effectiveness (commonly referred to as the three Es). The diagram below illustrates the relationship between the components of VfM and Spend, Inputs, Outputs and Outcomes and how collectively they contribute to VfM. Section 4.5 of this report, 'VfM drivers', provides analysis of each of these components against the four areas of problem gambling funding.

Diagram 3: VfM Components



Source: KPMG

Typically in a Value for Money review, significant emphasis is placed on assessing the outcomes achieved from the area under review. This includes considering the benefits delivered by problem gambling services, whether these benefits are as large as they can be and whether the value of the benefits exceeds the $18.6m funding

This outcomes-based assessment method of assessing the value for money of problem gambling services is a sound and logical approach and one that we would be able to undertake in the future. However, at the current time, such an outcomes-based approach is not possible. Our approach to assessing value for money has therefore purposefully focussed more on inputs and outputs (economy and efficiency), as we are aware that the Ministry's outcomes framework (effectiveness) has not yet been populated with data. Our assessment of outcomes has only been undertaken qualitatively and given the constraints of the review, we have relied solely on secondary data, rather than collecting data ourselves (primary).

Economy – This assesses if a reasonable price is paid for each unit of input. For example, are salaries per person in line with market?

Efficiency – This assesses if we receive good productivity per unit of input consumed. For example, are the outputs per person employed reasonable?

Effectiveness – This assesses if the units of output we are producing are the right outputs. For example, are the outputs of services achieving the government's outcomes?

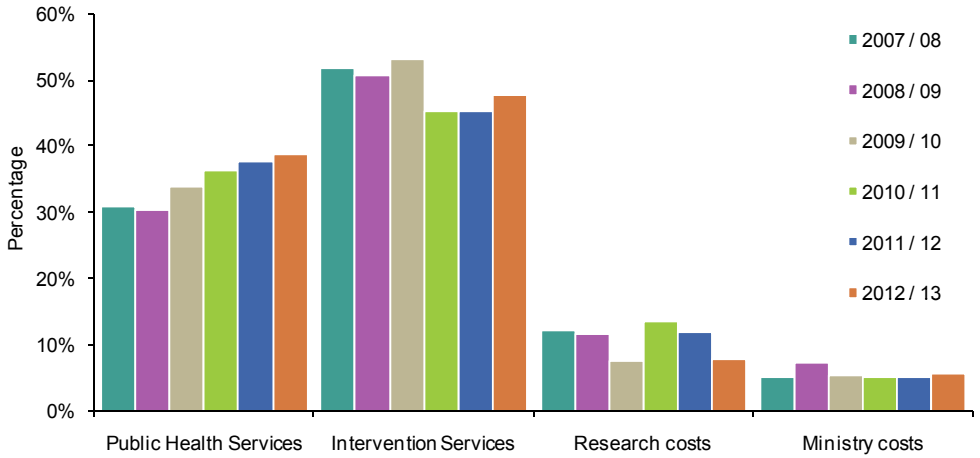
Given limited time and resources available, where possible we have adopted a materiality based approach to this review (directing most effort to the largest areas of spend). Intervention & Public Health services comprise together 83% (2009 / 10) of total problem gambling funding; accordingly the focus of this review has been directed proportionately to these areas. These areas that share the largest proportion of funding are most likely to impact the VfM of the overall problem gambling programme the most. Notwithstanding this, the review also considers the VfM of Ministry and Research costs, but with less emphasis.

2.2 What is value for money?

Value for Money methodology (cont.)

The graph below indicates the proportion of problem gambling funding allocated to each of the four areas of problem gambling service spend between 08 / 09 and 12 / 13.

Graph 2: Problem gambling services spend 2007 - 2013



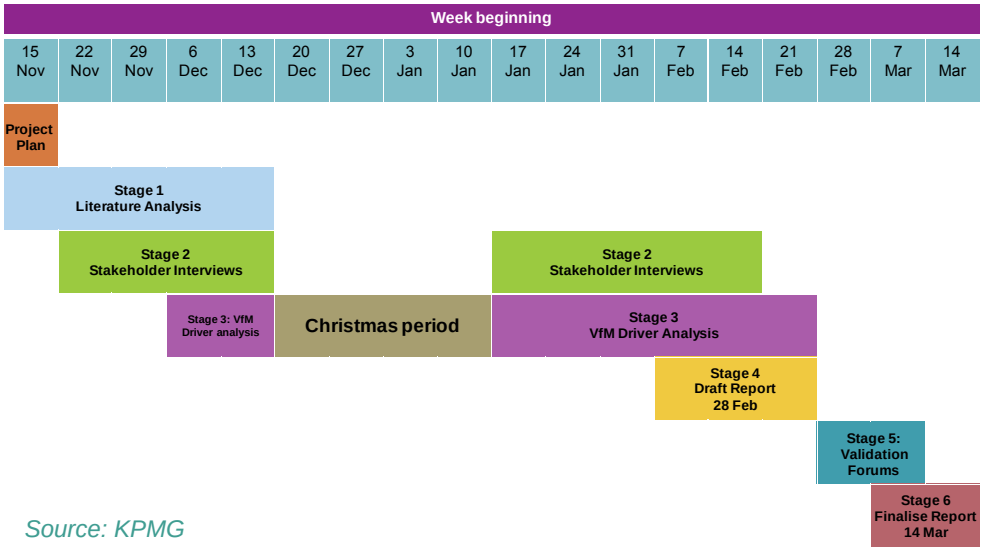
Source: Ministry of Health

2.3 Approach

Approach

The approach to this VfM review has been tailored to achieve the review objectives. Our approach has six key stages. Diagram 4 below sets out the timescale for this review and provides an overview of key stages of our approach.

Diagram 4: Timescale & approach



Source: KPMG

Project plan

This was the planning stage of our project in which we met with the Ministry to confirm the scope of the review and refined our methodology.

Stage 1: Literature analysis

This stage involved reviewing New Zealand and International literature relevant to problem gambling to validate the problem gambling service delivery. Relevant aspects of literature from this stage have been referenced throughout the document. A full list of literature is provided in Appendix 1 - Approach.

Stage 2: Stakeholder interviews

This stage focused primarily on qualitative data through seeking the views of key stakeholders. KPMG consulted many stakeholders, including the gambling industry, problem gambling service providers, the Ministry and the Department of Internal Affairs. A full list of stakeholders consulted is provided in Appendix 2 of this report.

The primary purpose of our consultation with stakeholders was to obtain their perceptions of the VfM of problem gambling services. Through this process we identified strengths and issues with service delivery. Wherever possible we sought data to support statements from stakeholders. In circumstances where we couldn't substantiate comments from stakeholders, this has been stated as anecdotal evidence. The results of this aspect of our analysis are provided in Section 4. We have considered strengths and issues identified by stakeholders in light of literature relevant to problem gambling services and activities undertaken internationally.

Stage 3: VfM Driver Analysis

This stage focused primarily on quantitative data through analysis of available data from the Ministry, internationally and analogue (other similar health) services. We identified a series of drivers of VfM. A driver is any factor that causes or affects VfM. For example, 'the degree of impact of a media campaign', will drive or affect the overall VfM. So, one is able to state, the greater the impact of the media campaign, the greater the overall VfM: all other things being equal (ceteris paribus). The phrase, 'all other things being equal , or, as an economist would state, 'ceteris paribus', is an essential concept to understand and apply. We are saying, if you hold constant all the other factors that affect VfM, then it is fair to state that the greater the impact of the media campaign, the greater the VfM.

The drivers we selected were drawn from our knowledge of this sector and from knowledge of key drivers of VfM from numerous other sectors in both the private and public sectors. The final list of drivers employed are those that we believe have the greatest impact upon overall VfM.

Drivers were selected for each of the four parts of problem gambling services: Interventions, Public Health, Research and Ministry costs. For each of these four services we aimed to identify drivers that affect the three components of VfM, the '3Es' of Economy, Efficiency and Effectiveness.

Approach (cont.)

For each driver we identified a measure designed to track the performance of that driver. So, for example for Driver 1, 'the cost of purchasing treatment services' the measure is the cost per FTE for intervention services. For each driver we identified a measure for the area being reviewed. The performance of the driver has been assessed by applying any or all of the potential comparators. These are:

- New Zealand problem gambling services across providers
- New Zealand problem gambling services over time
- Problem gambling services internationally
- Analogue (other alcohol or drug) services

The tables on the following pages list each of the drivers that we identified, provide an explanation of what we were seeking to measure with the driver and the relationship between the drivers and VfM

Review Team

The following people formed the KPMG team which completed this VfM review.

Table 1: KPMG Review Team

Name	Role
Mike Bazett	Project Partner
Peter Chew	Project Director
Christian Katene	Project Manager
Blair Wightman	Analyst
Liz Forsyth	Subject matter specialist
Martin Joyce	Subject matter specialist
Adrian Wimmers	Concurring Partner

Source: KPMG

2.3 Approach

The table below and on the next page identifies all of the drivers of VfM we adopted and indicates the measures we have used to indicate the performance of each driver.

VfM Driver Analysis

Table 2: Full list of VfM drivers and their associated measures

Driver	VfM Measure (how to track the performance of the driver)
Driver 1 – Cost of purchasing treatment services	The price the Ministry pays per Intervention FTE. Economy of treatment services ($ per intervention FTE).
Driver 2 – Cost of operating Helpline website	The cost of operating the Helpline website. Economy of the Helpline website ($ to operate website).
Driver 3 – Provider face-to-face time (including telephone)	The proportion of clinician time spent face-to-face with clients (including telephone counselling). Efficiency of resource allocation (Clinical time / Total available hours).
Driver 4 – Cost of a single intervention session	The average cost of each type of intervention session. Efficiency of service delivery (Total funding / Number of each type of session delivered).
Driver 5 – Unit cost of a single Helpline call	The average cost of a single Helpline call. Efficiency of service delivery (Total Helpline funding / Total calls)
Driver 6 – Cost of Helpline availability	The average cost of an hour of Helpline availability. Efficiency of service delivery (Total Helpline funding / Total available hours).
Driver 7 – Timeliness of treatment service	Wait-times for problem gambling services. Efficiency of resource allocation (Wait-time in days).
Driver 8 – Extent that providers deliver intervention contracts	Service provider performance against targets established in contracts. Effectiveness of intervention delivery (Actual performance / Targeted performance).
Driver 9 – Alignment of intervention services to target populations	Ministry processes to allocate intervention resources to geographic and demographic groups most at risk of gambling harm. Effectiveness of service delivery (Appropriateness of assumptions considered when allocating FTE).
Driver 10 – Degree that services meet individual needs	Extent to which services meet service user needs. Effectiveness of service delivery (Whether services meet needs).
Driver 11 – Quality of Helpline calls	Helpline satisfaction surveys. Effectiveness of service delivery (Service-user satisfaction with service delivery).
Driver 12 – Rate of drop out and re-presentations	Trends in drop-out rates and representations for problem gambling services. Effectiveness of service delivery (Proportion of clients that drop-out of services or re-present shortly after receiving treatment).
Driver 13 – Cost of purchasing Public Health services	The price the Ministry pays per Public Health FTE. Economy of treatment services ($ per Public Health FTE).

Source: KPMG

VfM Driver Analysis (cont.)

Table 2: Full list of VfM drivers and their associated measures (cont.)

Driver	VfM Measure
Driver 14 – Unit cost of a Public Health project	The average cost of a Public Health project. Efficiency of service delivery (Total funding / number of projects)
Driver 15 Alignment of Public Health services to target populations	Ministry processes to allocate Public Health resources to geographic and demographic groups most at risk of gambling harm. Effectiveness of service delivery (Appropriateness of assumptions considered when allocating FTE).
Driver 16 Extent that providers deliver Public Health contract	Service provider performance against targets established in contracts. Effectiveness of Public Health delivery (Actual performance / Targeted performance).
Driver 17 – Impact of awareness campaigns	Results of Synovate evaluation. Effectiveness of awareness campaigns (Review of evaluation of awareness campaigns).
Driver 18 – Proportion of provider overheads	Proportion of funding allocated by service providers to overhead costs. Economy of purchasing problem gambling services (Overheads / Total funding)
Driver 19 – Shortfall in FTE purchased by Ministry compared with actual FTE provided	Vacancies in FTE maintained by service providers. Economy of purchasing problem gambling services (Vacancies / Total FTE).
Driver 20 – Split between Public Health and Intervention services	Split between Public Health and Intervention services. , Efficiency of allocation of resources between preventative - Public Health and reactive - Intervention services (Public Health spend / Total spend).
Driver 21 Match of skill set to need	Allocation of problem gambling personnel based on need. Efficiency of resource allocation (Consider personnel skills against need).
Driver 22 – Alignment of actual demand for services against supply geographic and demographic	Alignment of services to meet demand (geographic and demographic). Efficiency of service provision (Retrospectively assessing supply vs. demand).
Driver 23 – Quality of policy advice	Quality of Ministry policy advice. Effectiveness of Ministry team (Review independent assessments of policy advice).
Driver 24 – Quality of contract management processes	Quality of Ministry contract management. Effectiveness of Ministry team (Review contract management processes).
Driver 25 – Quality of planning processes for research programme	Processes related to the planning, prioritisation and procurement of research. Effectiveness of Ministry team (Review contract management processes).
Driver 26 – Assessment of outcomes of research programme	Processes to incorporate the outcomes of research into policy. Effectiveness of Ministry team (Review contract management processes).

Source: KPMG

VfM Driver Analysis (cont.)

The diagram to the right sets out the relationship between all the drivers applied in this review and the overall VfM. This is called a driver tree since there is a causal relationship between all drivers and VfM. The relationship can be 'same' or 'opposite'.

As an example, consider 'Driver 5 – Unit cost of a single Helpline call' which shows an 'opposite' relationship (as depicted by the 'O' in the diagram). all other things being equal. So holding all other variables that affect VfM constant, if the unit cost of a call reduces, the overall VfM will increase.

Driver 11 – Quality of Helpline calls shows a 'same' relationship. As the quality of a call increases, all other things being equal VfM will increase.

We identified 26 drivers to analyse VfM. Note: This is an analysis approach and not a recommendation for ongoing VfM review. We developed measures of achievement for 19 of these drivers. For 13 of these drivers we were able to conclude on VfM. For the remaining 13 drivers we were unable to conclude for one of the four reasons listed below:

- The data available was highly subjective limiting our ability to draw robust conclusions
- Data was not available to measure achievement
- The effort required to measure the driver outweighs the benefits gained from its inclusion in this review
- The driver was deemed after investigation not to influence VfM.

If information on all drivers was collected, this would pose a significant administrative burden.

Diagram 5: VfM Driver Tree

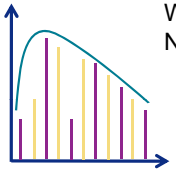
Source: KPMG

2.3 Approach

Approach

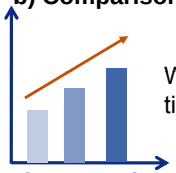
To assess the performance of each driver in terms of its impact on VfM we have applied up to 4 methods of comparison. The method(s) used was determined by the availability of data. Each of the methods are discussed below:

a) Comparison with New Zealand problem gambling services across providers



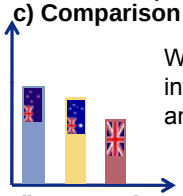
We compared performance across problem gambling service providers in New Zealand.

b) Comparison with New Zealand problem gambling services over time



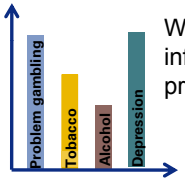
We identified trends in New Zealand problem gambling performance over-time.

c) Comparison with problem gambling services internationally



We compared New Zealand problem gambling services with available information from Australia (Victoria and Queensland), the United Kingdom and Canada.

d) Comparison with analogue (other alcohol or drug) services



We compared New Zealand problem gambling services with available information for alcohol and other drug treatment services, tobacco cessation programmes and depression services.

Stage 4: Draft Report

We prepared a draft report outlining the results of Stages 1 to 3 of this review and submitted this to the Ministry for comment.

Stage 5: Validation forums

In this stage we held two meetings. One with the Ministry and a second with a sample of stakeholders. The purposes of these meetings were to:

- Obtain feedback on the factual accuracy of aspects of the information within the report;
- Provide an overview of our approach to conducting the review
- Discuss the key strengths and development areas of our review
- Discuss key conclusions of the review.

The tables below and on the following page list the people that attended these sessions.

Table 3: Ministry validation forum attendees

Name
Dean Adam
Sean-Paul Kearns
Natu Levy
Carmela Petagna
Adrian Portis
Derek Thompson

Source: KPMG

Note: Validation does not imply confirmation or endorsement of findings.

Approach

Table 4: Stakeholder validation forum attendees

Name	Organisation
Graham Aitken	Problem Gambling Foundation
Pesio Ah-Honi Siitia	Problem Gambling Foundation
Maria Bellringer	Gambling Helpline
Lisa Campbell-Dumlu	The Salvation Army
Hannah Crump	Health Sponsorship Council
Andrew Gaukrodger	Sky City
Zoe Hawke	Hapui Te Hauora Tapui
Karen Jones	NZ Lotteries Commission
Paki Keefe	Te Rangihaeata Oranga
Mike Knell	New Zealand Community Trust
Shirley Lammas	Te Rangihaeata Oranga
Layla Lyndon Tonga	Nga Manga Puriri
Nellie Rata	Nga Manga Puriri
Gus Rieper	Clubs New Zealand
Bruce Robertson	Hospitality Association of New Zealand
Bernie Smulders	Woodlands Trust
Darren Walton	Health Sponsorship Council
John Wong	Problem Gambling Foundation

Source: KPMG

Stage 6: Finalise Report

The final stage of this review was to incorporate the comments from stakeholders and issue our report as final.

Section 3 - Context

3.1 Background to problem gambling services in New Zealand

Problem gambling in New Zealand

Gambling is a popular activity in New Zealand. National surveys have shown that 6 - 8 out of 10 people (aged 15 years and over) gamble at some time during a year (Department of Internal Affairs, 2008). In New Zealand the Government allows people to gamble and has put in place measures through the Gambling Act 2003 to minimise, prevent and address harm.

Problem gambling is gambling behaviour that results in any harmful effects to the gambler, his or her family / whanau, significant others, friends, and co-workers and through to the wider community. The Australian Productivity Commission report on problem gambling categorised problems associated with gambling as follows:

- Personal and psychological problems
- Gambling behavioural problems
- Interpersonal problems
- Work or study problems
- Financial problems
- Legal problems.

A 2010 KPMG report into fraud identified gambling as a motivator for fraud. Gambling was cited as a major fraud motivator in 2.1% of instances reported in the survey (KPMG, 2010). The downstream costs of gambling-related crime are significant for policing, justice and businesses themselves.

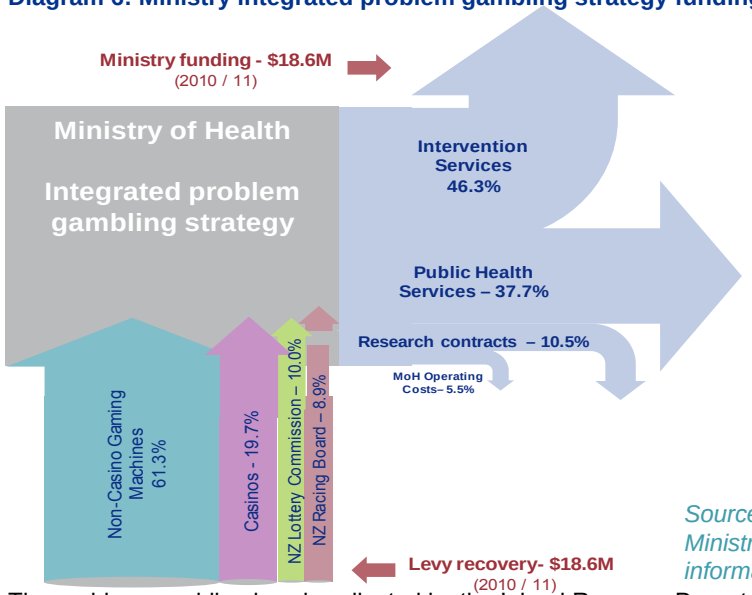
Problem gambling services have been developed in New Zealand to minimise and address the harmful effects of gambling. People of Maori or Pacific ethnicity are at significantly greater risk of gambling harm. After adjusting for age, Maori and Pacific adults were more than three and a half times more likely than adults in the total population to be problem gamblers (Ministry of Health, 2007, pg 79).

Funding for problem gambling services

The problem gambling levy is set under the Gambling Act 2003 to reimburse the Government for the costs of the problem gambling integrated strategy to prevent and minimise gambling harm.

The diagram below illustrates our understanding of Ministry problem gambling strategy funding and how this is recovered from the gambling industry through the problem gambling levy. As depicted on the lower section of the diagram, the problem gambling levy ($18.6 Million in 2010 / 11) is recovered from the gambling industry and is calculated according to a formula based on presentations to problem gambling services and expenditure on gambling. Accordingly, non-casino gaming machines in 'Pubs and Clubs' contribute the largest proportion of the levy (61.3%). This reflects the higher presentations and expenditure related to this form of gambling.

Diagram 6: Ministry integrated problem gambling strategy funding



Source: KPMG analysis of Ministry of Health funding information

The problem gambling levy is collected by the Inland Revenue Department, directed to the Ministry and, as part of Vote Health's appropriation, is used to recover the cost of the Ministry's problem gambling strategy. Problem gambling services, as shown on the right hand side of Diagram 4, include Intervention services, Public Health services, Research contracts and Ministry operating costs. Each of these services is defined further on the following pages.

3.1 Background to problem gambling services in New Zealand

Intervention services (46.3% of funding)

Intervention services refer to counselling and treatment sessions delivered to people experiencing harm from gambling. In the New Zealand service delivery$_{model}$, these services are most commonly delivered on a one-to-one, face-to-face basis between a clinician and a service user. Services are provided free of charge to all New Zealanders, with no limit to the number of sessions. Certain providers also offer alternative intervention sessions, for example group intervention. Intervention services are delivered on a reactive basis i.e. to address harm that already exists. There are four types of intervention sessions in the New Zealand service delivery model. These are:

1. **Brief intervention:** This service aims to encourage individuals experiencing harm from gambling to recognise and acknowledge the consequences of their gambling and either to make changes to their gambling behaviour or to seek specialist support where necessary.
2. **Full intervention:** These sessions are designed to provide a community-based assessment and intervention service for people with gambling-related problems that aims to minimise problem gambling-related harm to the service user and their family / significant others through provision of psychosocial interventions.
3. **Facilitation services:** The purpose of facilitation services are to minimise gambling - related harm to individuals and their families / significant others through referral to health and social services. Facilitation services are intended to address co-existing disorders that problem gamblers may have, e.g. addictions, mental health disorders and housing needs.
4. **Follow-up:** These services provide follow-up and motivational support to clients for 12 months after discharge from problem gambling intervention services (Facilitation or Full Intervention).

Public Health Services (37.7% of funding)

Public Health services include a wide range of preventative activities. Public Health is defined as 'the science and art of preventing disease, prolonging life and promoting health through the organized efforts and informed choices of society, organizations, public and private, communities and individuals' (Australian Government - Productivity Commission, 2010).

The New Zealand problem gambling Public Health model of delivery closely aligns with the Ottawa Charter for Health Promotion (World Health Organisation, 1986).

The Ministry contracts service providers to deliver five Purchase Units (based on the six action areas from the Ottawa Charter) for Public Health services.

The six action areas from the Ottawa Charter are:

Build Healthy Public Policy	Develop Personal Skills
Create Supportive Environments	Reorient Health Services
Strengthen Community Actions	Moving into the Future

Purchase units are a specific type of service for which the Ministry can contract. Purchase Units set out required outcomes, objectives, activities, reporting and targets for each service. Other areas of health treatment in New Zealand that adopt a Public Health approach include tobacco cessation, skin cancer prevention and mental health.

The five Public Health purchase units and their desired outcomes are:

1. **Policy development and implementation:** Increase adoption of organisational policies that support the reduction of gambling-related harm for employees and organisations' client groups
2. **Safe gambling environments:** Gambling environments are safe and provide effective and appropriate harm minimisation activities
3. **Supportive communities:** Communities have access to services that provide strong protective factors and build community, family and individual resiliency
4. **Aware communities:** Social marketing campaigns are delivered consistently at national, regional and community levels to improve community awareness and understanding of the range of harms that can arise from gambling. The Ministry also contracts the Health Sponsorship Council to deliver an awareness campaign over television, radio, print and the internet.
5. **Effective screening environments**: Relevant organisations, groups and sectors are made aware of the potential harms that can arise from gambling and actively screen and refer individuals to appropriate gambling intervention services.

3.1 Background to problem gambling services in New Zealand

Research Services (10.5% of funding)

Research services refer to the programme of research into problem gambling funded by the Ministry. This research ranges from analysis of the impact of gambling on specific communities to the impact of marketing, advertising and sponsorship on gambling behaviour. For example, current research projects being undertaken include:

- A study of the effectiveness of interventions for problem gambling,
- Characteristics of Youth Gambling,
- Investigation of the Influence of Gambling Venue Characteristics on Gamblers' Behaviour.

These are only a sample of the 14 research projects initiated in the 2007 to 2010 period.

Ministry operating costs (5.5% of funding)

Ministry operating costs relate to the management of the delivery of problem gambling services. These includes three core functions:

- *Policy analysis:* Providing policy advice to Ministers, developing the problem gambling strategic plan and service plan
- *Contract management:* Management of Public Health, intervention and research contracts with service providers
- *Data and information analysis:* Management and reporting on service provider performance and trends in client data within the CLIC database.

Legislative mandate

The strategic approach to problem gambling services in New Zealand is directed by section 317 of the Gambling Act 2003 which requires the Ministry to develop an '*Integrated problem gambling strategy focused on Public Health*'. The Act states that 'an integrated problem gambling strategy must include:

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

'New Zealand is the first jurisdiction to firmly place problem gambling within an explicit Public Health policy framework ' (AUT Gambling and Addictions Research Centre, 2005). The alternative to a Public Health policy framework is a reactive model such as that adopted by the United Kingdom where more than 98% of funding is dedicated to reactive treatment services.

3.1 Background to problem gambling services in New Zealand

Problem gambling strategic objectives

The Ministry has developed a six-year strategic plan to 'guide the structure, delivery and direction of Ministry-funded problem gambling services and activities' (Ministry of Health, 2010). The strategic plan has 11 objectives. These are:

Diagram 7: Government problem gambling Strategic Objectives

Source: Ministry of Health

Contracting model and sector structure

Intervention Services and Public Health Services are delivered currently through 24 problem gambling service providers, some with multiple contracts (represented by the circles in diagram 8 on page 27 and most of whom are Non-Governmental Organisations (NGOs). The Ministry purchases services on an input basis, whereby they contract with providers to purchase designated full-time equivalent (FTE) for each of the nine purchase units (4 Intervention, 5 Public Health). The provider is then required to hire an appropriately qualified FTE to deliver the contracted services.

In total the Ministry funds approximately 115 FTEs, 48 of whom deliver Public Health services and 67 of whom deliver Intervention services.

To assist with the delivery of the problem gambling model, the Ministry also contracts with service providers to deliver support services. Examples of these support services are:

- The National Coordination Service (which assists with organising newsletters, conferences and sector events)
- Workforce development providers - Abacus Counselling Training and Supervision Limited and Hapai Te Hauora Tapui Limited (addressing training needs within the workforce)
- Two gambling helpline services – Lifeline Auckland and Problem Gambling Foundation Asian services funded to provide information on gambling harm, refer callers to treatment providers and deliver telephone interventions.

In diagram 8 on page 27 we have illustrated our understanding of how the $18.6m (2010 / 11) of funding is allocated across the service providers, research programme and Ministry costs. Each problem gambling funding contract is depicted by a circle proportionate in size to the level of funding they receive. In the green coloured panel on the right, Ministry costs and research funding are shown, once again approximately proportionate to their size. Each shape is shaded according to the services they deliver, i.e. either Public Health, Intervention or Infrastructure (Support services). Not depicted in this diagram are the DIA or the Gambling Commission.

Regulators

The DIA is responsible for regulating gambling within New Zealand. Their role is to license gambling activities (except for casino gambling) and ensure compliance with the Gambling Act 2003. The Gambling Commission hears and manages casino licensing applications and appeals on licensing and enforcement decisions made in relation to gaming machines and other non-casino gambling activities. It is also responsible for advising Ministers on the problem gambling levy setting process every three years. The regulatory roles of the DIA and Gambling Commission are outside of the scope of this review.

3.1 Background to problem gambling services in New Zealand

Allocation of Ministry problem gambling funding

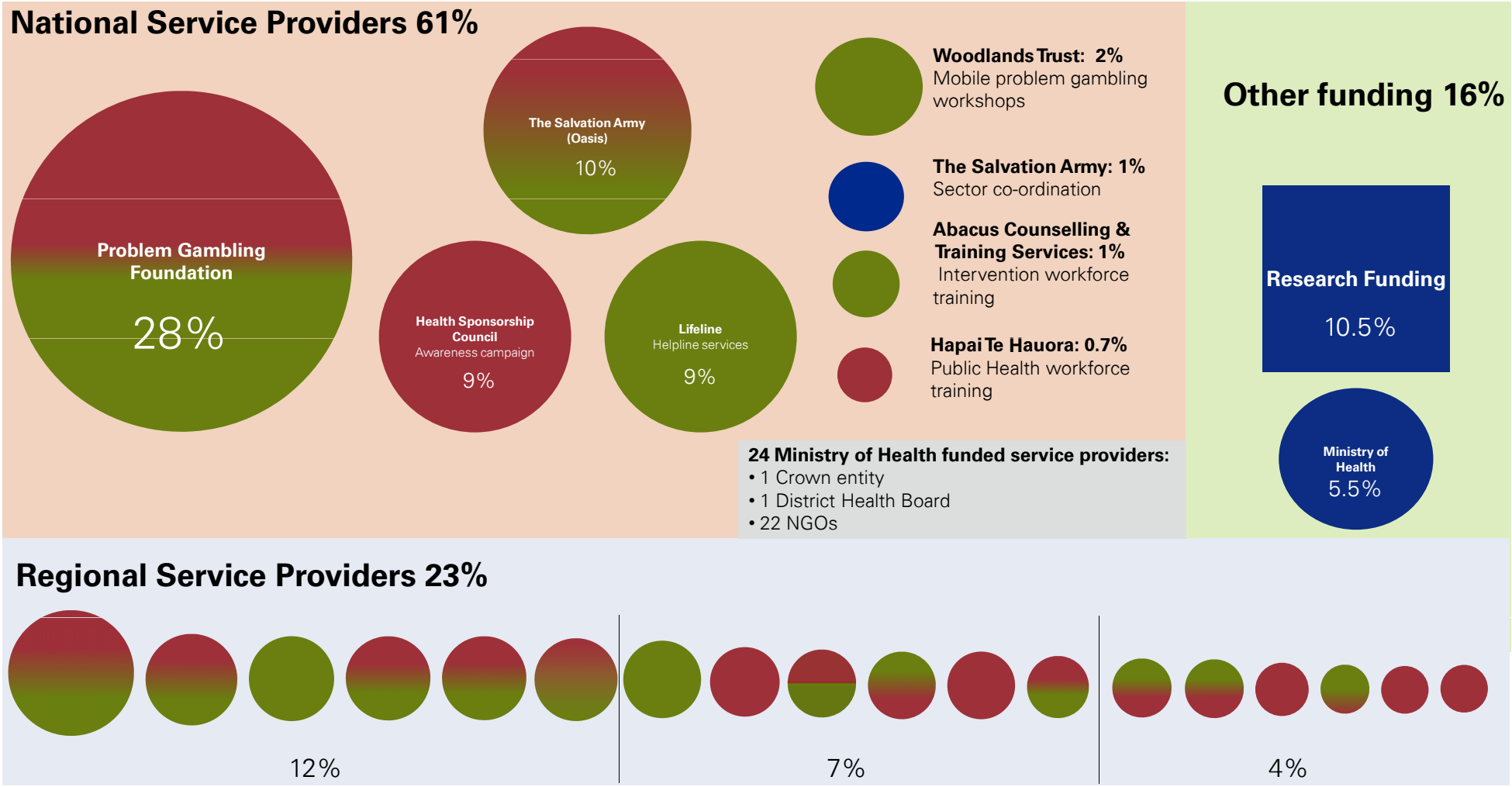
The analysis in diagram 8 shows:

- The majority of funding (56%) is allocated to the four largest service providers (Problem Gambling Foundation, The Salvation Army Trust, the Health Sponsorship Council and Lifeline Help Services)
- 18 of the 24 regional service providers receive 23% of funding
- Other funding consists of Ministry costs (5.5%) to manage the problem gambling programme and costs associated with the problem gambling research programme
- The majority of service providers are NGOs with the exception of the Health Sponsorship Council (Crown Entity) and Waitemata DHB (DHB).

Note: There are more circles in the diagram than the 24 providers stated. This is because certain providers deliver on more than one unique contract

3.1 Background to problem gambling services in New Zealand

Diagram 8: Allocation of problem gambling funding 2010 / 11



Source: KPMG analysis of Ministry of Health funding information

3.1 Background to problem gambling services in New Zealand

Performance measures within contracts

Each problem gambling service provider has targets established in their contracts with the Ministry that set out the level of achievement they are required to achieve. An overview of the targets for both Intervention and Public Health services is provided below:

Intervention services

The Ministry contracts for the delivery of 15 clinical hours per week per FTE. The target for clinical hours is further segmented into a specified number of each of the four intervention services. The contracts between service providers and the Ministry for intervention services set out the number of counselling sessions (interventions) that providers are expected to deliver each month. Contracted targets are set based on the FTE clinicians the Ministry has agreed to purchase from each provider. The larger the contract value, the proportionately higher the targets for service delivery. Targets are set for each type of intervention i.e. Brief, Full, Facilitation and Follow-up.

The example below reflects Ministry contractual expectations that service providers would deliver a total of 4 FTE purchased (i.e. 1 FTE for each Purchase Unit).

- 1FTE is expected to deliver 120 brief sessions per month (Average 15 to 30 minutes each)
- 1FTE is expected to deliver 60 Full sessions per month (Average 60 minutes each)
- 1FTE is expected to deliver 60 Facilitation sessions per month (Average 60 minutes each)
- 1FTE is expected to deliver 120 Follow-up sessions per month (Average 15 to 30 minutes each)

Public Health services

The contracts between service providers and the Ministry for Public Health services set out the number of Public Health projects that providers are expected to deliver or organisations in the community that they are expected to work with. Contracted targets are set based on the FTE health promoters the Ministry has agreed to purchase from each provider. The larger the contract value, the higher the targets.

Targets are set for each type of Public Health purchase unit as set out below:

The example below reflects Ministry contractual expectations that service providers would deliver a total of 5 FTE purchased (i.e. 1 FTE for each Purchase Unit).

- **Policy development and implementation:** 1FTE is expected to work with 8 medium* sized organisations per annum
- **Safe gambling environments:** 1FTE is expected to work with 8 medium* sized organisations per annum
- **Supportive communities:** 1FTE is expected to deliver 4 medium* sized mental health promotion projects per annum
- **Aware communities:** 1FTE is expected to deliver 8 medium* sized social marketing projects per annum
- **Effective screening environments:** 1FTE is expected to work with 8 medium* sized organisations per annum

* Note: 2 medium sized organisations or projects can be substituted for 1 large organisation or project

Achievement against the Public Health and Intervention performance measures above are reported to the Ministry either through the CLIC database (Intervention services) or six-monthly narrative reports to the Ministry (Public Health)

CLIC database

The Ministry administers the CLIC database which service providers use to record data and details for problem gambling service users. This database records demographic information for all clients that attend intervention sessions with a Ministry-funded service provider. The information recorded includes client age, ethnicity, Territorial Local Authority (TLA), type of counselling session, primary gambling mode and source of referral. The Ministry uses this database for managing the performance of service providers, understanding the demographic and demand profile of service users and monitoring trends in achievement over time.

Section 4 - Results

4.1 Overall conclusion

Summary

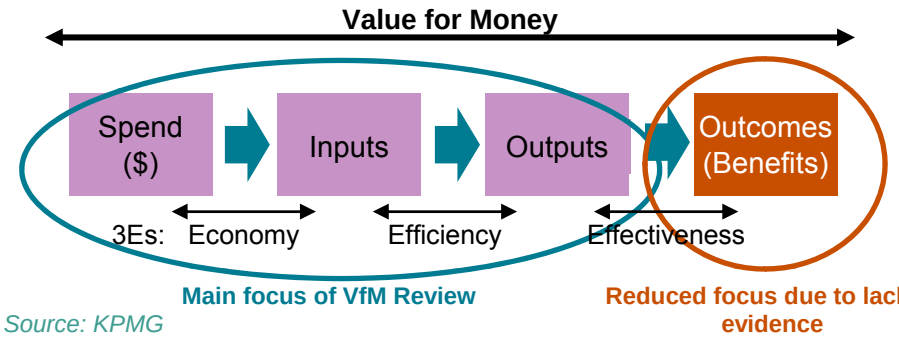
1. VfM Overall	Premature to conclude
2. VfM (Inputs & Outputs focus)	Good
3. Trend	Positive
4. Confidence in conclusions	Medium to High

Conclusion 1: It is premature to assess the overall VfM for Problem Gambling

Overall VfM is exactly what it says; the value received for the money spent. It is simply the ratio of the total costs compared to the total quantified benefits, or value delivered; 'the *bang for the buck*'. So, for 2010 / 11, VfM is the ratio of the cost of $18.6m compared to the quantified benefits. However, sufficient robust evidence does not exist to enable the benefits, or outcomes to be quantified. So, in terms of overall VfM, we have to conclude that it is premature to make this assessment. It is premature because the Ministry has established an outcomes framework and is in the process of undertaking the work required to populate and report on outcomes. This framework is intended to go some way towards providing better information upon which to assess and quantify the ultimate benefits accruing to New Zealand from the implementation of the Ministry's Problem Gambling Strategy.

Due to this lack of hard evidence to quantify the outcomes, the main focus of this review has had to be on inputs and outputs rather than outcomes, as illustrated below.

Diagram 2: Definition of VfM and focus of this review



Source: KPMG

Conclusion 2: VFM, covering our focus on inputs and outputs, is assessed as Good. Many significant strengths were identified. A shorter list of less significant areas for development were also identified. These are summarised in the next slides.

Caveat to Good assessment. Achievement is significantly below target in two important areas. We are unable to conclude if the reason is inappropriate targets or low provider achievement. If targets are appropriate, then achievement would thereby be low in these areas, in which case we would revise our VfM conclusion to Fair/Good.

The two areas where achievement is below target are both important drivers of intervention services VfM. Intervention services consume nearly 50% of costs. The first is Driver 3: Provider face-to-face time (includes telephone contact). The second is Driver 8: The extent that providers achieve intervention contract targets. The assessment of the appropriateness of targets is outside the scope of this review.

Conclusion 3: The trend in VfM is positive

There is fairly strong evidence that the VfM of problem gambling services, covering our main areas of focus, inputs and outputs, has increased significantly over the past three years. For six of the seven drivers, where a trend could be assessed, the trend was positive.

Confidence in conclusions

4. Our confidence in these conclusions is Medium to High given the quality and availability of the supporting evidence.

Large amounts of robust data exist and our conclusions were supported by both the quantitative and qualitative analyses. Throwing the net wide by looking across government sectors and the private sector, 26 potential drivers of problem gambling VfM were identified. Of these, 13 were both appropriate and feasible to apply. It was not feasible to conclude on the remaining 13 drivers due to:

- Insufficient objective data
- Excess effort required to measure the driver relative to the benefits that would have been gained
- Further analysis indicating the driver was not appropriate to this sector.

Numerous strengths exist, as well as some potential areas for development. Ten strengths have been identified and twelve development areas. These are described in the following pages

4.2 Strengths of problem gambling programme

Overview of strengths

New Zealand is frequently cited as providing world-leading support to those affected by harm from gambling when compared with jurisdictions internationally. The Public Health approach, national coverage, universal care, free service and support to ethnic minorities are reasons most frequently cited for New Zealand being at the forefront of the problem gambling field internationally.

The enthusiasm, sector knowledge, dedication and commitment of staff to supporting those at risk of problem gambling was apparent in our meetings with service providers.

Strengths of the problem gambling service in New Zealand include:

1. The preventative approach of Public Health to prevent and minimise harm
2. Intervention services appear innovative and well designed
3. Coverage is national and services are targeted to ethnic groups most at risk of harm
4. Awareness campaigns achieve good level of recall of the key messages
5. A comprehensive dataset exists of problem gambling service usage
6. The Problem gambling levy which recognises the gambling industry taking responsibility
7. Good relations between the Ministry and service providers exist which have led to a significant upward trend in performance over the last three years
8. VfM has improved significantly in the past three years
9. Ministry costs are reasonable
10. Good levels of client satisfaction with intervention services

1 The preventative approach of Public Health to prevent and minimise harm

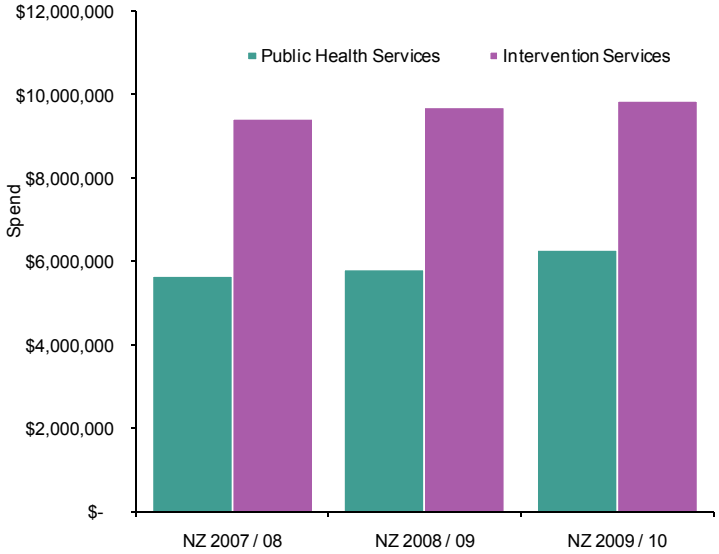
Section 317 of the Gambling Act 2003 requires the Ministry to develop an integrated problem gambling strategy focused on Public Health. This focus recognises the importance of prevention.

The Public Health approach is defined as 'the science and art of preventing disease, prolonging life and promoting health through the organised efforts and informed choices of society, organisations, public and private, communities and individuals' (Australian Government - Productivity Commission, 2010).

As part of its Public Health approach, the Ministry uses a population health framework to address gambling harm amongst different groups within the population. A population health approach addresses the differences in health status among, and within, populations. As stated by the Ministry, the goal of a population health approach is to maintain and improve the health status of the entire population and to reduce inequalities in health status between groups and subgroups (Ministry of Health, 2010). The Ministry's Public Health framework is broadly aligned to the Ottawa Charter for Health Promotion.

The split between intervention spend and Public Health spend over the last three years has been about 60 / 40. Graph 3 below sets out the spend on intervention and Public Health services over the period 2007 – 2010.

Graph 3: Spend on Intervention and Public Health services 2007 to 2010



Source: Ministry of Health

4.2 Strengths of problem gambling programme

1 The preventative approach of Public Health to prevent and minimise harm (cont.)

All providers interviewed indicated the Public Health approach was important in preventing problems associated with gambling and promoting healthy communities. In particular, it was stated that for some sectors of the community health promotion is an effective way to build awareness of problem gambling. For example, investment in Public Health initiatives in the Asian community over the last two years has opened the way for intervention services to become more acceptable according to one provider. Maori providers also agreed that Public Health works well for Maori service users. Dr. David Korn of the University of Toronto commented that, *'The Public Health framework is a real strength and reflects both a bold and balanced vision'.*

In jurisdictions around the world where problem gambling is of concern, a Public Health framework is increasingly being used for the development of strategies to prevent problems arising and to minimise harm associated with problem gambling. These frameworks recognise that:

- there is a range of different behaviours associated with gambling in the community – while some people do not gamble, others do so to varying degrees and within the latter group some community members have gambling problems;
- people who do not gamble obviously do not experience gambling problems, but among those who do gamble, as gambling behaviour becomes increasingly more problematic, so too does the range, intensity and complexity of problems associated with gambling; and
- multiple strategies are simultaneously needed to prevent gambling becoming problematic for members of the community and to reduce the harm being experienced by those for whom gambling is a problem.

Diagram 10 to the right depicts one conceptualisation of this Public Health framework (Korn & Shaffer, 2002).

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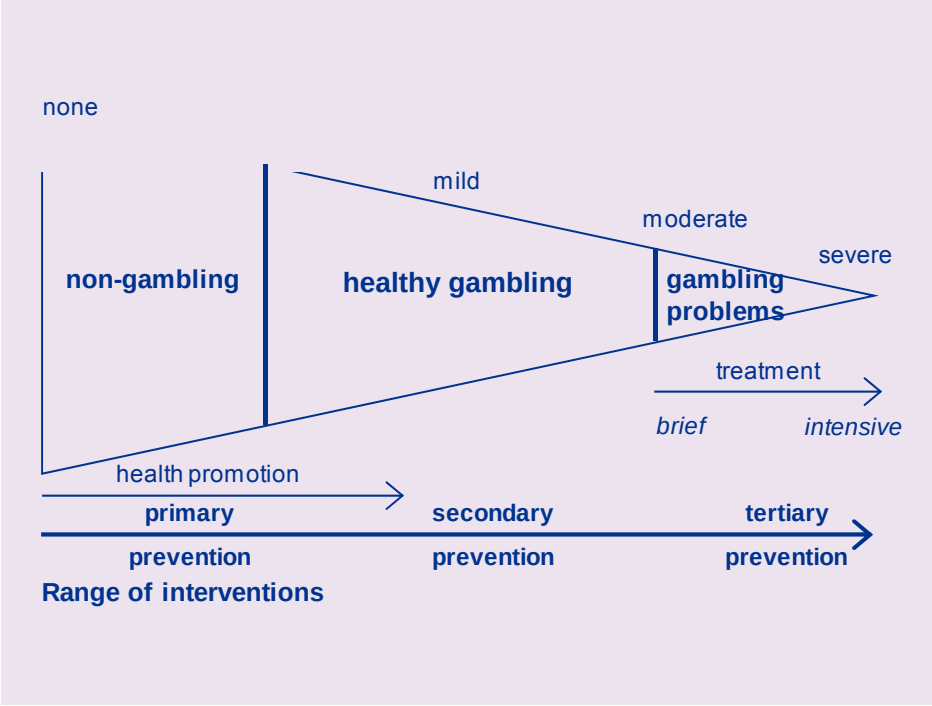
Diagram 10: Example of a Public Health framework for problem gambling



Source: Korn & Shaffer (2002)

4.2 Strengths of problem gambling programme

1 The preventative approach of Public Health to prevent and minimise harm (cont.)

Health promotion and prevention are integral components of a Public Health framework. The community needs to be informed of the risks of gambling and educated so they understand the nature of the product. Individuals who are at risk need to be appropriately supported so that gambling is not seen as the potential solution to any problems they may have. Strengthening community capacity and resilience are also important steps in a preventive approach.

Prevention strategies that support responsible gambling can be diverse and require cooperation between the gambling industries, governments, the community and gamblers themselves. Strategies that assist the recovered 'problem gambler' and minimise the likelihood of a relapse or any future problems are also needed – for example providing the 'problem gambler' with the option to voluntarily exclude themselves from gambling venues as a prevention measure.

Prevention strategies also need to be supported by further research to ensure the right approaches are used to target people at risk. Gambling research, and in particular research into the risk factors that may give rise to problem gambling, is still somewhat embryonic and evolving. The Australian Productivity Commission, for example, noted that its own study did not sufficiently address the varying impacts of gambling on different cultural groups and that *"more research will need to be conducted in this area"* (Australian Government - Productivity Commission, 2010, pg 712).

A Public Health framework recognises that problem gambling is influenced by a range of factors, and emphasises prevention and minimisation of gambling related harm, promoting the well-being of a community, or cohort within a community. Like issues associated with alcohol and the treatment process, problem gamblers do not move along the service continuum in a linear fashion (i.e. begin as non gamblers, then move to low gambling activities, and onto medium level gambling activities on so on), rather people can move up and down the continuum over time. For example, a problem gambler could, a year earlier, have been a non-gambler, but because of an external life event (or factor) could present to problem gambling services with severe issues, having never been in the service system before. This could include a range of life crises that could trigger the gambling activity and could lead to severe gambling issues (in the same way alcohol can affect people when a major life crisis occurs).

2 Intervention services appear innovative and well designed

The Ministry's intervention service model recognises that people affected by gambling harm can benefit from a range of services. The model aims to address not only the gambling behaviour, but also to reduce the impact of harm by facilitating the client's access to other services. The approach also acknowledges the widespread impact of problem gambling on the individual and their family / significant others. The model acknowledges that individuals are at different points in their readiness to change their gambling behaviour. Individuals require a range of interventions from screening and brief interventions to intensive interventions.

Brief intervention services

Brief intervention services are designed to engage with people at risk of gambling harm and encourage them to recognise the potential impacts of their own or another's gambling on their life. Some studies have found that any type of psychotherapy has beneficial outcomes for clients (Bergin & Garfield, 1994, pg161). Another study has found growing evidence that for many problem gamblers, short-term and less intense interventions might be as effective as longer, more intensive therapies (AUT Gambling and Addictions Research Centre, 2010b).

KPMG has experience with brief intervention models in Australia. Victoria Child and Family Services allocate funding specifically to brief interventions under the 'ChildFIRST Services' programme. This programme uses a brief intervention model on the basis that a light-touch may be all that is required to keep clients (particularly vulnerable families) stable. A brief intervention is up to 2 to 4 hours long and can include information provision, a phone call, or one-to-one sessions.

This early intervention would appear to be an effective mechanism to reduce the long-term costs to the service user, their family and society associated with the impact of problem gambling as it is aimed$_a$ t identifying problem gamblers early. It therefore suggests good VfM.

Full intervention services

There is broad support for the effectiveness of psychotherapy treatment (Bergin & Garfield, 1994, pgs147, 150 & 180). However, a more recent literature review found that it is not known how effective these services are in New Zealand in a problem gambling context. This study also questioned whether or not comparable outcomes could be produced more effectively using different approaches.

4.2 Strengths of problem gambling programme

2 Intervention services appear innovative and well designed (cont.)

This review also found that psychological interventions for problem gamblers are associated with favourable outcomes compared with no treatment (AUT Gambling and Addictions Research Centre, 2010b).

From a VfM perspective, the literature supports the view that, while gaps in the evidence exist, the current approach to treatment appears to be effective in relation to client outcomes (AUT Gambling and Addictions Research Centre, 2010a, pg 101).

Facilitation services

The Ministry introduced facilitation services into their intervention model in an effort to acknowledge the growing evidence that problem gamblers often present with co-existing issues, such as alcohol or other drug dependencies or mental health problems. It also recognises that problem gamblers usually experience social issues and that access to budgeting services and other social services can assist them in their recovery. The facilitation service recognises that merely referring someone to another service is not usually effective. Active effort and support are often required to help clients to receive the support they need for other problems in their life.

The key concept behind the facilitation service is that the problem gambling practitioner may not have the skills or capacity to provide ongoing support or the complex skills required to address co-existing issues. However, the practitioner should have the skills to support people to access other services.

Some providers expressed some concerns with the design of the facilitation service requirements, stating the requirements limited how providers could apply the services to meet service user needs. Providers commented that many 'social work' type activities that they undertake cannot be counted towards facilitation. Discussions with the Ministry reveal that this appears to be a training issue. The Ministry was able to demonstrate that most scenarios put forward by providers can be captured under the facilitation service requirements. An evaluation conducted by the Auckland University of Technology in 2008 found that both counselling staff and clients considered facilitation services to have a positive impact on client outcomes (AUT Gambling and Addictions Research Centre, 2010a, pg 101).

Facilitation appears to be an effective way to address all of a service user's needs and reduces the risk of relapse. This may lessen the long-term cost to society of supporting the service user and therefore suggests good VfM.

Follow-up

Follow up services allow service providers to support service users after they have ended their treatment. It also provides an opportunity to gather evidence about client outcomes following treatment and to help determine what works with clients.

In 2009 / 10 total performance against follow-up targets across all providers was 59%. Service providers noted that a major obstacle to achieving this target is that a significant number of service users are transient and thus difficult to keep track of. While this makes the task challenging, it does not reduce the rationale for providing follow-up services.

3 Coverage is national and services are targeted to ethnic groups most at risk of harm

Problem gambling services are delivered in all of the 15 largest cities and towns in New Zealand and also have good geographical reach into smaller towns. Smaller towns are typically serviced by mobile clinics. The Ministry purchase services in the areas most at risk of gambling harm. This is discussed further in Drivers 9: Alignment of intervention services to target populations and Driver 15:Alignment of Public Health services to target populations.

Mainstream and Maori services generally recorded clients in almost all Territorial Local Authorities (AUT Gambling and Addictions Research Centre, 2010a). Services can be provided to clients in remote areas via the Gambling Helpline. The Gambling Helpline, (in conjunction with 'Language Line'), can now deliver services in more than 41 languages.

The Ministry has contracted dedicated Maori, Pacific and Asian service providers, in support and recognition of the higher prevalence of problem gambling within these communities. In addition, all other service providers are inclusive of people from these communities. Services are fully funded and accordingly provided free of charge to service users. There are no limits to the number of sessions that a client can attend. Service providers also indicated that clients can access services immediately with no waiting list.

The Ministry is committed to improving Maori health gains and providing a culturally accessible and responsive service (Ministry of Health, 2010). All services are expected to be culturally safe and culturally competent.

4.2 Strengths of problem gambling programme

4 Awareness campaigns that achieve good level of recall of the key messages

A key component of the Public Health approach described above is the awareness campaign delivered by the Health Sponsorship Council. This campaign known as “Kiwi Lives” aims to ‘strengthen New Zealanders’ understanding and awareness of, and response to, the far reaching impacts of gambling’ (Synovate, 2009).

An evaluation report into the campaign concluded that, ‘the campaign has achieved excellent levels of recall and communication of the desired message’ particularly among younger age groups and Maori and Pacific people (Synovate, 2009).

83% of those surveyed had seen some media activity about problem gambling and 16% said they ‘did something’ as a result of seeing the advertisements (Note: the survey definition of ‘did something’ was somewhat unclear). This is supported by Smith, Hodgins, & Williams (2007) who stated that ‘awareness campaigns appear to have a very limited impact if people are not explicitly asked to attend to the information or have no intrinsic interest in it’. The effectiveness of the awareness campaign is discussed further in driver 17: Impact of awareness campaigns.

The Health Sponsorship Council advised us that they use the same advertising agency for both their tobacco cessation and problem gambling television awareness campaigns and accordingly receive a ‘reasonably good discount’.

5 A comprehensive dataset exists of problem gambling service usage

The Ministry administers the CLIC database for recording problem gambling service user data. This database records demographic information for all clients that attend intervention sessions with a Ministry-funded service provider. The information recorded includes client age, ethnicity, Territorial Local Authority, type of counselling session, primary gambling mode and source of referral.

We were advised anecdotally that the CLIC database is comprehensive and collects more data than problem gambling services in jurisdictions internationally and a greater level of detail than Mental Health or Alcohol or Other Drug addiction services. We were unable to substantiate the level of data collected by other jurisdictions, however, KPMG experience in Australia shows that most services collect a similar level of data and that this is reported on both a state and national basis. Our requests for information from the United Kingdom yielded a low level of detail (limited to total funding and total clients). This intimates that less information is collected in the United Kingdom.

6 The Problem gambling levy recognises the gambling industry taking responsibility

Problem gambling services are recovered through the problem gambling levy, not funded by the taxpayer. The levy is on a ‘polluter pays’ basis calculated according to a formula based on presentations to problem gambling services and expenditure on gambling, a proxy measure for the harm caused by gambling. During stakeholder interviews, gambling industry representatives acknowledged, without prompting, that harm is caused by gambling activities for some people who use their products. The gambling industry viewed the funding model for problem gambling services positively as recognition of the industry acknowledging its corporate social responsibilities. The problem gambling levy is fiscally neutral to the government in that the levy equals the spend on problem gambling services.

4.2 Strengths of problem gambling programme

7 Good relations between the Ministry and service providers exist which have led to a significant upward trend in performance over the last three years

Many service providers spoke positively of their relationships with Ministry contract managers and spoke of the quality of feedback received to improve performance. They described the contract managers as being professional, visible, transparent, stable and supportive. Gambling industry participants acknowledged the Ministry's efforts in tightening up contract management processes and providing a greater level of accountability.

8 VfM has improved significantly in the past three years

The trend assessed across the 13 VfM drivers we were able to conclude upon is on the whole positive, with the majority exhibiting a positive trend. This can be evidenced in the significant improvement across Drivers 3 – Provider Utilisation, Driver 4 Cost of a single intervention session and Driver 8 –Extent that providers deliver intervention contract.

9 Ministry costs are reasonable

Ministry costs equate to approximately 5.5% of the problem gambling funding, or $957,044 in 2010 / 11. Of that, 75% is direct salary costs for the 7.7 FTE employed to manage the problem gambling programme. The remaining 25% relate to overheads, travel costs and small projects. Confidential information available to KPMG indicates that these costs as a proportion of overall funding (5.5%) are in line with international jurisdictions.

We have assessed the efficiency and effectiveness of the Ministry team in Driver 23: Quality of policy advice and Driver 24: Quality of contract management processes. Some consideration should be given to the number of provider contracts which the Ministry manages given that problem gambling is a small sector relative to the mental health or alcohol or drug addictions sectors. Each provider, regardless of whether funded for a 1 FTE contract or 50 FTE contract, is required to prepare six monthly reporting to the Ministry and requires a similar level of Ministry contract management.

10 Good levels of client satisfaction with intervention services

The 2009 contract compliance audits of problem gambling services sought to obtain service-user perspectives of the intervention services delivered. All service users interviewed reported they were satisfied with the services that they received from problem gambling providers (sample of approximately three service users per service provider). Furthermore, as part of this VfM review, some service providers shared summarised analysis of customer feedback. This showed high levels of customer satisfaction.

We are cautious of the reliability of this information given that the sample of service users interviewed as part of the 2009 audit was supplied by each provider. Service providers also pointed out that overall response rates for satisfaction surveys were frequently low and that generally feedback is only received from customers who are happy with the outcomes of the service.

The Auckland University of Technology Stage Three Evaluation of Problem Gambling Intervention Services (2010) found that the vast majority of clients surveyed reported positive treatment outcomes and high levels of satisfaction with the treatment experience. Again, there is some question about the methodology for obtaining feedback, (for the same reasons as above) but we consider that the pattern of client satisfaction and outcomes that is reported from different sources provides some comfort around the message that clients are generally satisfied with respect to intervention services and intervention service outcomes.

We suggest that further consideration could be given to alternative ways of seeking customer feedback where appropriate. We suggest this could take the form of a question verbally at the end of the session or telephone call to obtain feedback on behaviour changes post-treatment. This is likely to be the best means of obtaining feedback given the transient and anonymous problem gambling population.

4.2 Development areas within problem gambling programme

Areas for development or further consideration

Areas that require further development or that should be considered further are:

1. Achievement below contract targets for many service providers
2. Achievement below target by providers of the proportion of their time spent with clients
3. The lack of clear evidence to support the appropriateness of weightings used to support the level of Public Health and Research spend
4. Limited evidence to support and drive the effectiveness of Public Health funding
5. Apparent confusion over intervention targets, how they are applied and what level represents an appropriate target
6. Perceived contract rigidity by providers that may drive sub-optimal behaviours
7. The desire for greater clarity, communication and reporting from the Ministry to industry on outcomes
8. Facilitation services have a higher unit cost than other sessions
9. The funding model does not incentivise high achievement
10. The ring-fenced nature of problem gambling funding creates some challenges
11. Some Public Health provider activities undertaken by service providers may be contrary to the Government's policy objectives with regards to problem gambling
12. There may be opportunities to improve collaboration with other government agencies

1 Achievement below contract targets for many service providers

As discussed in Driver 8: Extent that providers achieve intervention contract targets and depicted in the graph on the following page, service provider achievement against target has been consistently low although it is improving rapidly. This graph presents the proportion of service providers that achieve their overall target for intervention sessions.

Although there have been substantial improvements over the past three years. In 2009 / 10, 57% of service providers achieved 100% of their targets and 86% of service providers achieved 75% of their targets. The funding service providers receive is not affected by achievement of targets. The current achievement of service providers against intervention targets suggests that either targets are inappropriate or achievement is low:

a) **Targets are inappropriate (set too high).** If this hypothesis is correct, then the Ministry needs to set targets that take into account all non-clinical activities service providers undertake and agree these with service providers. The Ministry needs to set targets at a level that enables them to assess provider achievement) i.e. targets should be absolute rather than aspirational. The Ministry also needs to communicate clearly to providers that they are being held to account and their achievement will be assessed on the basis of these targets, or

b) **Targets are appropriate but achievement is low (57% of providers achieving 100% of their targets in 2009 / 10).** If this hypothesis is correct, then the Ministry is paying service providers for unsatisfactory achievement (over-payment). The Ministry needs to identify the cause of low achievement, address these causes and consider an at-risk payment model as we have suggested in Driver 8: Extent that providers achieve intervention contracts.

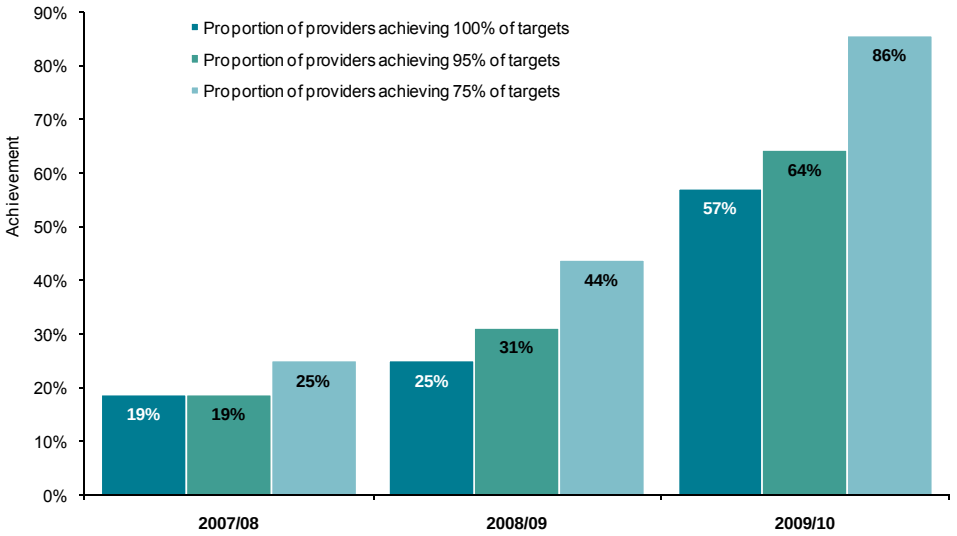
Any shift to a model whereby payment is based in part on achievement as we have suggested in Section 6.1 requires that targets be appropriate, achievable and agreed by all parties.

KPMG discussed intervention session target achievement with many service providers during our stakeholder interviews and also with the Ministry. We were unable to build a clear view on whether the issues with achievement relate to the appropriateness of the target or if the issues were related to low achievement.

4.2 Development areas within problem gambling programme

1 Achievement below contract targets for many service providers (cont.)

Graph 4: Proportion of service providers achieving contracted targets



Source: Ministry of Health

2 Achievement below target by providers of the proportion of their time spent with clients

Intervention practitioners were face-to-face (or on telephone) with clients for 26% & 33% in 2008 / 09 and 2009 / 10 respectively (of total time). The Ministry's targets for clinical hours approximates to 42% face-to-face time (equal to 15 hours per week). In terms of achievement of contracts this equals 62% and 78% achievement of clinical hours targets respectively. These targets are set at a level to exclude non face-to-face (or telephone) time spent booking, preparing and documenting sessions and non-attendance by clients. Achievement is significantly below target, suggesting low VfM. Alternatively, targets could be inappropriate. It was not possible to determine if this is an achievement issue or a target setting issue.

3 The lack of clear evidence to support the appropriateness of weightings used to support the level of Public Health and Research spend

We were unable to draw conclusions on the appropriateness of the weightings used to support the total level of spend for Public Health services

The Ministry presented a model that underpinned and explained their level of spend. The Public Health planning model 'calculated both the total sum FTE and also identified the spread and mix of FTE at a regional level'. This model (assessed in Driver 15: Alignment of Public Health services to target populations) included eight factors that the Ministry considers as influencing the need for Public Health services. Factors considered in the model include population, availability of gambling, and expenditure on gambling.

KPMG recognises the relationship between these factors and gambling harm and also that the Ministry's model aligns with the approach to forecasting demand for Public Health services adopted by other jurisdictions. The weightings that underlie these models are important and small changes can result in a more than proportionate impact on the overall level of spend. However there is a lack of evidence to support the weightings used and, therefore, we were unable to draw conclusions on whether the weightings allocated to each of these factors are appropriate.

Similarly, we were unable to draw conclusions on the appropriateness of the level of spend for Research services. We understand the Ministry has processes to plan and prioritise research projects. We were advised that the total level of spend is built 'bottom-up' based on the process to prioritise research projects. This process allocates weightings to outcomes of each research project and prioritises projects based on these. However the rationale for spending $2.5m (2010 / 11) on research rather than any other higher or lower amount is unclear.

We are not questioning the actual level of spend on Public Health and Research services but rather indicating that we are unable to conclude whether the weightings and assumptions that underlie the models are appropriate, due to a lack of supporting evidence to document the rationale. These assumptions may be appropriate, however we could not obtain comparative information to validate this.

It is relevant to note the observation of HP Consulting in their 2006 report into the problem gambling levy that 'total expenditure allocated to problem gambling appears high when compared to other health services'.

4.2 Development areas within problem gambling programme

3 The lack of clear evidence to support the appropriateness of weightings used to support the level of Public Health and Research spend (cont.)

We recommend that the Ministry continue to enhance the model and document the rationale used to calculate the level of Public Health and Research funding. For Public Health services, these enhancements could be underpinned by targeted research to quantify causal links between factors within the model and the need for these services. This may include reviewing existing client data and using this to underpin the current weighting of 1 FTE for every 200 NZ Racing Board outlets and 400 NZ Lotteries Commission outlets. The supporting evidence used to derive the weightings should then be documented as part of the model.

4 Limited evidence to support and drive the effectiveness of Public Health funding

As the Ministry is aware, less evidence exists to support the effectiveness of Public Health funding than currently exists for intervention services. This is in part an inherent limitation with many Public Health campaigns. This also reflects the infancy of gambling specific Public Health programmes (AUT Gambling and Addictions Research Centre, 2005).

Literature also suggests this lack of evidence exists across analogous Public Health services. *'In general, many of the Drug and Alcohol educational prevention programmes – including extensive school-based programmes – have not been shown to have large effects on future behaviour, if they have effects at all'* (AUT Gambling and Addictions Research Centre, 2010b). Professor Max Abbott also commented that *'Despite the popularity of different forms of Public Health prevention initiatives, their efficacy is largely unknown'* (AUT Gambling and Addictions Research Centre, 2010b)

This lack of information to support the efficacy and effectiveness of Public Health services reduces our ability to draw conclusions about the VfM of Public Health services. In drivers 15, 16 and 17 we have attempted to conclude on the effectiveness of Public Health services; however, only Driver 17 – Impact of awareness campaigns, had adequate evaluation of service effectiveness to enable a conclusion.

The Ministry has developed an outcomes framework for monitoring and reporting on the achievement of problem gambling outcomes. This framework was developed as part of the Ministry's Strategic plan 2010 – 2016 and the Ministry is currently commissioning work to monitor and report on progress against this framework. This outcomes framework provides further information on the causal links between Public Health activities and the minimisation of gambling harm.

5 Apparent confusion over intervention targets, how they are applied and what level represents an appropriate target

Each service provider has targets set within their contracts for the delivery of intervention sessions. Targets are set based on the level of utilisation the Ministry expects from its purchased FTE. As an example, one FTE is expected to achieve approximately 15 hours per week of clinical face-to-face treatment services (this also includes telephone interventions). This equates to around 60 full intervention sessions per month with the expected duration being one hour per session. These target levels are applied consistently across all providers (i.e. for all providers, one FTE purchased to deliver full interventions must deliver 60 sessions per month).

As seen in Driver 8: Extent that providers achieve intervention contract targets, achievement against targets has been low historically (although the trend is positive). Provider face-to-face time is similarly below target as depicted in Driver 3:Provider face-to-face time (including telephone).

Most providers raised concerns over the appropriateness of the level of intervention service targets, particularly for Brief Intervention services and Follow-up services. For Follow-ups, providers generally indicated the target (120 follow-up sessions per FTE per month) is unrealistic given the challenges in this area (i.e. transient population).

In addition, there is a lack of clarity as to the nature of targets in terms of whether they are seen as aspirational or absolute. Without this understanding we cannot conclusively determine whether achievement is poor or whether the targets are inappropriate.

The Ministry closely monitors provider achievement of targets and takes steps to address consistent under-achievement (through either reducing capacity or in extreme cases exiting the contract). However, it appears that there is some acceptance of a level of under-achievement for some providers because of unique factors that make achievement of those targets a challenge for certain providers. Examples include largely rural areas where the population is spread over a large geographical area. The Ministry is working to improve achievement levels.

4.2 Development areas within problem gambling programme

6 Perceived contract rigidity by providers that may drive sub-optimal behaviours

Targets may drive sub-optimal behaviours. Almost all providers commented that provider contracts were too rigid in terms of having overly tight criteria. The concern was that prescriptive service specifications stifled innovation and provided disincentives to providers to address service users' needs. Some providers were also concerned that activities they deem critical such as building relationships with those at risk of harm and what they term as social work activities are not captured in the data collection system.

We did not see any evidence that providers ignore service users' needs in order to meet contract targets. On the contrary, based on our interviews with providers and gambling industry stakeholders and through our review of provider audit reports and Ministry feedback, we got the sense that the opposite was occurring.

We do not agree that service specifications are restrictive and stifle innovation. While the Ministry has provided a preferred model of care, this is a model only and the Ministry recognises that meeting service user needs is paramount. In terms of Public Health services, our view of the service specifications is that they allow adequate room for providers to innovate and there is evidence of the Ministry being open to creatively designed initiatives. We suggest this issue is more a need for further training and knowledge sharing between providers. However, we do acknowledge that targets may drive sub-optimal behaviours.

7 The desire for greater clarity, communication and reporting from the Ministry to industry on outcomes

A common theme from discussions with the gambling industry was a desire for a greater level of clarity, communication and reporting from the Ministry, DIA and the Inland Revenue Department relating to the problem gambling levy.

Gambling industry stakeholders reported that currently they only receive reporting on the total number and proportion of service users accessing services. This only reports mode of gambling. There is limited analysis of trends, causes for trends or reporting on performance of the problem gambling programme towards the government objectives for problem gambling.

Some stakeholders from the gambling industry stated they could not provide a view on VfM due to the lack of adequate information. They sought greater clarity and enhanced understanding around the objective setting, allocation of funding and the effectiveness of that spend. Currently gambling industry stakeholders do not fully understand the rationale behind the level of levy funding or the rationale behind any increases / decreases of the levy.

Industry recognised that some good work has been done recently developing a national outcomes framework for gambling and problem gambling which should go some way towards addressing concerns regarding the effectiveness of problem gambling spend. In addition, a stronger audit trail of levy expenditure against budget with the publication of levy receipts against budget and actual expenditure was considered desirable.

8 Facilitation services have a higher unit cost than other sessions

Driver 4: Unit cost of a single intervention session shows that for both 2008 / 09 and 2009 / 10 the unit cost of a facilitation session was higher than other sessions. This is considerably higher than the cost of a full intervention session (about 130% higher). This suggests facilitation services are over-funded or that more effort needs to go into increasing the number of sessions delivered. It was suggested to us through this review that this may be due to providers failing to properly capture their facilitation efforts and that further training is needed.

Our view is that there is a high potential for facilitation services to address service users' other needs such as budgeting services for those facing financial hardship caused by their problem gambling. The Ministry should investigate the reason behind the high unit cost and take steps to address this.

4.2 Development areas within problem gambling programme

9 The funding model does not incentivise high achievement

Intervention and Public Health services are broken down into eleven Purchase Units which are funded on an FTE basis as described in Section 3.1 - context. Each Purchase Unit has an associated target for the number of sessions to be delivered or Public Health initiatives to be completed. However actual achievement against target does not influence the level of funding providers receive. Only if achievement is consistently very low does achievement impact funding. In these circumstances the Ministry will exit contracts with providers.

Good practice VfM principles suggest that funding/contracting models should be based on outcomes rather than inputs (i.e. FTE). We recognise there are challenges measuring outcomes for the delivery of health services and in particular addiction services.

An alternative funding model that aligns more to the principles of VfM is to fund providers based on outputs delivered (i.e. achievement against targets). This model incentivises providers to achieve contracted outputs. It rewards high performing providers and penalises poor performing providers. For this model to be fully effective it is important that there is a clear and evidence-based link between outputs and outcomes.

We also suggest that any shift to this model ensure that a portion of funding remains fixed rather than achievement-based. This would enhance the financial stability of service providers if demand for their services was to unexpectedly fall in the short-term.

10 The ring-fenced nature of problem gambling funding creates some challenges

HP consulting, in their 2006 report into the problem gambling levy, commented that 'as problem gambling services are provided on a stand-alone basis it is expected that significantly more administration and co-ordination costs are incurred than if a combined approach was undertaken'. This argument implies that economies of scale would exist if problem gambling services were integrated with other health or social services. Aside from the economies of scale argument, there are considerable health benefits associated with a combined or holistic approach to treatment services. KPMG is aware however that since 2006 the mix of service providers has changed, currently only 3 / 25 service providers offer problem gambling services on a stand-alone basis. Other service providers offer a varying range other health services.

The hypothecated (allocation of a levy/tax for a specific purpose) funding of problem gambling services means that full integration with other addiction treatment services is challenging. The facilitation service is an attempt to strike a balance between achieving a holistic treatment approach and avoiding unfairly burdening the gambling industry with having to fund services to treat indirect (and in certain circumstances not gambling) harms. Notwithstanding this, we agree that full integration will continue to be a challenge for problem gambling services under the current levy funding model and this may limit the effectiveness of the services.

11 Some Public Health provider activities undertaken by service providers may be contrary to the Government's policy objectives with regards to problem gambling

The gambling industry raised concerns throughout this review regarding some provider initiatives that were seen to be at odds with the Government's policy objectives.

One example involves media releases that convey messages that can be perceived as 'anti-pokies' (that is, anti-Electronic Gaming Machines (EGMs)). Gambling industry stakeholders take offence at what they describe as messages of moral outrage aimed at EGMs when the Government recognises gambling as a legal and popular activity in New Zealand that creates benefit (through entertainment and community funding).

These actions potentially put in jeopardy the Government's balanced position on gambling and problem gambling. In addition, a perceived 'anti-gambling' view by some stakeholders may result in an 'us versus them' or confrontational position. Dr David Korn of the University of Toronto, an internationally recognised academic in the field of problem gambling treatment, saw New Zealand as being in a strong position *to 'shape and clarify a mutually accepted model of engagement with both the gambling industry and government that balances costs and benefits of these stakeholder / interest groups. The challenge is to reduce tensions and foster a powerful as well as innovative collaboration that can be seen as a model for international adoption.'*

4.2 Development areas within problem gambling programme

11 Some Public Health provider activities undertaken by service providers may be contrary to the Government's policy objectives with regards to problem gambling

From a VfM perspective, the issue is whether these activities have a negative impact on the Government's policy objectives and whether time spent on these activities detracts providers from accomplishing more productive work. Providers argue that as private organisations they are engaging in activities that are consistent with their organisations' mission and that those activities are undertaken using privately raised funding. However, we note that provider contracts clearly require providers to perform the services in a manner that is consistent with and maintains the Ministry's actual and perceived political neutrality.

Aside from continued dialogue, the Ministry's only mechanism to manage such behaviour is through dialogue or actions to terminate or reduce funding.

12 There may be opportunities to improve collaboration with other government agencies

Both service providers and the gambling industry raised concerns over the level of collaboration between the Ministry and other government agencies. For example, stakeholders from both groups expressed frustration with the establishment of multi-venue exclusion orders (a process whereby people are able to exclude themselves from all class 4 gambling venues within a geographical area; a process often assisted by problem gambling providers). This process appears to lack direction from either the DIA or the Ministry and as a result problem gambling providers indicated they lacked the support required to adequately roll-out these initiatives. Industry commented that the fragmented region by region approach to establishing multi-venue exclusion orders taken by providers created significant duplication of effort, with different providers establishing differing processes and separately consulting on initiatives. KPMG acknowledges that the Gambling Act does not make special provision for multi-venue exclusion orders; however these are commonplace in practice and necessitate leadership from either agency (Ministry / DIA).

Service providers also reported issues with embedding screening and education programmes into other justice, education and social support agencies. Service users presenting to problem gambling services often have co-morbidities such as alcohol and drug addictions or other mental health concerns. In recognition of this, many service providers have attempted to integrate screens to identify problem gamblers within other government services. Service providers reported that uptake of these initiatives was varied and that better cross-government coordination led by the Ministry would assist with integrating services and ultimately enhance VfM. Worthy of acknowledgement are the facilitation services funded by the Ministry as these make significant progress towards integrating problem gambling with other health services.

We understand that the Ministry already has some relationships with other government agencies. The examples provided above indicate other possible opportunities for collaboration.

4.2 Perceptions of VfM in service delivery – Score out of 10

Perceptions of service delivery

At meetings with stakeholders for this review we asked stakeholders to share their overall perceptions of the current level of VfM from problem gambling services using a simple 0 to 10 scale where 0 is poor and 10 is good. This was used as a basis for initial discussions. The results of this assessment have not influenced our overall conclusion.

From our experience in similar reviews, stakeholders typically spend a much greater proportion of the time in meetings discussing areas for improvement. Whilst this measure of our approach is subjective and non-scientific it allows us to place these comments into perspective. Once the general level of performance is assessed and shared, the context is provided and the focus can move to areas for potential improvement ('How to get 10 / 10').

The Ministry / DIA and service providers rated the VfM as high and industry rated the VfM lower, at 4.6 on average. We also requested stakeholders break their overall score down to three categories: Intervention services, Public Health services and the Service Delivery Model. The low average score from the gambling industry was weighted down by very low scores for 'Service Delivery Model'. This reflects concern with the perceived lack of political neutrality among service providers. This concern is discussed in greater detail in Section 4.1. Removing this concern would increase industry scores to 5.7 / 10. One service provider rated service delivery as 11 / 10, hence the graph extends beyond the maximum score.

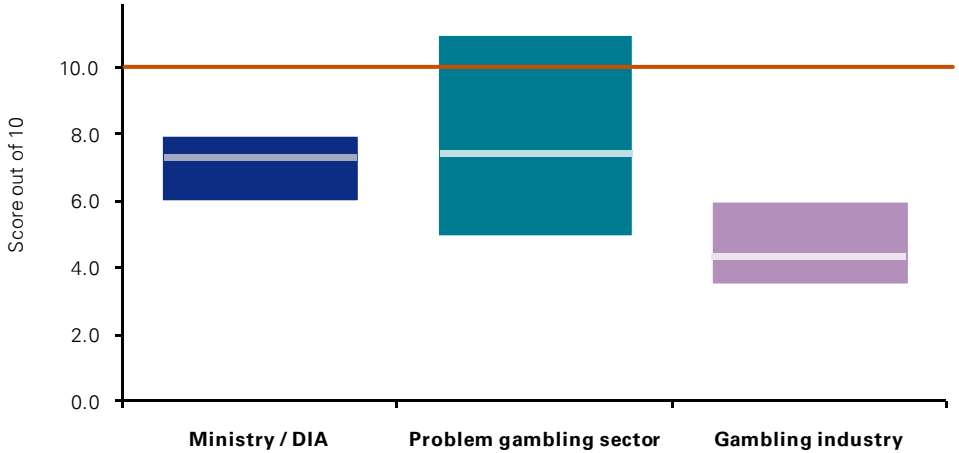
Based on this subjective and non-scientific measure, there is an indication that VfM is currently quite high but that there is room for improvement. In a recent VfM review KPMG completed in another sector, all parties rated the VfM as 4 / 10 on average. This indicated more significant deficiencies in the programme.

The population for this measure was split as follows:

- 7 Government representatives (Ministry and DIA)
- 34 Problem gambling sector representatives (Service providers and Researchers)
- 9 Gambling industry representatives

Approximately 90% of those we met with provided their perceptions for this measure.

Graph 5: Perception of VfM of problem gambling service delivery in New Zealand



Source: KPMG

Note: The 'problem gambling sector' comprises service providers, researchers & interested others

The lighter coloured bars in the graph above represent the average rating. The multi-coloured columns represent the range.

Key points

- The most commonly cited reason for the low average score of the gambling industry was concern with the lack of political neutrality among service providers as detailed in Development Area 11 in section 4.2.
- The Ministry & DIA were in the mid-range, but consistently recognising that while performance is good, areas always remain for potential improvement
- The greatest variation in perception was among the problem gambling sector, perhaps representative of the larger sample surveyed.

4.3 Introduction to analysis of VfM drivers – Quantitative analysis

Introduction to analysis of VfM drivers

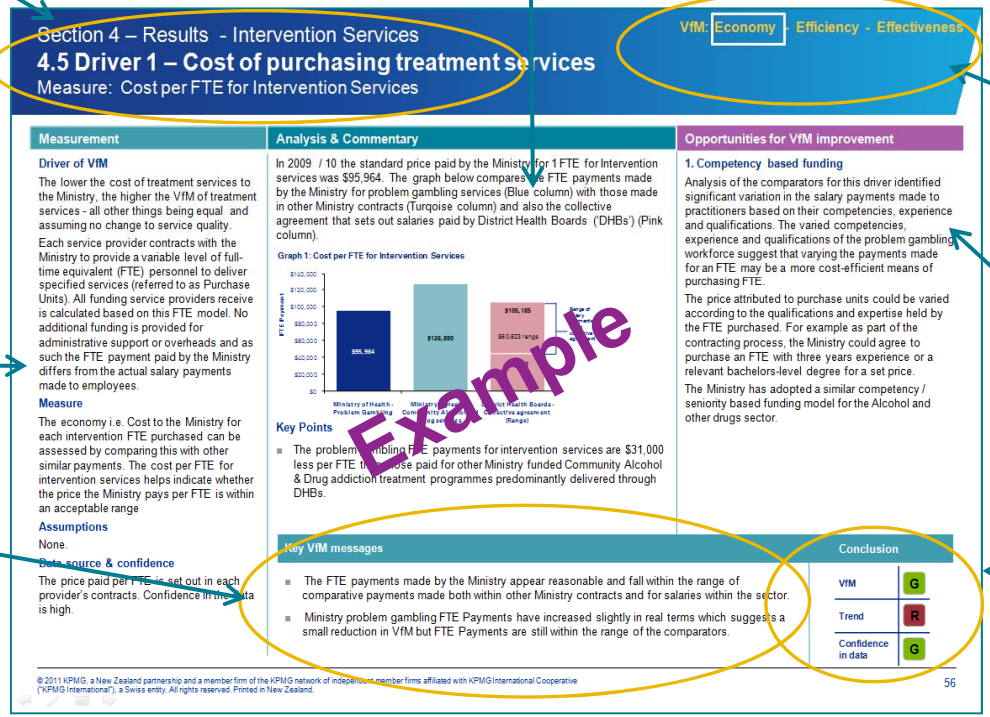
This section of the report sets out how we have presented our analysis of the VfM drivers. In the following pages we have used a standard layout with a common set of headings.

In our approach section, we identified 26 drivers of VfM. These are measures of the economy,efficienc y and effectiveness of each of the four components of problem gambling services.

Diagram 11: Illustration of Driver Structure

Heading
The heading of each driver identifies the problem gambling services that this driver relates to e.g. Intervention services. The text in bold sets out the title for the driver and the text immediately below sets out how the driver is being measured.

Analysis & Commentary
Analyses the data within the driver, where possible presents this graphically and provides a comparison of the driver over time, across service providers or against analogue or international comparators.



Measurement
Identifies factors that influence VfM.
This section also identifies:
- Driver of VfM
- Measure
- Assumptions
- Data source & confidence.

Key VfM messages
Summarises the analysis to two or three key bullets

VfM Components
Indicates which of the components of our VfM methodology this driver relates to: Economy, Efficiency or Effectiveness.

Opportunities for improvement
Identifies opportunities to improve the VfM of service provision.

Conclusion
Provides an overall conclusion for the driver. The framework for this conclusion is provided on the following page

Source: KPMG

4.3 Introduction to analysis of VfM drivers – Quantitative analysis

Framework for assessing VfM under traffic-light system

For each driver in the bottom right-hand corner we conclude on the VfM, trend and confidence in the data assessed. This uses the traffic-light system whereby red indicates poor performance, amber indicates fair performance and green indicates good performance. Our framework for applying the traffic-light system is described below and on the following page.

The assessment of VfM is based on both analysis of the results and trends of the driver and also compensating factors. Where compensating factors affect the conclusions these have been discussed in the 'Analysis & Commentary section'. For one driver, traffic-light conclusions are provided for two time-periods. This occurs when substantial change to the results of the driver has occurred over time. The assessments are based on quantitative data and qualitative evidence. The rating system for each driver is subjectively applied rather than based on quantifiable thresholds. The framework we have applied for applying the traffic-light system is below:

VfM Conclusion

Red	R	This driver suggests VfM is poor in this area. Significant opportunities for improvement exist.
Amber	A	This driver suggests VfM is fair in this area. Some opportunities for improvement exist.
Green	G	This driver suggests VfM is good in this area.
Grey	U	Data for this driver was insufficient to provide a VfM conclusion. If confidence in the data for this driver was assessed as Red we have not provided a VfM conclusion.

Trend

Red	R	The trend for this driver is negative. Performance has decreased over time.
Amber	A	The trend for this driver is stable. Performance has remained stable over time.
Green	G	The trend for this driver is positive. Performance has improved over time.
Grey	N	The trend was not assessed for this driver

4.3 Introduction to analysis of VfM drivers – Quantitative analysis

Framework for assessing VfM under traffic-light system (continued)

Confidence in data

Red	R	Confidence in the data for this driver was low. We were not able to draw conclusions from this data.
Amber	A	Confidence in the data for this driver was moderate.
Green	G	Confidence in the data for this driver was high.

Section 4 – Results

4.4 VfM driver conclusions – Quantitative analysis

Introduction

The table below summarises our conclusions for each driver that relates to intervention services. Overall the conclusion is VfM is mixed, the trend in the drivers is positive and confidence in the data is high

For five drivers we were unable to draw a conclusion on the VfM. We have provided reasons for this below.

Intervention Services	Impact	VfM Component	VfM Conclusion	Trend	Confidence in data
Driver 1 – Cost of purchasing treatment services	High	Economy	G	R	G
Driver 2 – Cost of operating helpline website	Low		We reviewed the data relevant to this driver and found that the cost of operating the helpline website was less than $10k per annum We deemed this to be immaterial and accordingly have not undertaken further work in this area.		
Driver 3 Provider utilisation (face-to-face time)	High	Efficiency	R	G	A
Driver 4 – Unit cost of a single intervention session	High		U	G	G
Driver 5 Unit cost of a single helpline call	High		R	N	G
Driver 6 – Cost of helpline availability	Medium		G	G	G
Driver 7 Timeliness of treatment service	Low		We were advised by service providers that service users are able to access services promptly without need for a waiting list. Based on this advice we did not review this driver further.		
Driver 8 Extent that providers deliver intervention contract	High	2007 - 2010	R	G	G
		2009 - 2010	A	G	G
Driver 9 Alignment of intervention services to target populations	High	Effectiveness	G	N	G
Driver 10 Degree that services meet individual needs	High		We were unable to obtain data to conclude on this driver. Discussion on the degree that services meet individual needs is provided in Section 4: strengths.		
Driver 11 – Quality of Helpline calls	Medium		The Helpline advised that they do operate a programme of reviewing customer satisfaction with services, however response rates were immaterially low and they generally only received responses from those that viewed the service positively.		
Driver 12 Rate of drop out and re-presentations	Medium		The Ministry extracted data from the CLIC database on drop-outs and re-presentations for problem gambling services. Upon further review we were unable to draw conclusions from this data as it was not possible to identify the impact of this on VfM.		

Section 4 – Results

4.4 VfM driver conclusions – Quantitative analysis

Introduction

The table below summarises our conclusions for each driver that relates to Public Health services. Overall we were unable to conclude on the VfM of Public Health services as we have not measured the achievement of two 'high impact 'drivers. Economy of Public Health services is high. The trend was positive for the one driver assessed and our confidence in the data varied.

For Driver 14 we were unable to draw a conclusion on the VfM. We have provided reasons for this below. For drivers 15 and 16 we were unable to conclude on the VfM. We developed and measured achievement and reported our results. We have presented our findings and inability to conclude in the respective drivers.

Public Health	Impact	VfM Component	VfM Conclusion	Trend	Confidence in data
Driver 13 – Cost of purchasing Public Health services	High	Economy	G	G	G
Driver 14 – Unit cost of a Public Health project	Medium	Efficiency	Information was not available to quantify the size or benefit of Public Health services.		
Driver 15 – Alignment of Public Health services to target populations	High	Effectiveness	U	N	G
Driver 16 – Extent that providers deliver Public Health contract	High		U	N	R
Driver 17 – Impact of awareness campaigns	High		G	N	G

Section 4 – Results

4.4 VfM driver conclusions – Quantitative analysis

Introduction

The table below summarises our conclusions for each driver that relates to both Public Health and intervention services. These drivers have been considered in our VfM conclusions for Intervention and Public Health services.

For two drivers we were unable to draw a conclusion on the VfM. We have provided reasons for this below. For drivers 18 and 20 we were unable to conclude on the VfM.

Intervention services & Public Health	Impact	VfM Component	VfM Conclusion	Trend	Confidence in data
Driver 18 Proportion of provider overheads	Medium	Economy	U	N	R
Driver 19 Shortfall in FTE purchased by Ministry compared with actual FTE provided	High		G	N	A
Driver 20 – Split between Public health and Intervention services	Medium	Efficiency	U	N	G
Driver 21 – Match of skill set to need	Medium		This purpose of this driver was to review the competencies of problem gambling practitioners against the requirements of the Ministry's purchase units. We were unable to obtain information on the competencies and qualifications of practitioners within the sector. The Ministry has commissioned two projects to develop a competencies framework for intervention and Public Health services respectively. We note that similar progress (outcome) measures are intended to be monitored as part of the National outcomes framework for gambling and problem gambling.		
Driver 22 – Alignment of actual demand for services against supply geographic and demographic	High	Effectiveness	We were unable to compare demand for services against supply on a geographic basis. We investigated using geo-spatial mapping software to graphically assess the supply of problem gambling services against risk factors e.g. gambling venue location and service demand. We were advised that this is not a practical measure on a national basis but more appropriate on a TLA level.		

4.4 VfM driver conclusions – Quantitative analysis

Introduction

The table below summarises our conclusions for each driver that relate to Ministry costs and research services. Overall the conclusion is VfM is good in these areas.

Ministry costs	Impact	VfM Component	VfM Conclusion	Trend	Confidence in data
Driver 23 – Quality of policy advice	Medium	Effectiveness	G	N	G
Driver 24 Quality of contract management processes	High	Efficiency Effectiveness	G	G	G
Research services	**Impact**	**VfM Component**	**VfM Conclusion**	**Trend**	**Confidence in data**
Driver 25 – Quality of planning processes for research programme	High	Economy Efficiency	G	N	G
Driver 26 – Assessment of outcomes of research programme	High	Effectiveness	G	N	G

4.4 VfM driver conclusions – Quantitative analysis

Intervention services

VfM Driver Tree conclusions

As outlined in our approach in section 2, we have presented each of the VfM drivers in a driver tree. Each of the VfM drivers are colour-coded according to our VfM conclusion. Our conclusion considers the overall relationship between the three components of our VfM methodology – Economy, Efficiency & Effectiveness and their impact on VfM. This analysis only relates to our quantitative analysis and does not consider the strengths or areas for development identified through our stakeholder interviews.

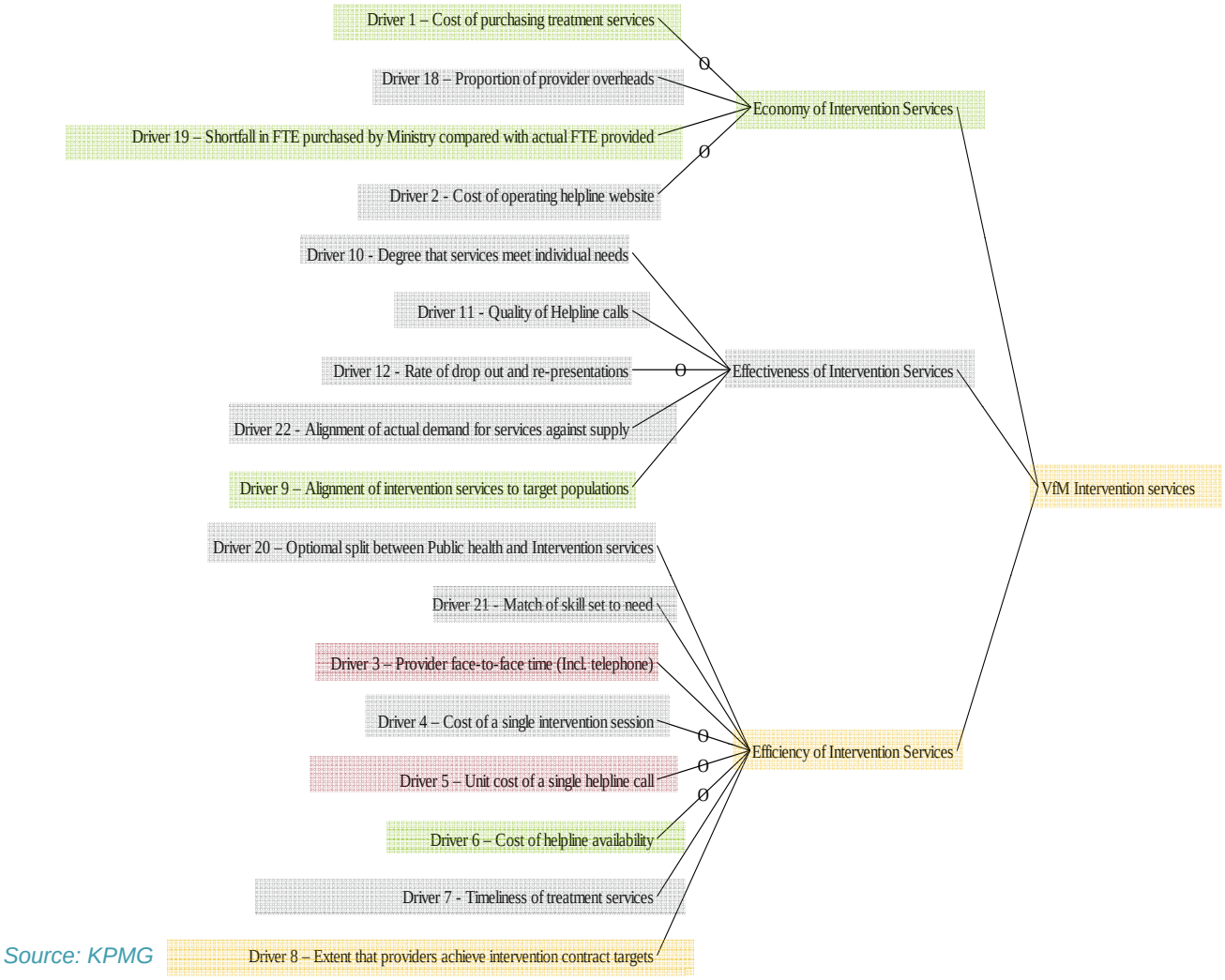
The drivers in grey represent areas where we developed measures to assess the VfM of service delivery but, for various reasons, were unable to draw conclusions from. These reasons include:

- Insufficient data was available to conclude
- Data available was highly subjective, limiting our ability to draw robust conclusions
- The effort required to measure the driver outweighed the benefits gained from its inclusion in this review.

KPMG is not suggesting that the Ministry collect data in all of these areas, but does suggest that a cost: benefit analysis be undertaken to review the practicality of reporting on certain key drivers. We have identified an 'opportunity for improvement' in the respective drivers where we suggest the Ministry do this.

The Ministry is currently developing a national outcomes framework for gambling and problem gambling. This outcomes framework includes 65 progress measures which will assist with understanding VfM in the future. This is because the outcomes framework will report on the outcomes of Ministry problem gambling services and on progress towards each of the 11 objectives for problem gambling.

Diagram 12: Intervention services VfM Driver tree

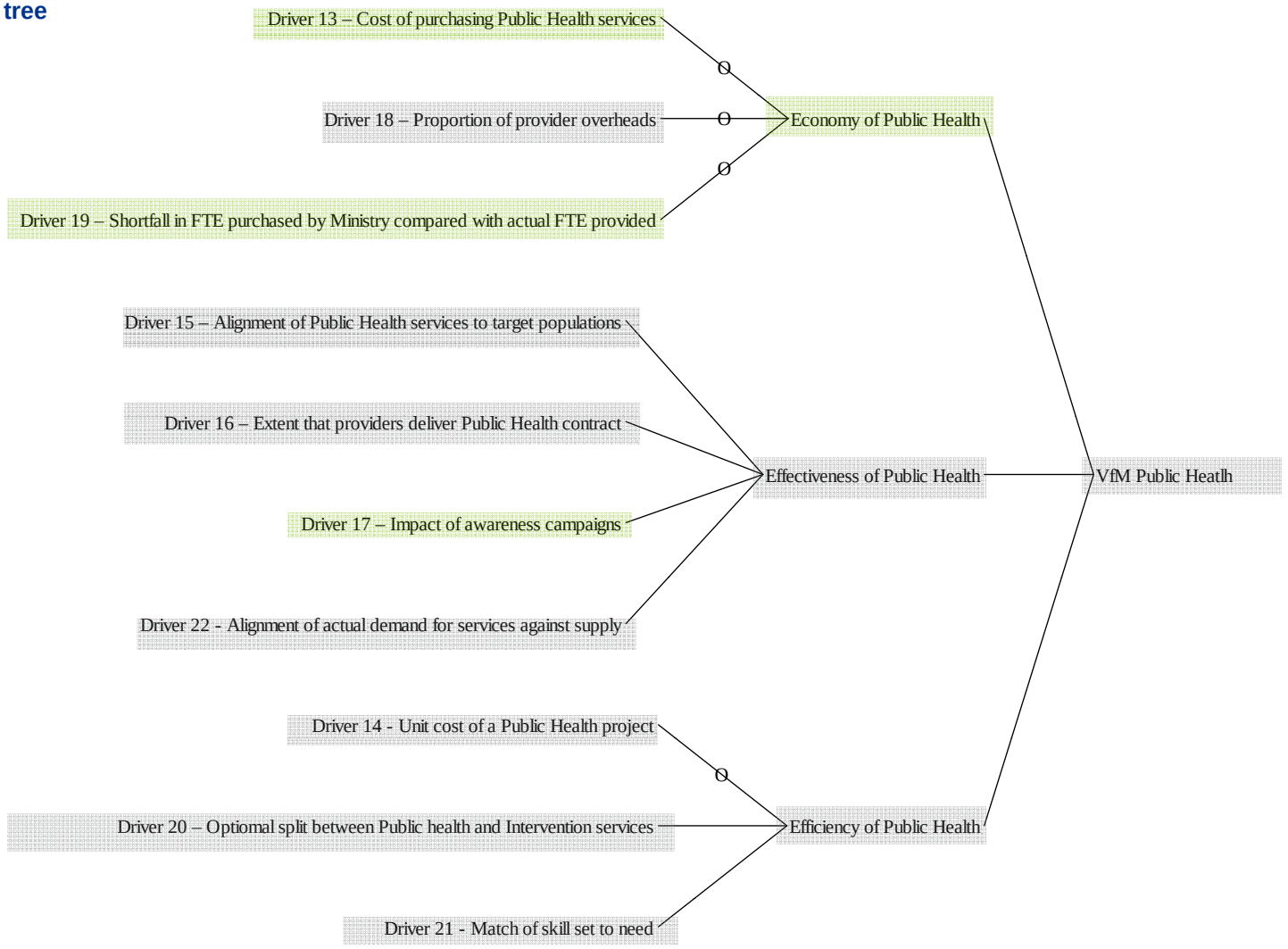


Source: KPMG

4.4 VfM driver conclusions – Quantitative analysis

Public Health services

Diagram 13: Public Health VfM Driver tree

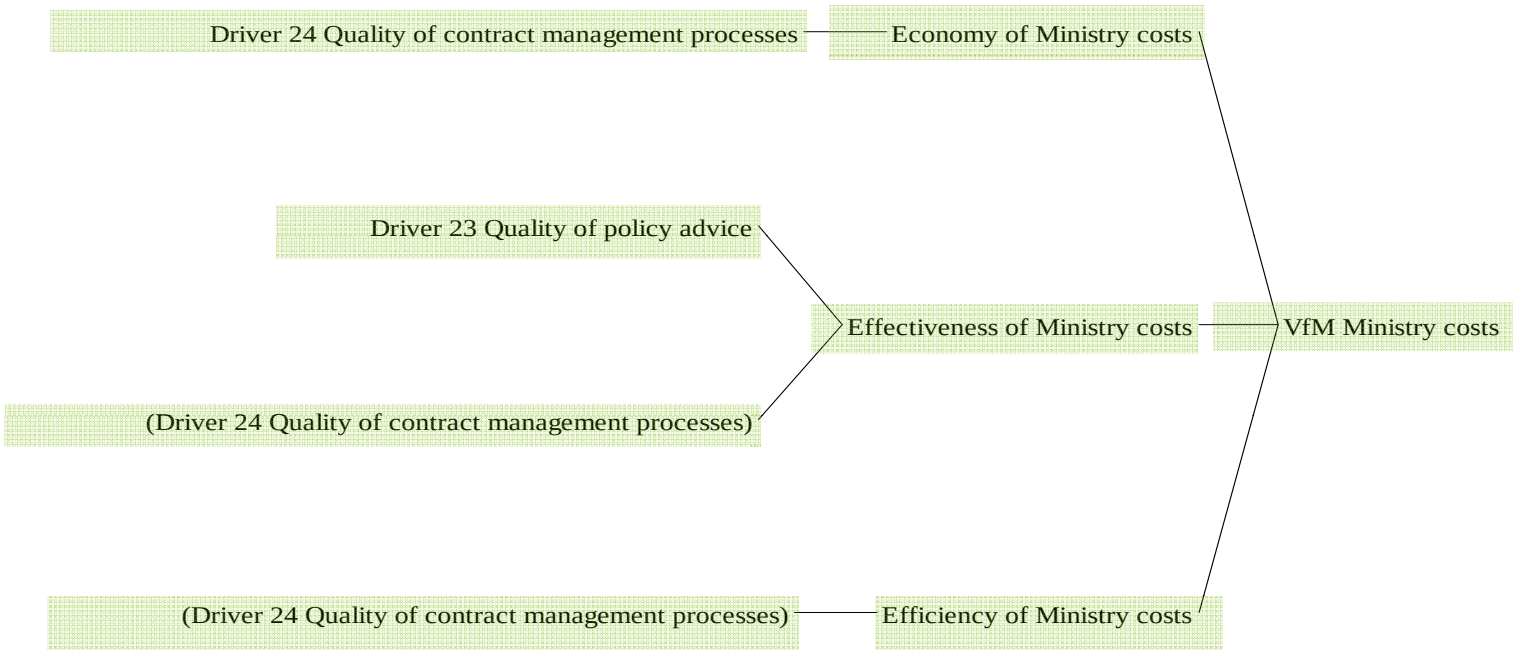


Source: KPMG

4.4 VfM driver conclusions – Quantitative analysis

Ministry costs

Diagram 14: Ministry costs VfM Driver tree

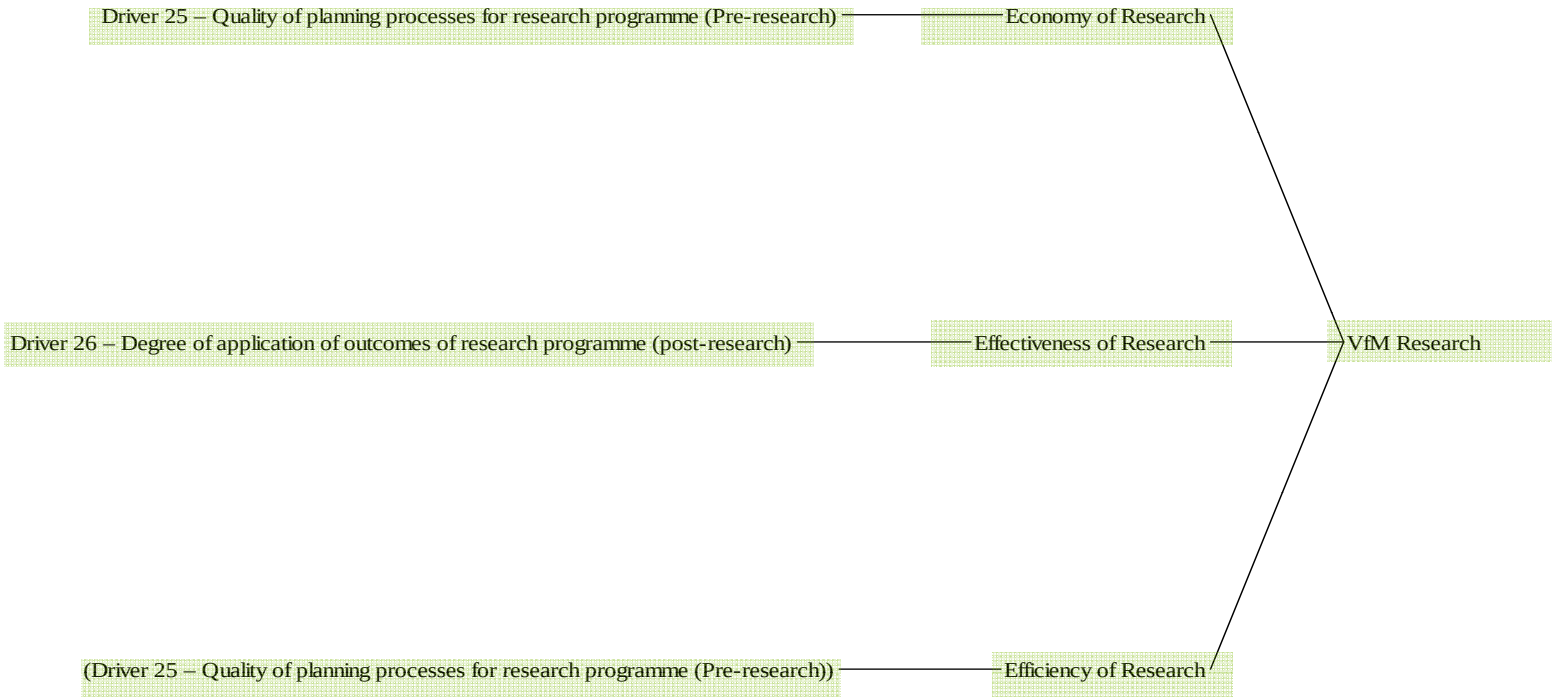


Source: KPMG

4.4 VfM driver conclusions – Quantitative analysis

Research services

Diagram 15: Research services VfM Driver tree



Source: KPMG

4.5 Driver 1 – Cost of purchasing treatment services

Measure: Cost per FTE for Intervention Services

Measurement

Driver of VfM

The lower the cost of treatment services to the Ministry, the higher the VfM of treatment services - all other things being equal and assuming no change to service quality.

Each service provider contracts with the Ministry to provide a variable level of full-time equivalent (FTE) personnel to deliver specified services (referred to as Purchase Units). All funding service providers receive is calculated based on this FTE model. No additional funding is provided for administrative support or overheads and as such the FTE payment paid by the Ministry differs from the actual salary payments made to employees.

Measure

The economy i.e. Cost to the Ministry for each intervention FTE purchased can be assessed by comparing this with other similar payments. The cost per FTE for intervention services helps indicate whether the price the Ministry pays per FTE is within an acceptable range

Assumptions

None.

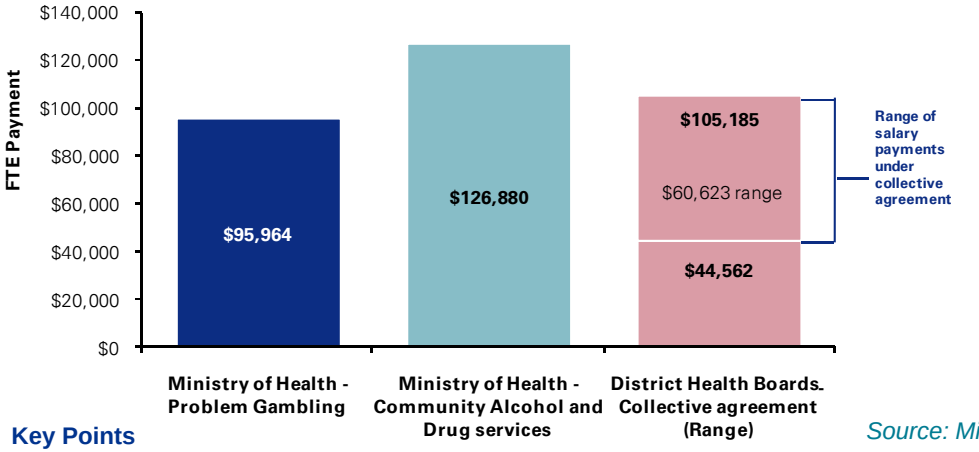
Data source & confidence

The price paid per FTE is set out in each provider's contracts. Confidence in the data is high.

Analysis & Commentary

In 2009 / 10 the standard price paid by the Ministry for 1 FTE for Intervention services was $95,964. The graph below compares the FTE payments made by the Ministry for problem gambling services (Blue column) with those made in other Ministry contracts (Turquoise column) and also the collective agreement that sets out salaries paid by District Health Boards ('DHBs') (Pink column).

Graph 6: Cost per FTE for Intervention services



Source: Ministry of Health & Public Services Association

Key Points

- The problem gambling FTE payments for intervention services are $31k less per FTE than those paid for other Ministry funded Community Alcohol & Drug addiction treatment programmes predominantly delivered through DHBs.
- Payments fall within the range of salaries with the DHB collective salary agreement.

Analysis & Commentary continued on the following page

Key VfM messages

- The FTE payments made by the Ministry appear reasonable and fall within the range of comparative payments made both within other Ministry contracts and for salaries within the sector.
- Ministry problem gambling FTE Payments have increased at a rate above inflation which suggests a reduction in VfM, but FTE Payments are still within the range of the comparators. Due to this reduction in VfM we have concluded that the trend is red.

Conclusion

VfM	G
Trend	R
Confidence in data	G

4.5 Driver 1 – Cost of purchasing treatment services

Measure: Cost per FTE for Intervention Services

VfM: **Economy** - Efficiency - Effectiveness

Analysis & Commentary

Comparators

1) *International - Not feasible*

The New Zealand FTE contracting model is unique and not comparable internationally. Cost of living and associated variances reduce the feasibility of comparing FTE payments with international salary levels.

2) *Analogue - No direct comparison*

Problem gambling FTE payment compares favourably with alcohol & other drugs and falls within the range of salary payments made by DHBs.

The most direct comparison for problem gambling services is the Ministry Purchase Unit for Community Alcohol and Drug services. The cost for 1 FTE for this purchase unit in 2009 / 10 was $126,880 compared with the $95,964 for problem gambling services. These are not directly comparable to the problem gambling sector as Community Alcohol and Drug services are predominantly provided by DHBs rather than the NGO structure for problem gambling service delivery.

The District Health Boards / PSA, Allied, Public Health & Technical Multi Employer Collective Agreement for the period up to 31 October 2010 has a salary range from $44,562 for a graduate alcohol & other drug clinician to $75,656 for an advanced practitioner. The range for qualified counsellors extends to $105,185 for the most advanced psychologist. The FTE payments made by the Ministry fall within this range and, allowing for administrative costs and overheads, this FTE payment appears appropriate. The Ministry FTE payments are expected to cover any overheads or administrative costs incurred by service providers.

3) *Historical - Payments have increased in real terms which suggest a reduction in VfM.*

Payments have increased by 10.8% between July 2007 and July 2010 (from $89,139 to $98,800). This is greater than the rate of inflation of 8.4% over the same period and indicates an increase in real terms (Statistics New Zealand, 2010). In the Ministry's service plan budgets FTE payments are set to increase by 1% for 2010 / 11 and 2% for each of 2011 / 12 and 2012 / 13. This appears appropriate. We were advised that all providers receive an equivalent payment for 1 FTE.

Opportunities for VfM improvement

1. Competency based funding

Analysis of the comparators for this driver identified significant variation in the salary payments made to practitioners based on their competencies, experience and qualifications. The varied competencies, experience and qualifications of the problem gambling workforce suggest that varying the payments made for an FTE may be a more cost-efficient means of purchasing FTE.

The price attributed to purchase units could be varied according to the qualifications and expertise held by the FTE purchased. For example as part of the contracting process, the Ministry could agree to purchase an FTE with three years experience or a relevant bachelors-level degree for a set price.

The Ministry has adopted a similar competency / seniority based funding model for the Alcohol and other drugs sector.

2. More detailed financial reporting to re-assess FTE payments

If further detail was provided in financial reporting from service providers it would be possible to understand better the overhead / administrative costs incurred by providers and set the FTE payments at the standard salary level in the market plus an allowance for these costs. We have attempted to assess these costs in VfM driver 18.

3. Consider alternative funding models

We suggest the Ministry explore alternative funding models such as the output / outcome funding model discussed in section 6.

4.5 Driver 2 – Cost of operating Helpline website

Measure: Cost per annum to operate website

We reviewed the data relevant to this driver and found that the cost of operating the Helpline website was less than $10k per annum. We deemed this to be immaterial and accordingly have not undertaken further work in this area.

4.5 Driver 3 – Provider face-to-face time (including telephone)

Measure: Clinical hours as proportion of total available hours

Measurement

Driver of VfM

The greater the proportion of intervention practitioner time allocated to delivering counselling sessions the better the VfM - all other things being equal.

Measure

This measure assesses the proportion of total time spent face-to-face with clients by intervention personnel. This is calculated as the proportion of total available working hours spent delivering intervention sessions (referred to as clinical hours). This measure includes interventions delivered both face-to-face and over the telephone.

Assumptions

For this measure "available hours" are assumed as:

- 37.5 hour working weeks (7.5 hour day)
- 45.8 working weeks in the year (52 weeks less 4 weeks annual leave, less 11 days statutory holidays).

Service providers receive an additional 20% infrastructure provision - an additional FTE allowance funded for all providers to provide time for Kaumatua involvement, practitioner workforce development and involvement in research projects. This has been excluded from the total available hours in our analysis.

The available hours were multiplied by the total intervention FTE contracted for by the Ministry each year.

Measurement

Assumptions

Both the contracted FTE and clinical hours attributed to the Gambling Helpline have been removed from this measure. This is to reflect the unique nature of Helpline delivery whereby time not spent delivering interventions could be spent providing general information to clients or completing referrals to face-to-face services. We have assumed that the clinical hours target of 15 hours per week is appropriate and absolute for this driver.

Data source & confidence

The data to calculate the FTE contracted for intervention services was obtained from Ministry spreadsheets which outline funding from provider contracts. Actual clinical hours information was obtained from the CLIC system used by service providers for entering data for each session delivered. The CLIC system does not record complete information for sessions with more than one counsellor, e.g. Group sessions. Confidence in the data is moderate.

Analysis & Commentary

The Ministry's targets for clinical hours equate to approximately 42% face-to face time (equal to 15 hours per week). These targets are intended to reflect time spent booking, preparing and documenting sessions, entering client data in the CLIC system and non-attendance by clients. Full utilisation of practitioners in sessions would not be considered ideal, as a portion of practitioner time needs to be spent on training, documenting sessions etc.

We understand from the Ministry that targets for Alcohol and Other drug contracts with in the Ministry are set at 20 clinical hours per week. This is more than the targets for problem gambling (at 15 hours per week). We were advised that the 5 hour variance between the targets for the two services was reflective of the mobile nature of some problem gambling services whereby clinicians can attend clients in their home and a higher rate of non-attendance at problem gambling services.

Analysis & Commentary continued on the following page

Key VfM messages	Conclusion	
■ The proportion of provider time spent face-to-face with clients has improved by 8% between 2008 / 09 and 2009 / 10 ■ The face-to-face time percentage is significantly below the target of 42% in both years and accordingly we have concluded that VfM is poor ■ We have assumed that the clinical hours target of 15 hours per week is appropriate and absolute for this driver. Accordingly, achievement is below target.	VfM	R
	Trend	G
	Confidence in data	A

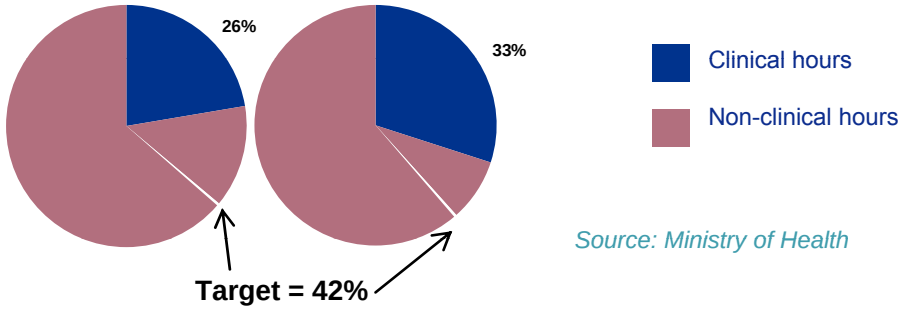
4.5 Driver 3 – Provider face-to-face time (including telephone)

Measure: Clinical hours as proportion of total available hours

Analysis & Commentary

As depicted in Graph 7 below, intervention practitioners spent 26% & 33% (in 2008 / 09 and 2009 / 10) respectively face-to-face with clients. The 7% improvement in time spent face-to-face with clients mirrors the trend presented in driver 11, the extent that providers deliver contracts, whereby significant improvement in achievement has occurred in the 2009 / 10 year. The white line on the graph below represents the 42% face-to-face target.

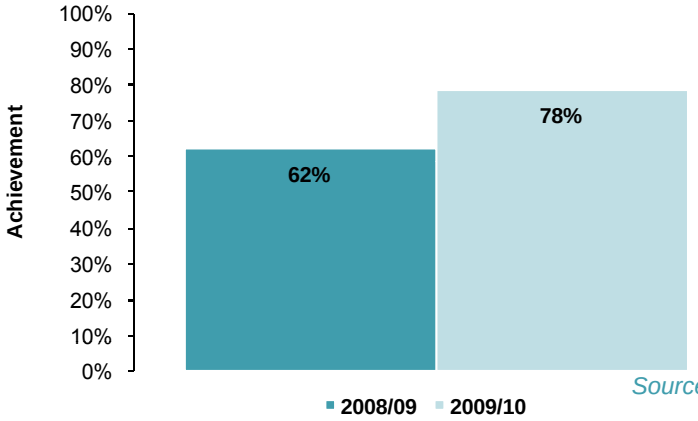
Graph 7: Proportion of provider time spent face-to-face with clients



Source: Ministry of Health

Graph 8 below shows service provider achievement against the 15 hour per week clinical hours target. The graph indicates 62% achievement of target in 2008 / 09 and 78% in 2009 / 10.

Graph 8: Achievement of target of 15 clinical hours per week



Source: Ministry of Health

Opportunities for VfM improvement

1. Sharing best practice

Further analysis could be undertaken into the variance in this driver between providers. This may identify reasons why certain providers have higher rates of face-to-face time with clients. This analysis may suggest higher demand for services or reasons why they apply their time more efficiently.

2. Measures of the efficiency of non-clinical time

We recommend that performance measures be developed to measure the efficiency of non-clinical time. This should involve identifying activities that form the Pink component of Graph 7 (e.g. CLIC data entry, reporting and preparation for sessions) and developing performance measures to measure these activities.

4.5 Driver 4 – Unit cost of a single intervention session

Measure: Unit cost of a single intervention session

VfM: Economy - **Efficiency** - Effectiveness

Measurement

Driver of VfM

The lower the cost to the Ministry of a single intervention session, the greater the VfM - all other things being equal.

Measure

The measure used is the unit cost of a single intervention session. The Ministry contracts with providers to deliver one of four types of intervention sessions. These are Brief, Full, Facilitation and Follow-up. Each of these are described in more detail in section 3.1 of this report. The measure was calculated by dividing the total spend on intervention services by the number of each type of session delivered for each year.

Assumptions

The total spend on intervention services includes a 20% infrastructure provision – This is an additional FTE allowance funded for all providers to provide time for Kaumatua involvement, practitioner workforce development and involvement in research projects. This provision has been included in the unit cost of a session.

Data source & confidence

The data to calculate the total spend on intervention services was obtained from Ministry spreadsheets that outline funding from provider contracts. Actual information on sessions delivered was obtained from the CLIC system used by service providers for entering data for each session. Confidence in the data is high.

Analysis & Commentary

The Ministry funds problem gambling services on an input basis per FTE. Because of this funding model the unit cost set out below is purely theoretical. However, this analysis does show the relationship between funding levels and session delivery. If funding decreases without an equal decrease in session delivery, unit costs decrease. Likewise if session delivery increases without an equal increase in funding, unit costs decrease.

As indicated on the graph on the next slide, the unit cost of each of the four types of intervention, has fallen. Thus taken together, the combined unit cost of a session has fallen from $199 in 2008 / 09 to $134 in 2009 / 10. This is a 33% reduction. The trend is caused by a combination of both decreases in funding and increases in session delivery. In 2009 the Ministry reduced or exited a number of provider contracts '*due to low service utilisation during the 2008 calendar year*' (Ministry of Health, 2009). Another reason for the reduction in funding relates to the cessation of initial funding provided to establish the delivery of intervention sessions by the Gambling Helpline.

The unit cost of a brief intervention session has fallen from 2008 / 09 to 2009 / 10. This appears to have been caused by a 45% increase in brief sessions delivered and a concurrent reduction in funding for brief sessions.

The unit cost of a full intervention session has remained relatively constant between 2008 / 09 and 2009 / 10. Approximately 65% of all sessions delivered are full sessions.

Facilitation sessions have the highest theoretical unit cost in both years. This appears to be driven by the low volume of these sessions delivered relative to funding. Facilitation sessions do have the capacity to be significantly longer than other sessions, however, the data obtained from the CLIC system suggests this is not the case.

The unit cost of delivering each follow-up session reduced between 2008 / 09 and 2009 / 10. This reduction can be attributed to a 40% decrease in the FTE contracted for follow-up sessions in 2009 / 10 and a concurrent increase in service delivery.

The reduction in the theoretical unit cost indicates that in 2009 / 10 the Ministry has better matched the supply of FTE to service demand.

Analysis & Commentary continued on the following page

Key VfM messages

- The unit cost of all intervention sessions fell in 2009 / 10, from $199 in 2008 / 09 to $134 – this is a positive trend
- Full intervention sessions have the lowest theoretical unit cost of all intervention sessions yet are 2-4 times longer than brief or follow-up sessions
- The unit cost used in this driver is theoretical. The Ministry fund inputs (FTE) not sessions
- We can not draw conclusions on the VfM of this driver as we could not obtain any comparators

VfM	U
Trend	G
Confidence in data	G

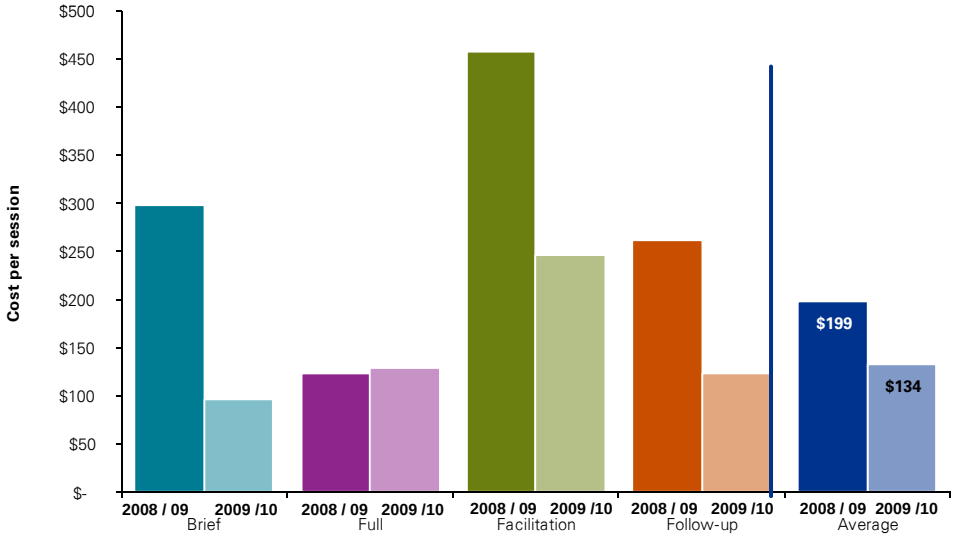
4.5 Driver 4 – Unit cost of a single intervention session

Measure: Unit cost of a single intervention session

VfM: Economy - **Efficiency** - Effectiveness

Analysis & Commentary

Graph 9: Average cost of a single counselling session



Source: Ministry of Health

Comparators

Historical – Improving trend

The unit cost of all intervention sessions fell in 2009 / 10. This has been caused by substantial increases in the delivery of sessions (as presented in Driver 8– Extent that providers deliver against intervention contracts).

Key Points

- The unit cost of each type of intervention session has fallen between 2008 / 09 and 2009 / 10 and has fallen substantially for Brief, Facilitation and Follow-up sessions. On average this reduction has been by 33%.
- The expected variation in unit cost between the longer sessions (Full) and the shorter sessions (Brief & Follow-up) has not occurred. Full sessions can take 2-4 times as long as Brief & Follow-up sessions, yet the average cost is less.

Opportunities for VfM improvement

1. Unit cost of facilitation sessions

Effort should be directed to either increasing sessions delivered or decreasing funding for Facilitation sessions. Facilitation sessions are designed to actively support people experiencing harm to access specialist mental health, alcohol and other drug, or social services.

2. Development of targets

The Ministry should consider developing targets for the unit cost of intervention sessions and use these to manage performance between providers.

4.5 Driver 5 – Cost of a single Helpline call

Measure: Cost of a single Helpline call

VfM: Economy - **Efficiency** - Effectiveness

Measurement

Driver of VfM

The lower the cost per Helpline call, the greater the VfM - all other things being equal. Lifeline Auckland receives a fixed level of funding for delivering a telephone helpline service. Since 1 November 2008 this service has operated 24 hours a day 7 days per week.

Measure

The efficiency of the delivery of the helpline service can be assessed by calculating the cost of a single call.

Assumptions

This driver includes all funding allocated to Lifeline Auckland to deliver Helpline services, both funding for the provision of the general helpline and funding specifically for the delivery of telephone counselling sessions. This driver focuses only on funding for Lifeline Auckland and excludes the small amount of funding ($186k in 2010 / 11) allocated to the Problem Gambling Foundation to provide a helpline for people from Asian speaking backgrounds. This driver also excludes Intervention sessions the helpline is contracted to deliver. These do not materially influence this driver (for 2009 / 10, average of 4 sessions per week).

Data source & confidence

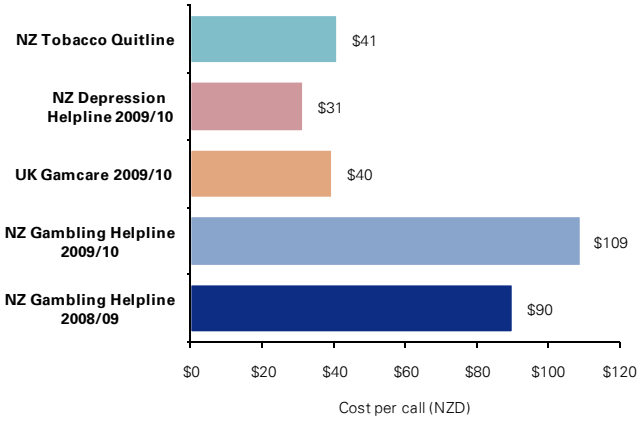
The data to calculate the total spend on Helpline services was obtained from Ministry spreadsheets which outline funding from provider contracts. Actual information on calls delivered was obtained from the Helpline.

Analysis & Commentary

New Zealand has a toll-free helpline service, which provides telephone counselling, information for callers and also referrals to other health providers. The New Zealand helpline experiences *'very high call numbers relative to the country's population'* (AUT Gambling and Addictions Research Centre, 2010a).

The cost of a single helpline call has increased from $90 in 2008 / 09 to $109 in 2009 / 10. Over this period, funding for the Gambling Helpline has remained relatively constant on average at $1.473m per annum. The reason for this negative trend in cost per call is a reduction in the number of interactions (incoming and outgoing calls) that the Helpline make and receive. Lifeline Auckland advised that the increase in average cost for 2009 / 10 relates to the Helpline's involvement in the Randomised Clinical Trial Effectiveness Study. In this trial participants are referred to one of four problem gambling treatment pathways and do not receive the standard level of follow-up support from the helpline. For this reason, comparisons below are against the 2008 / 09 year.

Graph 10: Average cost per helpline call



Source: Ministry of Health, The Quit Group & GamCare

Analysis & Commentary continued on the following page

Key VfM messages

- The New Zealand Gambling Helpline average cost per call is more than double that of all comparators (125% higher than the UK Gambling Helpline, 190% higher than the NZ Depression Helpline, 137% higher than the NZ Tobacco Quitline)
- The cost per call for the New Zealand Gambling Helpline increased in 2009 / 10 however this may have been due to a clinical trial. The trend is therefore unclear.

Conclusion

VfM	R
Trend	N
Confidence in data	G

4.5 Driver 5 – Cost of a single helpline call

Measure: Cost of a single helpline call

Analysis & Commentary

As noted under Assumptions, we recognise that Helpline undertakes a number of other activities, such as performing Full Intervention treatment services and maintaining a number of problem gambling-related websites. In addition, we recognise there are some limitations to comparing New Zealand with the United Kingdom who presumably can take advantage of larger economies of scale. However, we do not consider these limitations to materially impact on the above analysis.

Comparators

The actual call information for the Gambling Helpline and Depression helpline include interactions (i.e. both inbound and outbound calls) whereas the UK GamCare helpline reports on inbound calls only. This difference is likely to overstate the cost per call for the UK GamCare helpline. The UK Gamcare provides counselling sessions over the internet and face-to-face. Our understanding is that this service does not provide telephone counselling.

International: Not favourable

The average cost of a single helpline call received in New Zealand is 125% higher at $90 than the UK GamCare gambling helpline at $40. This service operates for fewer hours than the Gambling Helpline and receives less funding.

Analogue: Not favourable

The average cost of a single helpline call received in New Zealand is 190% higher at $90 than the New Zealand Depression Helpline at $31. This service operates for fewer hours than the Gambling Helpline and receives less funding.

The average cost of a single helpline call received in New Zealand is 137% higher at $90 than the New Zealand Tobacco Quitline at $41.

Opportunities for VfM improvement

1. Benchmarking Helpline funding

The average cost per call to the Gambling Helpline is two to three times higher than the available comparators. We recommend the Ministry undertake a benchmarking exercise to understand reasons for this variation.

We understand that the comparator organisations are not directly comparable with that of the NZ Gambling Helpline in that they are not 24 / 7 services. This is somewhat mitigated as we were advised that the Ministry negotiated the change to 24 / 7 services for the helpline without additional funding.

4.5 Driver 6 – Cost of helpline availability

Measure: Cost of a single hour of helpline availability

VfM: Economy - **Efficiency** - Effectiveness

Measurement

Driver of VfM

The lower the cost for each hour the helpline is available, the greater the VfM - all other things being equal. The gambling helpline receives a fixed level of funding for delivering a telephone helpline service. Since 1 November 2008 this service has been operated 24 hours a day 7 days per week (24 / 7) by Lifeline Auckland.

Measure

The efficiency of the delivery of the helpline service can be assessed by calculating the cost of a single hour of availability.

Assumptions

This driver averages the cost of helpline availability over the year and ignores demand-based factors. For example, the cost of helpline availability is likely to be higher during peak-times as more counsellors are employed to answer the higher demand. This driver focuses only on funding for Lifeline Auckland and excludes the small amount of funding ($186k in 2010 / 11) allocated to the Problem Gambling Foundation to provide an Asian helpline.

Data source & confidence

The data to calculate the total spend on helpline services was obtained from Ministry spreadsheets that outline funding from provider contracts. Actual information on hours of availability was obtained from the helpline

Analysis & Commentary

The cost per hour of availability for the gambling helpline fell from $193 in 2008 / 09 to $169 in 2010 / 11. This is less than the cost per hour of availability of the UK gambling$_{hel}$ pline (GamCare) but higher than the New Zealand depression helpline at $114 per hour of availability. The higher cost per hour of availability in 2008 / 09 reflects the shorter hours of operation prior to 1 November 2008 (14 hours per day). The Ministry negotiated the increase in operating hours with Lifeline without additional funding. We were unable to obtain data on the pattern of calls to the helpline to assess whether certain times throughout the day experienced higher cost of availability than others.

The graph on the following page provides a comparison between the average cost of availability for the New Zealand gambling helpline and the two comparators listed below.

Comparators

International: Favourable

The UK GamCare helpline operates 18 hours per day but receives a similar level of funding to the New Zealand gambling helpline. Accordingly the cost per hour of availability is higher than the New Zealand gambling helpline.

Although the UK helpline has reported a higher cost per hour, their cost per call is significantly less than the New Zealand helpline (Refer Driver 6). This is likely to be reflective of the much higher population in the UK, but does also suggest that callers will wait until the service is open. During this review we were advised by the Ministry that they view the gambling helpline as a *'safety net'* given *the 'higher potential for suicidality in some problem gamblers'.* This view is supported by the Australian Productivity Commission who reported that *'thoughts of suicide and attempted suicides are considerably higher among the population of problem gamblers than for the population as a whole*' (Australian Government - Productivity Commission, 1999, pg.J33).

Analogue: Unfavourable

The cost per hour of availability of the depression helpline for the 2009 / 10 year is less than for the gambling helpline. The depression helpline operates reduced hours (16 hours per day). Other than the reduced hours, the depression helpline provides a good comparator to the gambling helpline in that the helpline provides telephone counselling, information for callers and also referrals to other health providers.

Key VfM messages

- The cost per hour of Gambling Helpline availability falls between the two comparators.
- The cost per hour of availability has fallen since 2008 when the Ministry negotiated the shift to 24 hour availability (previously 14 hours per day) without additional funding.

Conclusion

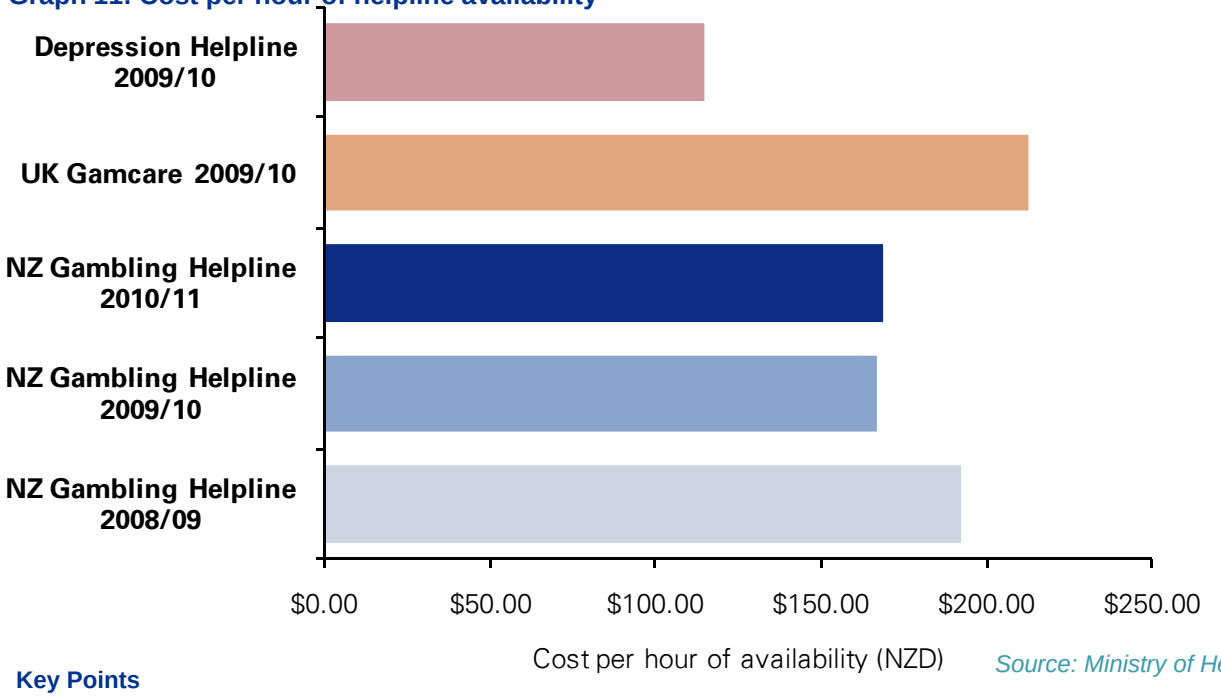
VfM	G
Trend	G
Confidence in data	G

4.5 Driver 6 – Cost of helpline availability

Measure: Cost of a single hour of helpline availability

Analysis & Commentary

Graph 11: Cost per hour of helpline availability



Source: Ministry of Health & GamCare

Key Points

- The cost per hour of Gambling Helpline availability is between the two comparators. This, when taking into account the 24 / 7 availability suggests good VfM.
- The cost per hour of availability has fallen since 2008 when the Ministry negotiated the shift to 24 hour availability (previously 14 hours per day) without additional funding. This further strengthens the case that good VfM is being provided now.

4.5 Driver 7 – Timeliness of treatment service

Measure: Length of time taken to receive service

We were advised by service providers that service users are able to access services promptly without need for a waiting list. Based on this advice we did not review this driver further.

4.5 Driver 8 –Extent that providers achieve intervention contract targets

Measure: Volume of Services delivered against contract targets

Measurement

Driver of VfM

The more providers deliver their intervention contract targets the greater the VfM, all other things being equal. This assumes that the targets are appropriate. Each provider has targets established in their contracts with the Ministry that set out the number of counselling sessions (interventions) that they are expected to deliver each month. Contracted targets are set based on the Full-time equivalent (FTE) clinicians the Ministry has agreed to purchase from each provider. The larger the contract value, the higher the targets. Targets have remained the same per FTE since 2008.

Measure

The effectiveness of the delivery of intervention services can be assessed by analysing each provider's achievement against contractual targets.

Assumptions

Targets are set for each type of intervention i.e. Brief, Full, Facilitation and Follow-up. This driver examines total achievement for each provider against the aggregated total of their targets. This driver assumes that the targets allocated within contracts are appropriate.

Data source & confidence

Target data for this driver comes from each provider's contract with the Ministry. Actual performance was obtained from the CLIC system used by service providers for entering data for each session delivered. Confidence in the data is high.

Analysis & Commentary

Comparators

Across providers significant variation

19% of service providers achieved all of their contracted targets in 2007 / 08 and 25% in 2008 / 09 (this was calculated by assessing the proportion of service providers exceeding all of their targets each year). The trend has improved noticeably in the 2009 / 10 year for which the most recent data is available, where 57% of providers met all of their targets and 86% of providers exceeded 75% of their targets. Many providers met their targets for the delivery of 'Full interventions' but did not achieve other targets.

Mitigating factors for this achievement include geographic isolation of the provider, geographic spread of clients and challenges obtaining clients within certain cultures. Several service providers raised concerns with the service delivery model that they are required to follow. Particularly difficulties in meeting targets for following up on clients that have withdrawn from or completed a treatment programme. Service providers advised us that the problem gambling population is known to be transient and thus often difficult to follow-up.

The Ministry exited contracts with providers where there had been sustained evidence of low performance against targets.

The provider with the highest level of achievement, Odyssey House, operates a *'therapeutic community model'.* This model is significantly different from that of other service providers in that Odyssey House operates residential 'live-in' treatment programmes. This different service delivery model means that Odyssey House is not directly comparable to other providers, accordingly we have deemed their performance to be 100% for each year.

Woodlands Trust also have a different approach to service delivery in that they provide workshop style group therapies. The Ministry is satisfied that Woodlands Trust has achieved their contractual targets for each of 2007/08, 2008/09 & 2009/10', The group therapy model of service delivery used by Woodlands Trust has meant that the CLIC database has historically not captured the entirety of their service delivery, accordingly we have deemed their performance to be 100% for each year.

The next highest achieving provider, Hauora Waikato Maori Mental Health Services proactively liaised with the Ministry to reduce their contracted FTE (and thus their targets) in the 2009 / 10 year to reflect better their actual demand. This has significantly improved their achievement of target to 166% for the 2009 / 10 year.

Analysis & Commentary continued on the following page

Key VfM messages

- For this driver we have assumed that the targets are appropriate
- 19% of service providers achieved their contracted targets in 2007 / 08, 25% in 2008 / 09 and 57% in 2009 / 10.
- 86% of providers achieved 75% of their targets in 2009 / 10
- There has been a rapid and substantial improvement over the past three years.

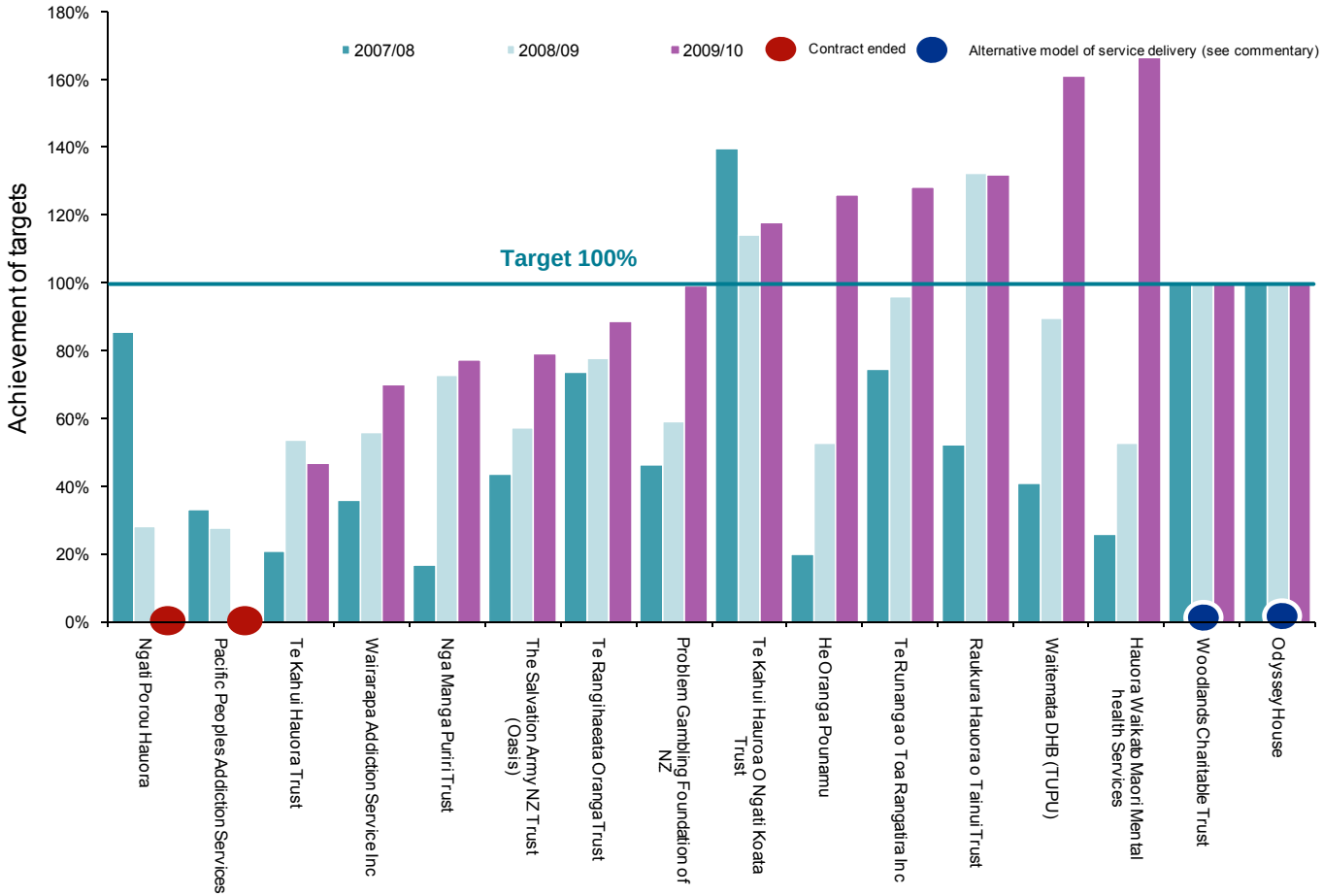
Conclusion

	2007 - 2010	2009 / 10
VfM	R	A
Trend	G	G
Confidence in data	G	G

4.5 Driver 8 –Extent that providers achieve intervention contract targets

Measure: Volume of Services delivered against contract targets

Graph 12: Volume of Services delivered against contract targets 2007 - 2010



Service providers (Ranked according to achievement– Lowest to highest achievement against session delivery targets for 2009 / 10)

Source: Ministry of Health

Analysis & Commentary

Lifeline Auckland (the entity that deliver the Gambling Helpline service) also have a contract to deliver intervention services over the telephone. We have not included Lifeline Auckland for the purposes of this driver as the Ministry intended telephone counselling services delivered by Lifeline Auckland to be a 'back-stop' for circumstances where the client does not have access to or does not wish to be referred to a face-to-face service provider. As Lifeline Auckland are encouraged to refer clients to face-to-face services, this may be contrary to the Ministry's mandate outlined above if they were to strive to meet a service volume level. The Ministry does not specify intervention service targets for Lifeline Auckland in its current contract.

Graph 12 lists the intervention service providers from left to right in ascending order of achievement for 2009 - 10. Each of the different coloured columns illustrates a separate funding year.

Key Points

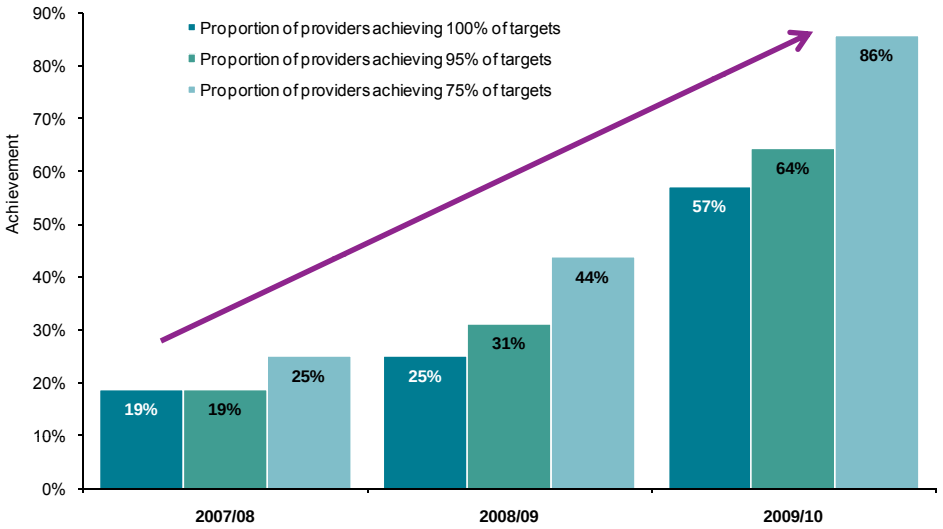
- Two service providers had their contracts with the Ministry exited;
- There is significant variation between service provider performance
- There do not appear to be common factors between providers achieving their targets and those not achieving. Provider size, geographical and cultural factors do not appear to influence achievement.

VfM: Economy - **Efficiency** - Effectiveness

4.5 Driver 8 – Extent that providers achieve intervention contract targets

Measure: Volume of Services delivered against contract targets

Graph 13: Proportion of service providers achieving contracted targets 2007 / 08 to 2009 / 10



Source: Ministry of Health

Analysis & Commentary

Comparators

International & Analogue: Not feasible: It has not been possible to compare achievement to international jurisdictions or to analogue services. The best comparison is to assess this driver across all providers (Graph 12) engaged for intervention services and also for each of the last three years (Graph 12 & 23).

It is unclear whether targets are seen as aspirational or absolute. Without this understanding we cannot conclusively determine whether achievement is low or whether the targets are inappropriate.

The measurement of achievement against targets considers only the quantity of services delivered (outputs) and does not measure the outcomes or efficacy of treatment.

Graph 13 above charts the improvement in provider achievement of contract over the period 2007 to 2010.

Key Points

- The proportion of providers reaching 100% of their targets has increased from 19% in 2007 / 08 to 57% in 2009 / 10
- 86% of providers achieved 75% of their targets in 2009 / 10
- Many (43%) of providers, are still not achieving 100% of their targets in 2009 / 10.

Opportunities for VfM improvement

1. Partial 'at-risk' funding

Contracts and funding could be modified to create an 'at-risk' component of funding based on achievement of service delivery targets. This mechanism should enhance the effectiveness of service delivery. An at-risk funding model is discussed in Section 5 of this report.

VfM: Economy - Efficiency - Effectiveness

4.5 Driver 9 – Alignment of intervention services to target populations

Measure: Appropriateness of assumptions for allocating FTE

Measurement

Driver of VfM

The better services are aligned to population geography & demography, the greater the benefit from expenditure and the greater the progress towards government objectives - all other things being equal.

In 2009 the Ministry prepared a service plan that outlined the services required to advance the Government's 11 strategic objectives for problem gambling for 2010 – 2016. Included within the service plan is detail of the funding the Ministry requires to deliver problem gambling services. This level of required funding is calculated by determining the level of intervention services, (calculated in FTE terms), the Ministry wishes to purchase. The Ministry purchasing is allocated both geographically i.e. number of FTE in each region and also demographically i.e. number of FTE to deliver each of General, Maori, Pacific or Asian services.

Measure

The appropriateness of the allocation of intervention FTE by geography & demographics. i.e. are services purchased in the right areas and ethnic groups in which people with gambling problems are most likely to be found? The degree of alignment to actual demand is tracked in Driver 11 & 25 'Extent that providers deliver against contract targets'.

Assumptions

None

Measurement

Data source & confidence

This driver reviews the appropriateness of the Ministry's allocation of intervention FTE. This focussed on spreadsheets used to allocate FTE. These spreadsheets supported the 2010 - 2013 Problem gambling service plan.

Analysis & Commentary

The analysis completed by the Ministry in allocating intervention FTE geographically and demographically considered the following factors:

Factors considered to allocate intervention FTE geographically and demographically

1. The number of problem gamblers or people with moderate-risk gambling within each Territorial Local Authority (TLA). This was calculated by multiplying the population of each ethnicity from the 2006 census in each TLA by the prevalence rate of problem or moderate-risk gambling as set out in the '2006 / 07 New Zealand Health Survey'.
2. The number of predicted new clients for each ethnicity within each TLA. This was calculated based on internal Ministry estimates of the forecast presentation rate for each ethnicity multiplied by the number of problem gamblers or people with moderate-risk gambling within each ethnicity.
3. The amount of time as a proportion of an FTE each client will consume. This was calculated by dividing the number of clients attending sessions by the clinical hours delivered for 2008. 1 FTE was treated as 15 clinical hours per week for 48 weeks each year.

The result of the three factors above was an FTE total required for each TLA allocated to either General, Maori, Pacific or Asian services. The total of FTE for TLAs within each region was calculated and any FTE values below 0.5 in a region were ignored. The Ministry sought to purchase FTE within all regions with an FTE quantum greater than 0.5.

Comparators

International and Analogue: Not feasible

The model of allocating and purchasing FTE by region is not comparable to analogue or international jurisdictions.

Key VfM messages

- The Ministry's model for forecasting demand for services and allocating intervention FTE accordingly appears coherent, logical and well thought out.

Conclusion

VfM	G
Trend	N
Confidence in data	G

4.5 Driver 10 – Degree that services meet individual needs

Measure: Results of analysis of treatment effectiveness

We were unable to obtain data to conclude on this driver. Discussion on the degree that services meet individual needs is provided in Section 4: strengths.

4.5 Driver 11 – Quality of Helpline calls

Measure: Length of time taken to receive service

The Helpline advised that they operate a programme of reviewing customer satisfaction with services, however response rates were immaterially low and they generally only received responses from those that viewed the service positively.

4.5 Driver 12 – Rate of drop out and re-presentations

Measure: Proportion of client drop-outs or re-presentations

The Ministry extracted data from the CLIC database on drop-outs and re-presentations for problem gambling services. Upon further review we were unable to conclude from this data as it was not possible to identify the impact of this on VfM.

4.5 Driver 13 – Cost of purchasing Public Health services

Measure: Cost per FTE for Public Health services

VfM: **Economy** - Efficiency - Effectiveness

Measurement

Driver of VfM

The lower the cost to the Ministry, the higher the VfM of Public Health services - all other things being equal.

Each service provider contracts with the Ministry to provide a variable level of Full-Time Equivalent (FTE) personnel to deliver specified services (referred to as Purchase Units). The cost per FTE for Public Health services helps indicate whether the price the Ministry pay per FTE is within an acceptable range. All funding received by service providers is calculated based on this FTE model. No additional funding is provided for administrative support or overheads. As such the FTE payment paid by the Ministry differs from actual salary payments made to employees.

Measure

The economy i.e. Cost to the Ministry for each Public Health FTE purchased can be assessed by comparing this with other similar payments.

Assumptions

None.

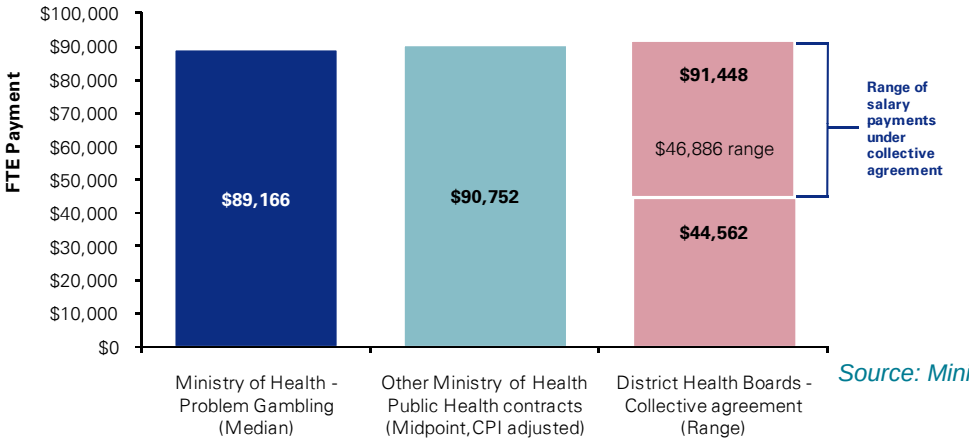
Data source & confidence

The price paid per FTE is set out in each provider's contracts. Confidence in the data is high.

Analysis & Commentary

In 2009 / 10 the price paid by the Ministry for 1 FTE for Public Health services ranged from $87,151 to $98,345 with a median payment of $89,166. The Ministry is currently looking to reduce the variation between providers for the FTE rate.

Graph 14 Cost per FTE for Public Health services



Source: Ministry of Health & Public Services Association

The graph above compares the FTE payments made by the Ministry for problem gambling services (Blue column) with those made in other Ministry contracts (Turquoise column) and also the collective agreement that sets out salaries paid by District Health Boards (DHBs) (Pink column).

Key Points

- The problem gambling FTE payments for intervention services are approximately equal to other Ministry funded Community Alcohol & Drug addiction treatment programmes delivered through DHBs.

Analysis & Commentary continued on the following page

Key VfM messages

- The FTE payments made by the Ministry appear reasonable and falls between comparative payments made both within other Ministry contracts and for salaries within the sector.
- FTE Payments have decreased in real terms which suggests an increase in VfM.

Conclusion

VfM	G
Trend	G
Confidence in data	G

4.5 Driver 13 – Cost of purchasing Public Health services

Measure: Cost per FTE for Public Health services

VfM: **Economy** - Efficiency - Effectiveness

Analysis & Commentary

Comparators

International: Not feasible

The New Zealand FTE contracting model is unique and is not comparable internationally. Cost of living and associated variances reduce the feasibility of comparing with international salary levels.

Analogue : Favourable comparison

The problem gambling FTE payment compare favourably with Alcohol & Other Drugs and falls between the range of salary payments made by DHBs.

The Ministry has other contracts with NGOs for Public Health service delivery outside of problem gambling which also use FTE capacity as a purchase model. Ministry documentation indicates that 'a fully funded FTE is priced in the range of $85k to $90k for the 2008 / 09 year'.

The District Health Boards / PSA, Allied, Public Health & Technical Multi Employer Collective Agreement for the period up to 31 October 2010 has a range from $44,562 for a graduate health promoter to $91,448 for the most advanced practitioner. The FTE payments made by the Ministry fall within this range and allowing for administrative costs and overheads, this FTE payment appears appropriate.

Historical & across providers: Costs have declined in real terms

Payments have increased by 2.6% between July 2007 and July 2010. This compares with inflation of 8.4% over the same period. In the Ministry's service plan budgets FTE payments are set to increase by 2% for each of the 2011 / 12 and 2012 / 13 years. This appears appropriate. Payments for Public Health FTE varied slightly between providers in 2009 / 10 due to historical regional differences.

Opportunities for VfM improvement

1. Competency based funding

Analysis of the comparators for this driver identified significant variation in the salary payments made to practitioners based on their competencies, experience and qualifications. The varied competencies, experience and qualifications of the problem gambling workforce suggest that varying the payments made for an FTE may be a more cost-efficient means of purchasing FTE.

The price attributed to purchase units could be varied according to the qualifications and expertise held by the FTE purchased. For example as part of the contracting process, the Ministry could agree to purchase an FTE with three years experience or a relevant bachelors-level degree for a set price.

The Ministry has adopted a similar competency / seniority based funding model for the Public Health personnel in the Alcohol and other drugs sector.

2. More detailed financial reporting to re-assess FTE payments

If further detail was provided in financial reporting from service providers it would be possible to understand better the overhead / administrative costs incurred by providers and set the FTE payments at the standard salary level in the market plus an allowance for these costs. We have attempted to assess these costs in VfM driver 18 on the following pages.

The opportunities for improvement related to Driver 13 are the same as those identified for Driver 1 – Cost of purchasing intervention services.

3. Consider alternative funding models

We suggest the Ministry$_{ex}$ plore alternative funding models such as the output / outcome funding model discussed in section 6.

4.5 Driver 14 - Unit cost of a Public Health project

Measure: Cost of a single Public Health session

Information was not available to quantify the size or quantity of Public Health projects, accordingly we could not develop a unit cost for this driver.

VfM: Economy - Efficiency - Effectiveness

4.5 Driver 15 – Alignment of Public Health services to target populations

Measure: Appropriateness of assumptions for allocating FTE

Measurement

Driver of VfM

The better services are aligned to population geography & demography the greater the benefit from expenditure and the greater the progress towards government objectives - all other things being equal.

In 2009 the Ministry prepared a 'service plan' that outlined the services required to advance the Government's 11 strategic objectives for problem gambling for 2010 – 2016. Included within the service plan is detail of the funding the Ministry requires to deliver problem gambling services. This level of required funding is calculated by determining the level of Public Health services (calculated in FTE terms) the Ministry wishes to purchase. The Ministry purchasing is allocated both geographically i.e. number of FTE in each region and also demographically i.e. number of General, Maori, Pacific or Asian services.

Measure

The appropriateness of the allocation of Public Health FTE by geography & demographics. i.e. are services purchased in the right areas and ethnic groups in which people with gambling problems are most likely to be found?

Assumptions

None

Measurement

Data source & confidence

This driver reviews the appropriateness of the Ministry's allocation of Public Health FTE. The analysis focussed on spreadsheets used to allocate FTE. These spreadsheets supported the 2010 - 2013 Problem gambling service plan.

Analysis & Commentary

The analysis completed by the Ministry in allocating Public Health FTE geographically and demographically considered the following factors:

Factors considered to allocate Public Health services FTE geographically and demographically

1. The population within each region. This was calculated by allocating 1 FTE (or portion thereof) for every 750,000 people within each TLA.
2. The availability of Non-Casino Gaming Machines (NCGMs). This was calculated by allocating 1 FTE (or portion thereof) for every 1,150 NCGMs within each TLA.
3. The availability of Electronic Gaming Machines (EGMs) licensed in casinos. This was calculated by allocating 1 FTE (or portion thereof) for every 1,150 EGM licensed in Casinos within each TLA.
4. The availability of New Zealand Racing Board totalisator agency board (TAB) outlets. This was calculated by allocating 1 FTE (or portion thereof) for every 200 TAB outlets within each TLA.
5. The availability of New Zealand Lotteries Commission (Lotto) outlets. This was calculated by allocating 1 FTE (or portion thereof) for every 400 Lotto outlets within each TLA.
6. Average expenditure per EGM in the TLA compared to the national average. This was calculated by assessing the expenditure per EGM in the TLA as a proportion of average EGM expenditure nationally.

Three additional factors considered to allocate Public Health services FTE geographically and demographically are discussed on the following page.

Analysis & Commentary continued on the following page

Key VfM messages

- The Ministry's model for forecasting demand for services and allocating FTE accordingly appears coherent, and logical however we were unable to draw conclusions on whether the weightings that underlie the model are appropriate.

Conclusion

VfM	U
Trend	N
Confidence in data	G

VfM: Economy - Efficiency - Effectiveness

4.5 Driver 15 – Alignment of Public Health services to target populations

Measure: Appropriateness of assumptions for allocating FTE

Analysis & Commentary

Factors considered to allocate Public Health services FTE geographically and demographically (continued)

7. The level of social deprivation within each$_{reg}$ ion compared to the national average. This was calculated by assessing the proportion of census units within each TLA with social deprivation scores between 7 and 10.
8. A weighting allocated to Maori, Pacific or Asian ethnicities of 2 (i.e. double).
9. The proportion of the population within each TLA of Maori, Pacific, Asian or General (Other) ethnicity.

The weightings behind factors 1 to 8 above were used by the Ministry to develop a risk-based approach to allocating FTE to the delivery of Public Health services. The specific weightings were derived from discussions within the National Problem Gambling Team.

We were unable to conclude on the appropriateness of the Ministry's model for aligning Public Health services to target populations. We understand the rationale behind the Ministry's eight factors that affect gambling harm, we are not able to conclude on whether the specific weightings are appropriate. As discussed in development area 3 in section 4.2, small changes to the weightings that underlie this model have a significant impact on the level of spend.

Comparators

International and Analogue: Not feasible

The model of allocating and purchasing FTE by region is not comparable to analogue or international jurisdictions.

Opportunities for VfM improvement

1. Alternative model

KPMG is not able to suggest a more appropriate model for allocating Public Health services. We acknowledge that an inherent limitation in Public Health services is the ability to forecast demand. We are aware that this model conforms to models for forecasting Public Health services in Australia.

4.5 Driver 16 – Extent that providers deliver Public Health contract

Measure: Volume of services delivered against contract targets

Measurement

Driver of VfM

The more providers deliver their contracts the greater the VfM - all other things being equal. This driver assumes targets are appropriate. Each provider has targets established in their contracts with the Ministry that set out the number of Public Health projects they need to deliver or organisations they need to work with. Contracted targets are set based on the Full-time equivalent (FTE) practitioners the Ministry has agreed to purchase from each provider. The larger the contract value, the higher the targets.

Measure

The effectiveness of the delivery of Public Health services can be assessed by analysing each provider's achievement of contractual targets.

Assumptions

Targets are set for each Public Health purchase unit the provider is contracted for. This driver assumes that the targets allocated within contracts are appropriate.

Data source & confidence

Target data for this driver is sourced from each provider's contract with the Ministry. Actual service delivery achievement was obtained by reviewing qualitative reports prepared by providers for the Ministry. Due to the limitations described in the panel to the right, our confidence in the data for this driver is low.

Analysis & Commentary

There are four key limitations that limit our ability to adequately conclude on this driver. For this reason we are unable to draw conclusions and have rated this driver grey for VfM and Trend in the bottom right of this page. The four key limitations are described below:

Limitations

1. The provider reports (in isolation) do not provide an independent assessment of work conducted. The Ministry has other contract management processes in place to verify provider activity. The reports are prepared by service providers and the level of involvement or quality of their involvement can not be objectively substantiated from this reporting
2. The amount of evidence and background information provided within the reports is not consistent. Some providers have given examples of activities only, while others provide a complete record of all activities. This restricts our ability to compare the driver across providers
3. The style and specificity of reporting differs. Some providers discuss meetings with 'several' or 'many' organisations, while others provide actual numbers of organisations they have worked with. Some providers discuss the number of organisations worked with, while others discuss the number of activities conducted without specifying the number of organisations with whom the activity was conducted
4. Each of the providers' targets specifies the number of large / medium projects or organisations they need to work on / with. Large / medium are defined in the contracts but it is difficult to apply these definitions to organisations/projects listed in provider reports and to apply that definition consistently

On the following page we set out two initiatives the Ministry has in progress and the impact these will have on the measurement of Public Health achievement.

Analysis & Commentary continued on the following page

Key VfM messages

- Four key limitations reduce our confidence in the data related to this driver. The low confidence in this data means we that we are unable to conclude on the VfM of this driver.

Conclusion

VfM	U
Trend	N
Confidence in data	R

4.5 Driver 16 – Extent that providers deliver Public Health contract

Measure: Volume of services delivered against contract targets

Analysis & Commentary

Initiatives currently undertaken by the Ministry to improve the measurement of Public Health achievement

While we have not been able to draw robust conclusions in relation to the efficiency and effectiveness of Public Health services, discussions with the Ministry of Health demonstrate that a more focussed approach in measuring outcomes for Public Health activities has been introduced with effect from the 2010-2011 year.

1) Effective from 1 July 2010 the Ministry has enhanced the six monthly reporting template to include a programme logic model. The reporting template now includes a section which requires service providers to profile a Public Health project that they have completed or commenced in the previous period. Service providers are asked to describe their involvement in detail, explain linkages to the Ministry strategy, and report whether outcomes were achieved.

2) In addition, indicators to measure Public Health effectiveness are to be introduced into the Ministry's Problem Gambling Outcome Monitoring Framework. It is anticipated that the results from these steps should positively impact future trends and the comprehensiveness of reporting.

Comparators

International & Analogue: Not feasible

The information available within New Zealand was inadequate for comparison.

4.5 Driver 17 – Impact of awareness campaigns

Measure: Results of Synovate evaluation

VfM: Economy - Efficiency - **Effectiveness**

Measurement

Driver of VfM

The greater the impact of the awareness campaign, the greater the VfM - all other things being equal.

The Ministry funds the Health Sponsorship Council (HSC) to deliver an awareness campaign aimed at *'reducing mental, social and financial harms by reducing the incidence and impact of problem gambling'* (Health Sponsorship Council, 2010). HSC appointed Market Research agency 'Synovate" to *'determine the awareness of, and response to, the second stage of the Kiwi Lives mass media campaign among the public'* (Synovate, 2009).

Measure

The effectiveness of the awareness campaign can be assessed by reviewing the results of the Synovate evaluation.

Assumptions

None

Data source & confidence

This data for this driver is based on the Evaluation of Stage 2 of the Kiwi Lives programme by Synovate. The evaluation was based on the results of a survey with a population of 1595. Our confidence in the data is high.

Analysis & Commentary

The evaluation report completed by Synovate concluded that *'the campaign has achieved excellent levels of recall and communication of the desired messages'.*

Key points from the evaluation include:

- Recall among Maori and Pacific peoples has been particularly positive,
- 86% agreed that they now had a greater understanding about the impact of problem gambling in the community,
- 78% have seen at least one of the advertisements, and 15% have seen all three advertisements,
- 36% of those who have seen the advertisements spontaneously recall the message that help is available,
- 16% said they 'did something' as a result of seeing the advertisements, and
- Overall the television campaign is not reaching Asian populations as well as other ethnic groups.

The evaluation of the campaign indicates high-levels of recall amongst both the general population and also Maori and Pacific ethnic groups (those most at risk of gambling harm). Importantly, the evaluation highlighted good levels of understanding of the key messages. A small proportion of those surveyed identified as having high participation in Electronic Gambling Machines and accordingly are more likely to be affected by gambling harm. Of this group *'86% agreed that they now had a greater understanding about the impact of problem gambling in the community'.* This suggests that the messages of the awareness campaign are reaching the target audience.

Key VfM messages

- The problem gambling awareness campaign achieved a high-level of recall particularly amongst Maori and Pacific peoples (those at highest risk from gambling harm)
- The awareness campaign compares positively with available comparators

Conclusion

VfM	G
Trend	N
Confidence in data	G

4.5 Driver 17 – Impact of awareness campaigns

Measure: Results of Synovate evaluation

Analysis & Commentary

Comparators

Analogue: Favourable

In the Smoking Not Our Future campaign – 24% of those surveyed had seen TV advertisements and one-third of respondents (35%) who recalled seeing the advertisements reported they had taken action or thought about their smoking behaviour as a result of the campaign.

International: Favourable

In the New Zealand awareness campaign *'86% agreed that they now had a greater understanding about the impact of problem gambling in the community'.* This compares favourably with the 55% response in public awareness reported from the South Australian media campaign (Ministerial Council on Gambling, 2008) and equals the 86% awareness reported in Phase 4 of the Victoria awareness campaign (Ministerial Council on Gambling, 2008). Jackson, Thomason and Ho (2002) as cited in AUT Gambling and Addictions Research Centre, (2010b) found that following a mass-media campaign in Victoria Australia, calls to the regional gambling helpline increased significantly.

4.5 Driver 18 – Proportion of provider overheads

Measure: Proportion of funding allocated to overheads (Percentage)

VfM: **Economy** - Efficiency - Effectiveness

Measurement

Driver of VfM

The lower the proportion of funding allocated to overheads as opposed to front-line salaries, the greater the VfM - all other things being equal. The aim is to maximise the proportion of funding allocated to front-line delivery and reduce overheads down to an appropriately low-level. Very low overheads may suggest that resources are allocated inefficiently and that clinical personnel are undertaking administrative tasks.

The Ministry purchases FTE from service providers to deliver intervention and Public Health services. The Ministry purchases these FTE for a fixed annual payment. Analysis of the economy of actual FTE payments is presented in drivers 1 and 20 (FTE Payments for Intervention & Public Health services) of this report. No additional funding is provided for administrative support or overheads, thus the FTE payment paid by the Ministry includes these costs and differs from actual salary payments made to employees.

Measure

This measure assesses the proportion of Ministry funding allocated to *front-line salaries*.

There is no single clear definition of what equates to an overhead. We have defined overheads in the top right of this page.

Measurement

Measure (cont)

Only costs directly related to the salaries of Intervention and Public Health practitioners have been included in the definition of front-line salaries. This definition excludes other factors such as administrative, contract management or managerial support costs, overheads or profit. These costs are represented by the balance of the measure i.e. non front-line costs. For this measure we refer to these costs as *overhead*.

Assumptions

Certain providers subcontract their service delivery to another organisation. In these instances it was not possible to identify which costs related to front-line salaries. We have therefore excluded all providers with a significant sub-contracted relationship from this measure.

Data source & confidence

We attempted to obtain the information for this driver from six monthly reporting submitted to the Ministry by each provider. The six monthly reports include a standardised financial reporting template that requires providers to detail all direct salary costs. For the reasons outlined below our confidence in the data is low.

Analysis & Commentary

Information for this driver was inadequate for us to conclude on VfM. Financial information within six monthly service provider reports contained varying levels of detail and this information was not comparable across service providers. For service providers who subcontract all or part of their service delivery we were unable to ascertain how funding was allocated as these providers did not provide financial reporting for the subcontractor.

Our initial analysis of the information available suggests significant variation in the proportion of funding allocated to salaries by providers. In light of the limitations above we were unable to conclude on this driver.

Key VfM messages

- We were unable to obtain sufficient information to conclude on this driver.

Conclusion

VfM	U
Trend	N
Confidence in data	R

4.5 Driver 18 – Proportion of provider overheads

Measure: Proportion of funding allocated to overheads (Percentage)

VfM: **Economy** - Efficiency - Effectiveness

Opportunities for VfM improvement

1. Increase confidence in data

If further detail was provided in financial reporting from service providers it would be possible to understand better the overhead / administrative costs incurred by providers and set the FTE payments at the standard salary level in the market plus an allowance for these costs.

2. Learnings from low overhead providers

Further analysis could be undertaken of the differences between providers with a high proportion of overheads and those with low levels of overheads. We suggest this focus on providers who have the highest proportion of overheads.

VfM: **Economy** - Efficiency - Effectiveness

4.5 Driver 19 - Shortfall in FTE purchased by Ministry vs. actual FTE provided

Measure: Level of vacancies carried by service providers

Measurement

Driver of VfM

The greater the shortfall in FTE between what is purchased by the Ministry compared with what is actually provided the lower the VfM - all other things being equal.

The Ministry purchases FTE from service providers to deliver intervention and Public Health services. The Ministry purchases these FTE for a fixed annual payment on the basis that each service provider will employ a full-time practitioner for each FTE contracted to deliver services. As such, if providers report vacancies in their contracts, to maximise VfM, a portion of the vacant position should be recovered by the Ministry.

Measure

This measure assesses the level of vacancies reported by service providers for the 2009 / 10 year.

Assumptions

The data used to assess this driver was obtained from qualitative reports prepared by providers for the Ministry every six months.

Data source & confidence

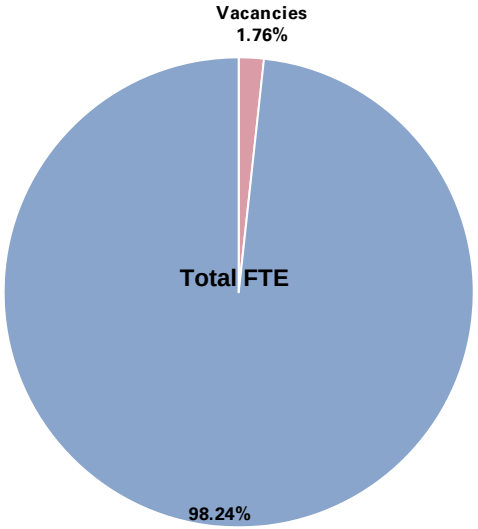
The information for this driver was obtained from six monthly reporting submitted to the Ministry by each provider. The six monthly reports include a standardised FTE reporting template that requires providers to detail all FTE employed. These reports do not provide an objective assessment of activity and accordingly our confidence in the data is moderate.

Analysis & Commentary

Three service providers reported vacancies for 2009 / 10. One vacancy was filled within three months and the other two have been long-term vacancies, either not yet resolved, or taking more than six months to reach resolution. Detail supporting each of the three vacancies is presented on the following page.

This analysis identified 2 long-term FTE vacancies in the 2009 / 10 year. As a proportion of the total 113.9 FTE contracted by the Ministry, this equates to a 1.76% shortfall. As a proportion of the total FTE contracted, this is not material and accordingly we have concluded that VfM is good. The shortfall (level of vacancies) is represented on the graph below by the pink wedge.

Graph 15: Vacancies as proportion of total FTE 2009 / 10



Source: Ministry of Health

Key VfM messages

- The shortfall in FTE employed by service providers as a proportion of the total FTE purchased is 1.76%. This represents 2 out of the 113.9 FTE.
- Given the small number of vacancies in 2009 / 10 we conclude that VfM is good.

Conclusion

VfM	G
Trend	N
Confidence in data	A

VfM: **Economy** Efficiency - Effectiveness

4.5 Driver 19 - Shortfall in FTE purchased by Ministry vs. actual FTE provided

Measure: Level of vacancies carried by service providers

Analysis & Commentary

Detail supporting each of the three vacancies is presented below. The two long-term vacancies represent the 1.76% of vacancies as a proportion of total FTE in 2009 / 10 as shown in graph 15 on the previous page. The action taken by the Ministry is represented by the blue italics.

- *Reimbursement:* Provider A had a vacancy for an intervention practitioner for three months. When this was filled, the Ministry recovered the majority of funding from the service provider. The balance (minority) of the funding was left with the provider to facilitate the new counsellor's training needs.
- *Monitor:* Provider B reported issues with sub-contractors whereby, for one six month period, two sub-contractors were terminated and as a result of this, delivery against targets was poor. This provider has undergone significant strategic change and a shortage of alternative providers to supply services necessitated the Ministry monitor the service provider rather than terminate the contract.
- *Monitor:* Provider C has reported a position vacant for nine months. This time represents two periods of vacancy as an appointment was made after five months and subsequently the person was seconded to another organisation following a few months service. The provider has partially back filled the subsequent vacancy. The Ministry has yet to recover any funding, however, we understand this is under action.

The Ministry has a three-yearly audit programme for assessing service provider compliance with contract. One objective of this audit programme is to identify non-compliance with the FTE levels within contracts.

Opportunities for VfM improvement

1. Formalised obligations within contracts

The Ministry could consider stronger enforcement of the contractual obligation for service providers to repay funding in instances where a vacancy remains for more than a reasonable period. We suggest three months is a reasonable period.

4.5 Driver 20 – Optimal split between Public Health and Intervention services funding

Measure: Appropriateness of split between Public Health and Intervention Services

Measurement

Driver of VfM

An optimum balance will exist between preventative and reactive treatment services. While it will be extremely hard to identify this optimum level, high or low extremes suggest lower VfM. The greatest benefit is obtained when the marginal benefit from an extra dollar of spend is equal.

Measure

This measure assesses the appropriate split between Public Health and Intervention services. This relates to the VfM component of Efficiency as Public Health services are primarily focussed on implementing preventative measures to minimise the harm from gambling. One example of these measures is campaigns to raise awareness of gambling harm in order to advise communities to seek help at an early stage. The optimum balance between Public Health and Intervention services (or the balance between preventative and reactive services) is considered the most efficient allocation of problem gambling funding.

Assumptions

For this measure we have classified all areas of problem gambling funding (except Ministry costs and Research) as either public Health or Intervention services. The 20% infrastructure provision has been apportioned to Public Health and Intervention services in accordance with the FTE purchased or these areas respectively.

Measurement

Data source & confidence

This driver is calculated based on historic funding information, as such, our confidence in the data is high.

Analysis & Commentary

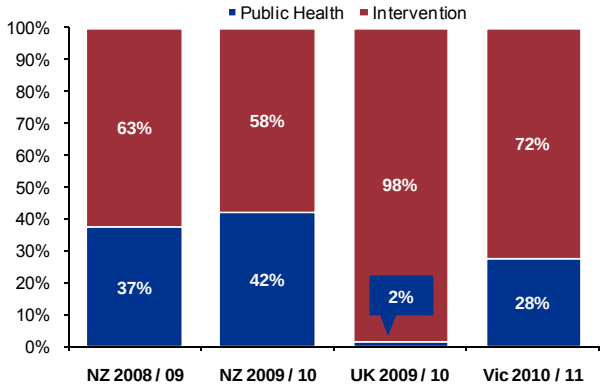
Our analysis indicates that the balance between Public Health and Intervention services in New Zealand ranges between 37:63 and 42:58. As discussed in Section 3.1 this reflects the Public Health approach mandated by the New Zealand Gambling Act 2003.

Comparators

International:

The United Kingdom ratio of Public Health to Intervention spend is 2:98 and in Victoria Australia, the ratio is 28:72.

Graph 16: Balance of problem gambling spend between Public Health and Intervention services



Source: Ministry of Health, RGF, Victoria Department of Justice

Key VfM messages

- The optimum level of spend between the two services is unknown. NZ is not at either extreme of spend (neither weighted heavily to Public Health or Intervention) and based on available information, the split between the two services is not inappropriate.

Conclusion

VfM	U
Trend	N
Confidence in data	G

4.5 Driver 21 - Match of skill set to need

Measure: Appropriateness of practitioner competencies

This purpose of this driver was to review the competencies of problem gambling practitioners against the requirements of the Ministry's purchase units. We were unable to obtain information on the competencies and qualifications of practitioners within the sector. The Ministry has commissioned two projects to develop competencies frameworks for intervention and Public Health services respectively. We note that similar measures of progress to those considered in this driver are intended to be monitored as part of the National outcomes framework for gambling and problem gambling.

4.5 Driver 22 - Alignment of actual demand for services against supply

Measure: Appropriateness of matching service supply to communities at risk

We were unable to compare demand for services against supply on a geographic basis. We investigated using geo-spatial mapping software to graphically assess the supply of problem gambling services against risk factors e.g. gambling venue location and service demand. We were advised that this is not a practical measure on a national basis but more appropriate on a TLA level.

4.5 Introduction to Ministry cost drivers

Introduction to Ministry cost drivers

This section on Ministry costs reviews the VfM of the administrative portion of the problem gambling programme. Ministry costs equate to approximately 5.5% of the problem gambling funding or $957,044 in 2010 / 11. Of that, 75% is direct salary costs for the 7.7 FTE employed to manage the problem gambling programme. The remaining 25% relate to overheads, travel costs and small projects. Confidential information available to KPMG indicates that these costs as a proportion of overall funding (5.5%) are in line with international jurisdictions.

Relative to the size of the national programme, Ministry costs appear reasonable.

Ministry costs comprise four key areas:

- Administration of research programme
- Provision of policy advice
- Management of problem gambling service provider contracts
- Administration and management of CLIC database (service user database).

In this section we consider the two largest (based on proportion of total Ministry costs) components of the Ministry costs: policy advice and contract management. Management of the CLIC database is discussed in strength 5 in section 4.2 and the management of the research programme is discussed in Drivers 25 & 26.

To assess the VfM of Ministry contract management processes, a standard approach is to develop measures based on the size / number of contracts managed per FTE and compare these across the Ministry. However, we consider that this would not be an appropriate measure of VfM as these measures are influenced by many variables and accordingly we would be unable to draw conclusions based on comparators. We were advised by the Ministry that large contracts can be as time-intensive for contract managers as smaller contracts.

We developed two drivers to measure the VfM of Ministry costs. These are:

- Driver 23 - Quality of policy advice
- Driver 24 - Quality of contract management processes.

4.5 Driver 23 – Quality of policy advice

Measure: Results of independent review of Ministry policy advice

VfM: Economy - Efficiency - **Effectiveness**

Measurement

Driver of VfM

The greater the quality (effectiveness) of Ministry policy advice, the greater the VfM, all other things being equal.

Measure

The effectiveness of Ministry policy advice can be assessed by reviewing the results of independent reviews of Ministry policy documents. The results of these reviews can then be benchmarked against 248 other reviews of policy papers undertaken by the New Zealand Institute of Economic Research (NZIER).

Assumptions

None.

Data source & confidence

The information for this driver was obtained from independent reports on Ministry policy advice prepared by NZIER. Our confidence in this data is high however a significant limitation of this driver is that the report only considers two pieces of policy advice from the Ministry problem gambling team. We understand the samples for review were selected by the Ministry at random.

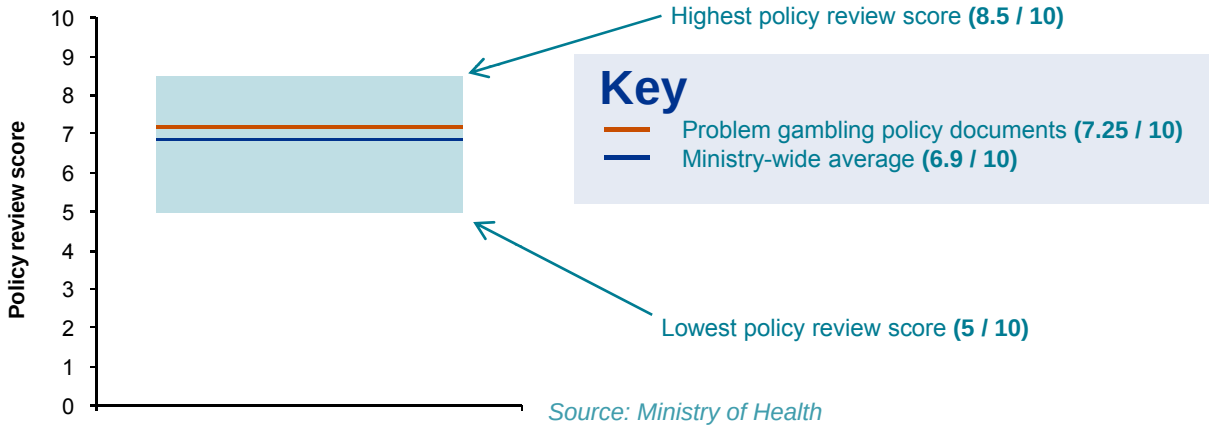
Analysis & Commentary

The NZIER have independently reviewed Ministry policy documents in 2006, 2008, 2009 and 2010. The Ministry submitted two documents for review, the 'Release of consultation document: preventing and minimising gambling harm 2010 – 2016' and a briefing to the Minister.

The overall conclusion from NZIER on these documents was that the *'Paper does its job. Needed clarity on the framework and another good edit to lift it to the next level'* and *'Covers the issue and gives the Minister the necessary advice'*. The papers received a score of 7 and 7.5 out of a maximum score of 10. This is interpreted as 'adequate and good (respectively)' by NZIER. The graph below compares the rating for this document against 248 other Ministry policy samples reviewed by the NZIER.

KPMG also reviewed independent feedback provided on briefing papers prepared by the problem gambling policy team. This feedback indicated an average score of 4.2 / 5 (equivalent to 8.4 / 10) for the six briefing papers reviewed

Graph 17: Independent review of Ministry policy advice



Source: Ministry of Health

Key VfM messages

- Policy advice from the Ministry problem gambling team was rated as being above the Ministry average when independently reviewed.
- Independent feedback on problem gambling policy advice shows that it is favourable.

Conclusion

VfM	G
Trend	N
Confidence in data	G

4.5 Driver 24 – Quality of contract management processes

Measure: Completion of key contract management processes

VfM: Economy | Efficiency - Effectiveness

Measurement

Driver of VfM

The greater the efficiency and effectiveness of Ministry contract management processes, the greater the VfM, all other things being equal.

Measure

The efficiency and effectiveness of Ministry contract management processes can be assessed by reviewing Ministry activity in key areas. The key contract management processes assessed by this driver are:

- Responses to six monthly service provider reports,
- Development and monitoring of service provider work-out plans to implement recommendations arising from the audit programme.

Assumptions

None

Data source & confidence

The responses to six-monthly reports and audit work-out plans for this driver were obtained from the Ministry. A sample of five providers was selected at random by KPMG. Our confidence in this data is high.

Analysis & Commentary

All five service providers sampled had prepared six-monthly reporting to the Ministry for both the July to December 2009 period and January to June 2010. Six-monthly service provider reports include reporting on:

- Major achievements
- Issues
- Areas for improvement
- Compliance with FTE levels within contract
- Financial reporting
- Performance against each purchase unit

These reports are important as they assist the Ministry with 'Monitoring (including verifying) delivery against the contract' and 'Assessing the effectiveness of the services delivered'. These are two important contract management processes as set out in Treasury 'Guidelines for Contracting with Non-Government Organisations for Services Sought by the Crown'.

Ministry contract managers had prepared written responses to all reports sampled. The Ministry responses commented on service provider performance and raised any concerns the Ministry had with service delivery. Our analysis identified that the Ministry contract managers had developed a work-out plan for all service providers sampled. These work-plans were comprehensive and monitored all outstanding audit issues to completion. These work-out plans also recorded remedial actions (where appropriate).

We observed that over the last three years the Ministry has actively taken steps to address provider under-performance. This includes exiting providers contracts where there has been sustained evidence of low service utilisation. Other under-performing providers have had funding reduced. In one case the Ministry took steps to recover funding when a provider failed to fill a vacant position after a number of months.

During our stakeholder interviews we received feedback from both gambling industry participants and service providers that was largely positive in relation to the effectiveness of the Ministry's contract managers. Comments from service providers related to the contract managers being professional, visible, transparent, stable and supportive. Industry were complimentary of the Ministry's willingness to engage and praised their professionalism. They also acknowledged the Ministry's efforts in tightening up contract management processes and providing a greater level of accountability.

Key VfM messages	Conclusion	
■ Ministry contract management processes were applied consistently for all service providers sampled.	VfM	G
	Trend	G
	Confidence in data	G

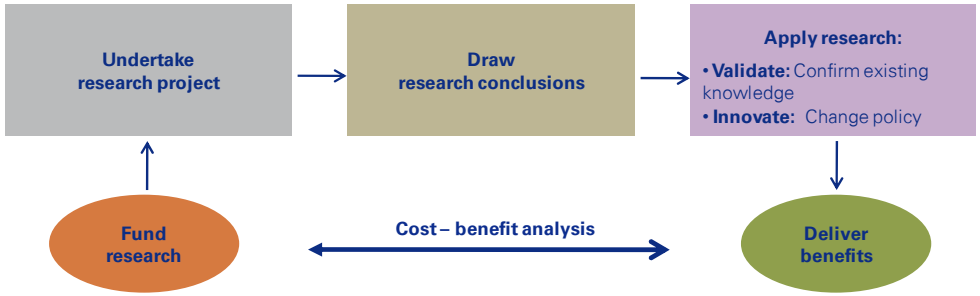
4.5 Introduction to Research drivers

Introduction to research drivers

Standard practice for measuring the VfM of research programmes involves undertaking a cost-benefit analysis between the costs of the project and the benefit obtained from research outcomes.

Diagram 16 below sets out the high-level process for assessing the VfM of a research project. For problem gambling research, strong information is available to assess the costs of a project. However we were not able to obtain robust information to quantify and assess the benefits.

Diagram 16: Process to assess VFM of Research



Source: KPMG

To address these limitations, for this VfM review, we used the quality of the two key research processes as an indirect, or proxy measure.

Driver 25 - Quality of planning processes for research programme. This driver documents and reviews the processes that relate to pre-research tasks. Specifically, these include planning, prioritising and procuring projects. This driver considers both the economy and efficiency of research, both considering how research is prioritised and how it is procured.

Driver 26 - Quality of processes to assess the outcomes of research projects. This driver documents and reviews the processes that relate to post-research tasks. Specifically, these include the peer review, feedback and acceptance of research projects and processes undertaken by the Ministry to drive benefits from research projects.

Opportunities for VfM improvement

1. Quantify benefits

We were not able to obtain robust information to quantify and assess the benefits of research against the costs. We recommend the Ministry quantify and document the expected benefits of each project prior to issuing the RfP. Once the project is completed, the Ministry can then assess the actual benefits derived from the research against the expected benefits and conclude on the VfM of each project.

VfM: Economy - Efficiency - Effectiveness

4.5 Driver 25 – Quality of planning processes for research programme (pre-research)

Measure: Extent to which research programme aligns with good practice planning processes

Measurement

Driver of VfM

The better the Ministry research programme employs good practice planning processes, the greater the VfM of investment in the overall research programme - all other things being equal.

Measure

The extent to which the Ministry problem gambling research programme aligns with good planning processes. This is one of two key processes relating to the management of the problem gambling research programme. The other key process, 'Assessment of outcomes of research programmes' is discussed in driver 26.

Assumptions

None

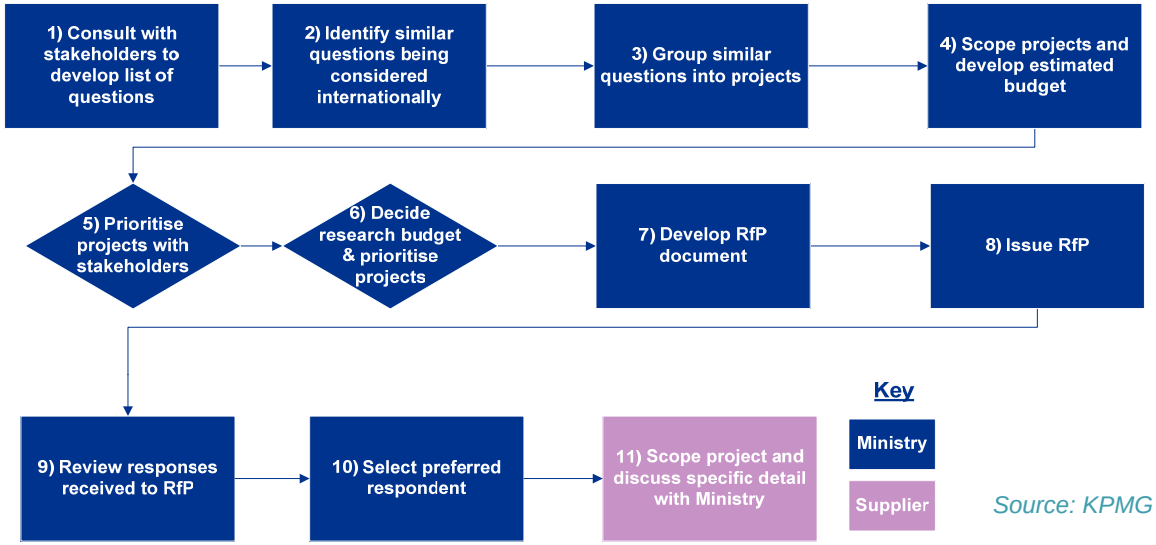
Data source & confidence

Information for this driver was obtained through meeting with the Senior Research Analyst within the National Problem Gambling Team of the Ministry, and from a review of the Ministry research strategy and list of research projects for the 2007 to 2010 period as set out on the Ministry website.

Our confidence in the data for this measure is high but our confidence in the overall VfM conclusion is medium as this is only an indirect measure of VfM rather than a quantifiable direct measure.

Analysis & Commentary

Diagram 17: High-level overview of planning processes for research programme



Source: KPMG

Note: The steps above are described in more detail on the following page.

Based on our understanding of the process above and the results of stakeholder interviews we conclude that Ministry processes for planning, prioritising and procuring research appear robust and appropriate. The processes to prioritise research and to procure projects via open tender support the VfM of the research programme.

Key VfM messages

- The processes for planning, prioritising and procuring research appear robust and adequate.

Conclusion

VfM	G
Trend	N
Confidence in data	G

VfM: Economy - Efficiency - Effectiveness

4.5 Driver 25 – Quality of planning processes for research programme (pre-research)

Measure: Extent to which research programme aligns with good practice planning processes

Analysis & Commentary

The Ministry process for the planning, prioritisation and procurement programme is set out below:

1. The Ministry consults with service providers, the gambling industry, other units within the Ministry and DIA representatives to develop a list of questions or hypotheses that the problem gambling research programme could address. Through the consultation process, the Ministry request that each stakeholder prioritises the list of questions. Potential research questions are also checked to ensure they align with the Ministry's strategic objectives.
2. The Ministry checks with international problem gambling research agencies to identify any common projects planned or being undertaken to avoid duplication and to influence the prioritisation process in step 5.
3. The Ministry groups questions with other similar questions into projects.
4. The Ministry scopes projects to estimate their size and set an initial estimated budget. The estimated budget is established based on comparison with comparable projects purchased by the Ministry.
5. The Ministry prioritises projects with Ministry and DIA personnel, research providers, Stakeholder Reference Group and other interested parties. This ensures that scarce funding is applied to the projects that will deliver the most benefit.
6. The Ministry develops a budget for the research programme and selects the priority projects that fit within the allocated budget.
7. The Ministry prepares a Request for Proposal (RfP) document for the projects selected in Step 6. In this stage the Ministry provides an estimated budget range for each project. This is based on:
   - Review of other research projects being commissioned across Government
   - Internal review by a research peer review team within the Ministry
   - Review by the Ministry purchasing team
8. The Ministry issues the RfP via the government electronic tender system (GETs).
9. The Ministry receives responses to the RfP and establishes a panel to determine the preferred candidate. RfPs are reviewed by the panel against pre-determined criteria. One of these criteria is whether the project offers VfM.
10. A successful respondent (supplier) is selected.
11. The supplier scopes the project and discusses the project's specific detail with the Ministry. If challenges are identified that impact the ability for the project to deliver on agreed outcomes, the Ministry will consider terminating the project or modifying the scope.

The Ministry also periodically engages research suppliers to undertake literature reviews to identify gaps in knowledge which future research could potentially address.

VfM: Economy - Efficiency - **Effectiveness**

4.5 Driver 26 – Assessment of outcomes of research programme (post-research)

Measure: Extent to which Ministry assess outcomes of research projects

Measurement

Driver of VfM

The better the Ministry assesses, utilises and incorporates outcomes from the research programme the better the overall VfM - all other things being equal.

Measure

The extent the Ministry assesses outcomes of research projects can be assessed through identifying and reviewing Ministry processes in this area. This is one of two key processes relating to the management of the problem gambling research programme. The other key process 'Planning, prioritisation & procurement of research programme' is discussed in driver 25.

Assumptions

None

Data source & confidence

Information for this driver was obtained through meeting with the Senior Research Analyst within the National Problem Gambling Team of the Ministry, and from a review of the Ministry research strategy and list of research projects for the 2007 to 2010 period as set out on the Ministry website.

Our confidence in the data for this measure is high but our confidence in the overall VfM conclusion is medium as this is only an indirect measure of VfM rather than a quantifiable direct measure.

Analysis & Commentary

The Ministry process for assessing the outcomes of research programmes are set out below:

Diagram 18: High-level overview of post-research processes

Key

Ministry | Supplier | Peer Reviewer

Source: KPMG

1. The Ministry monitors progress and receives regular updates from the research supplier
2. The Supplier prepares a report for the research project and submits to the Ministry
3. The report is submitted for independent Peer Review (in most situations)
4. The Ministry reviews the research report, and prepares written feedback, identifying any concerns requiring remedial action by the supplier
5. The Supplier makes changes where required and issues the research report as final
6. The Ministry advises acceptance of the research report
7. For most projects (we were advised circa 80 – 90%), the supplier presents to the Stakeholder Reference Group on the results of the research
8. The Ministry applies the outcomes of research either validation of current service delivery or innovation – changes to service delivery i.e. New policy, changes to service specifications, and minimum standards.

Key VfM messages

- The processes for assessing the outcomes of research appear robust.

Conclusion

VfM	G
Trend	N
Confidence in data	G

Section 5 – International context

Section 5 – International context

5.1 Introduction to International comparators

Introduction to international comparators

One aspect of our approach to this review was to compare New Zealand problem gambling services with other services internationally. This section of the report introduces each country with which we have compared New Zealand services and discusses the following key areas:

- Problem gambling policy context
- Problem gambling strategy
- An overview to service delivery
- Information and statistics on service delivery.

We endeavoured to obtain comparative information for each of our 26 drivers. Where we could obtain comparative information this has been included in the analysis for the respective driver in Section 4.

As part of this review KPMG requested comparative information for the following international jurisdictions:

- Victoria, Australia
- Queensland, Australia
- United Kingdom

Information was supplied by Victoria and the United Kingdom. This has been incorporated into the document where relevant.

How does New Zealand align with other jurisdictions?

All jurisdictions are addressing problem gambling using a Public Health approach that incorporates:

- primary intervention which aims to prevent a problem from occurring of which health promotion and information are integral.
- secondary intervention that is aimed at high-risk groups in the population such as young males, indigenous communities and culturally and linguistically diverse communities.
- tertiary intervention that responds to people already experiencing gambling issues utilising services such as counselling and financial counselling.

Overall, New Zealand is similar to other jurisdictions in Australia. The similarities include:

- use of a Public Health framework for responding to problem gamblers (or other health and community care related issues);
- service delivery elements of counselling (problem gambling and financial), 24 hour help line and community education/communication;
- implementing new and innovative forms of treatment (i.e. Web-based counselling) to reach problem gamblers (known to be a hard to reach population)
- building up research capabilities to better understand the impacts of problem gambling, and how best to respond; and
- local responses based on local needs using non government agencies with some specific focus on different cohorts of problem gamblers (such as Indigenous, Maori etc).

5.1 Introduction to International comparators

Similarities and differences

Some of the strengths across the jurisdictions with whom New Zealand closely aligns include:

- Efforts to fully integrate secondary prevention services into a range of social and health settings and to ensure that staff in these settings have the skills to screen and refer clients on to specialist services, particularly in Victoria in concert with their Alcohol and Drug services.
- Central helplines which offer more than just advice, information and referral but also provide long-term, follow up support to problem gamblers – although the UK currently only provides these services over the internet.
- Improved performance management frameworks to better assess the outcomes of service provision. For example, Victoria has moved to a more outcomes focused framework, rather than just outputs and activity levels.
- Acknowledging the value of community education and community partnerships whereby there are multiple level strategies to target whole of population and local community and population cohort levels – particularly in Victoria and Queensland.

As noted there are similarities across the jurisdictions in relation to problem gambling strategies and service provisions. There are, however, some differences when compared to New Zealand:

- The UK is beginning to recognise the value of community education as a means to respond to problem gambling – a review in 2008 recommended increasing the funding available for these activities. A Public Health approach has been mandated in New Zealand since the introduction of the Gambling Act in 2003,
- Availability of data (or lack of collection) – this is particularly pertinent for the UK and Canada where information is hard to obtain, or not available, compared to New Zealand where thorough data collection is in place, and
- The extent of the problem – that is, the prevalence rates are different, and the screening tools are different meaning useful comparison of the problem gambling rates is challenging.

Section 5 – International context

5.2 Problem gambling service delivery in Victoria, Australia

Policy Context

In October 2006, the Ministerial Statement Taking Action on Problem Gambling: A strategy for combating problem gambling in Victoria (Taking Action) was released. Taking Action, which commits $132.2 million to problem gambling over a five-year period, 2006 / 07 to 2010 / 11, outlines the major initiatives and actions the Victorian Government will take to address the harm caused by problem gambling (Victorian Auditor-General, 2010).

Taking action on problem gambling strategy

The Taking Action strategy identifies six priority action areas. These include:

- Building better treatment services
- Ensuring a more socially responsible gambling industry
- Promoting healthy communities
- Improving consumer protection
- Enhancing the regulator
- Fostering gambling research.

Taking Action ensures that the Government's problem gambling strategies will be informed by the following guiding principles: (Department of Justice, Victoria, Australia, 2006)

- Net community benefit: policies and strategies to address problem gambling must deliver a net community benefit to Victoria,
- A whole-of-community approach: the prevention and minimisation of the harm caused by problem gambling requires a whole-of-government approach,
- A long-term approach: problem gambling cannot be reduced overnight and needs long-term investment,
- An evidence-based approach: policy and strategies designed to respond to the harm caused by problem gambling must be evidence based,
- A multi-faceted approach: a diverse range of responses is required to address the issue of problem gambling,
- Cultural relevance: the strategies need to meet the needs of Victoria in a culturally and linguistically appropriate manner, and
- Open and informed decisions: decisions on strategies should be well-informed and the reasons for decisions should be open and transparent.

No targets were set for measuring achievement of strategy objectives, nor were appropriate key performance indicators developed to determine achievement of outcomes. As such, the Department of Justice's ability to effectively measure ongoing performance of the strategy has been hindered.

Victorian problem gambling service system overview

This section provides an overview of the Victorian problem gambling service system environment as it currently operates. As of 2009 / 10 there were (Victorian Auditor-General, 2010):

- 17 agencies providing Gambler's Help services (not including the 24 hour Gambler's helpline, Gambler's Online or other state-wide services),
- 88 service outlets that provided Gambler's Help services, including counselling and financial counselling,
- $32.6 million was spent across a range of initiatives under the Strategy – however, the breakdown across services, community education, research and administration is not available publically,
- A new gambling counselling website was launched in August 2009 – with 12,850 visits from 10,000 unique visitors,
- 600 people sought online counselling (69% after hours),
- 11,424 counselling calls to the Gamblers Helpline,
- 132% increase in calls to Gamblers Helpline from family / friends during July 2009 as a result of a new advertising / education campaign (compared to the same period the year before),
- 150 visitors a day to a website launched targeting 18-24 year old men where they could calculate how much they spend on gambling and assess their risk, and
- 96.7% of clients received a service within five days of referral (target: 90%) – compared to 97.2% in 2008 / 09, and 95.5% in 2007 / 08.

5.2 Problem gambling service delivery in Victoria, Australia

Problem gambling community education in Victoria

The Victorian Government's Problem Gambling Community Awareness and Education Strategy was released in March 2009. It presents an integrated,multifaceted ran ge of programmes that will target both individual behaviours and whole of community awareness, to attain and maintain real social change (Department of Justice, Victoria, Australia, 2009).

The strategic approach that has been developed includes the following focus areas:

- Build community resilience to problem gambling in Victoria,
- Educate and target community segments (such as people with mental health issues, co-morbid addictions, people in vulnerable communities, people with culturally and linguistically diverse backgrounds etc) at risk of developing a gambling problem in Victoria, and
- Service awareness and promotion.

Several programme initiatives were also established as a component of the Strategy. These include state-wide communications, community education through an integrated health promotion approach, school-based learning, partnerships and stakeholder engagement and online programmes. Examples of these initiatives are shown in the table below (Department of Justice, Victoria, Australia, 2009).

Table 5: Examples of Victoria community education initiatives

Type of initiative	Examples
State-wide communications	State-wide Communication Campaign Responsible Gambling Awareness Week Player information standards High value channels
Community Education	Local community education Gambler's Help services Provider education Primary Care Partnerships
School-based learning	Consumer Affairs – Consumer Education in Schools BIG DEAL resource Resource guide for school counsellors
Partnerships and stakeholder engagement	Partnerships with sporting organisations (such as AFL) Place-based partnerships Industry training and collaboration Potential partnerships with peak health organisations
Online	Engage target audiences New navigation of website Information portal Online counselling

Problem gambling community education in Victoria

Each programme within the strategy will be closely monitored and evaluated against a set of clear criteria developed to support the implementation of Taking Action on Problem Gambling.

Local community education

The key objective of community education is to deliver a range of integrated activities to increase awareness about responsible gambling, problem gambling and help services.

On July 2008, a new innovative community education model was introduced in Victoria regarding problem gambling. The new model is delivered through two avenues – the existing structure of the Department of Human Services Primary Care Partnerships (PCPs) model and the Gambler's Help Services Community Education Programme. By working together, the model addresses all three objectives of the strategy.

- Building resilience: this is achieved through PCPs working with member agencies to promote social inclusion and social connectedness by addressing the social determinants of health and co-morbidities,
- Risk awareness: awareness about the issue of problem gambling and the risk of the problem is promoted by Gambler's Help services and locally by the PCPs with their member agencies. Gambler's Help services also provide provider education to non-problem gambling services to raise awareness of problem gambling and its impacts, and
- Service promotion: Gambler's Help services promote help locally and PCPs promote services to member agencies. Furthermore, health promotion activities targeted towards providers, also strengthen the capacity and raise awareness of non-problem gambling services professionals to identify and respond to individuals and their families who are experiencing the impacts of problem gambling.

Section 5 – International context

5.2 Problem gambling service delivery in Queensland, Australia

Policy Context

The Queensland Responsible Gambling Strategy was released by the Queensland Government (Treasury) in February 2002. It provided an overview of the achievements that were already made towards responsible gambling in Queensland and provided a framework for future action. The Strategy also addressed the impact of problem gambling on individuals, families and communities.

The six priority action areas that were identified within the strategy included:

- Enhance responsible gambling policies and programmes through research,
- Increase community knowledge and awareness of the impacts of gambling,
- Reduce the risk factors for problem gambling through early intervention,
- Develop a state-wide system of problem gambling treatment and support services,
- Ensure gambling environments are safer and more supportive for consumers, and
- Promote partnerships to address state-wide and local gambling issues and concerns.

In 2008, the Queensland Government announced an evaluation of the Strategy as part of the introduction of a range of enhanced gambling harm minimisation measures.

Queensland problem gambling service system

In 2001, problem gambling affected 0.83 percent of the Queensland population (Queensland Office of Liquor and Gaming regulation, 2010). However the 2008 - 09 Queensland household gambling survey showed that approximately 12,000 Queenslanders or 0.37 percent of the adult population are problem gamblers. The survey covered 11 Queensland regions (Queensland Department of Employment, Economic Development and Innovation, 2010a).

Currently there are 14 Gambling Help Services across Queensland (Queensland Department of Employment, Economic Development and Innovation, 2010b). These services support people in the community experiencing problems as a result of gambling and they also provide support to gambling providers.

Problem gambling community education in Queensland

In Queensland, evaluations of the Problem Gambling and Responsible Gambling Communication Campaigns have found relatively$_{hi}$ gh levels of awareness. During various phases of the campaign there was a 44 percent increase in hits on the Responsible Gambling website (launched in 2001), a 10 percent increase in people seeking help through Gambling Help Line and an 11 percent increase in people seeking help though Gambling Help Services.

The second priority of the Strategy was to increase community knowledge and awareness of the impacts of gambling. It was proposed that this be achieved through the development of a communication strategy including: market research and concept testing; media campaigns; venue signage; brochures; education resources; websites; and evaluations (Queensland Department of Employment, Economic Development and Innovation, 2010a).

The 2002 Strategy also stated that community education and awareness strategies will be targeted to the whole population, as well as to specific groups or communities. These strategies were proposed to include a multi-level approach, targeted at different groups, including young people through school education and health and social welfare professionals through education and training for early identification of problem gambling (Queensland Government Treasury, 2002).

5.2 Problem gambling service delivery in the United Kingdom

Policy Context

Gambling Act 2005 and the Gambling Commission

The Gambling Act 2005 was introduced in four stages (the final stage coming into effect on 1 September 2007) and incorporated Internet gambling, allowed the establishment of 16 new casinos, and established a new regulatory body (the Gambling Commission), moved a range of responsibilities for the licensing of gambling premises to local government and permitted casinos and internet gambling providers to advertise.

The Gambling Commission was set up under the Gambling Act 2005 to regulate most commercial gambling in Great Britain (United Kingdom Gambling Commission, No date). The Commission also has the responsibility to measure and monitor the proportion of adults in the UK with gambling problems. These statistics are collected by the British Gambling Prevalence Survey.

Responsible Gambling Strategy Board

The Gambling Commission also works closely with the Responsible Gambling Strategy Board (RGSB) (set up in 2008) to reduce the prevalence of problem gambling. The Responsible Gambling Strategy Board advises the Gambling Commission and the Department for Culture, Media and Sport, on research, education and treatment programmes needed to support a national responsible gambling strategy and associated funding requirements (Responsible Gambling Strategy Board, 2009).

The RGSB forms part of a tripartite structure comprising a single purpose fundraising body (The GREaT Foundation), led by industry; a distributing body (The Responsible Gambling Fund); and RGSB, which determines the strategy and priorities for research, education and treatment, and passes a strategic funding framework to the Responsible Gambling Fund. The Gambling Commission has made available £250k in the 2009 / 10 and 2010 / 11 financial year to fund the activities of the RGSB (Responsible Gambling Strategy Board, 2009b).

Each year the RGSB releases an annual strategic plan. The RGSB strategy in turn influences the Responsible Gambling Fund (RGF) in how it funds research, education, prevention and treatment. The RGF was set up in 2009, to distribute funds for gambling-related research, education and training activities.

Policy Context

Responsible Gambling Strategy Board (Continued)

By 2011 / 12 it is anticipated that a gambling National Helpline will be set up, and that it will be closely linked to the Gambleaware website. The aim of these two help sources will be to offer resources and support to the following groups (Responsible Gambling Strategy Board, 2010):

- The general public,
- Gamblers not at risk or experiencing harm,
- At-risk gamblers not currently experiencing or causing harm as a result of their gambling activities,
- Gamblers experiencing or causing harm as a result of their gambling activities, and
- Significant others experiencing gambling-related harm.

GREaT foundation

GREaT Foundation was established in 2002 as Britain's largest funding body responsible for tackling problem gambling through the funding of research, education and treatment from voluntary donations.

United Kingdom problem gambling service system

In 2007, the British Gambling Prevalence Survey was conducted. The survey benchmarked the participation in gambling in Great Britain. According to the 2007 BGPS, the rate of problem gambling in Great Britain was 0.6 percent, which equates to about 284,000 adults (United Kingdom Gambling Commission, 2010).

As at April 2010, there were 3,997 Commission operating licenses in force, which was a 4 percent reduction compared to the same point in 2009 (United Kingdom Gambling Commission, 2010).

5.2 Problem gambling service delivery in the United Kingdom

GamCare

GamCare is the leading provider of information, advice, support and free counselling for the prevention and treatment of problem gambling in the UK. GamCare operates the national telephone helpline (GamCare Helpline) and online helpline (NetLine) and offers both face-to-face and online counselling, free to clients. GamCare also has an Online Forum and Chat Room which is available to any individual who wants to share their experiences. GamCare also aims to create awareness about responsible gambling and treatment and encourage an effective approach to responsible gambling within the gambling industry (GamCare, 2010).

In 2009 / 10, GamCare received £2.46million from the RGF.

GamCare face-to-face counselling is delivered by staff in London, Manchester and through the internet. Online Counselling is primarily reserved for clients who live outside the areas where GamCare or GamCare Partners provide face-to-face counselling. The online counselling sessions are 50 minutes in duration and are conducted via an MSN-like dialogue box on the same day and same time every week.

GamCare also provides short-term residential treatment at Broadway Lodge. There are 33 beds for the Primary Care residential centre, with an additional 22 places for those needing Secondary Care (GamCare, No date).

Gamble Aware

Gamble Aware is managed by the GREaT Foundation (formerly known as the Responsibility in Gambling Trust), which is an independent charity which funds treatment, research and education about responsible gambling (Gamble Aware, No date). The purpose of the website is to provide information to the public about responsible gambling, gambling regulations, how to recognise a gambling problem and how and where to seek help.

Problem gambling community education

The 2008 Gambling Commission's Review of Research, Education and Treatment, identified that education preventative education spending should have two key aims. These are to prevent, or reduce the likelihood of, those groups at risk and potentially at risk from developing gambling problems, by ensuring all gamblers have information to make informed choices; and providing signposting for those who already have a problem.

Recommendations made by the Review include (United Kingdom Gambling Commission, 2008):

- Ensure that targeted programmes with children and young people relating to problem gambling continue and that £500k be allocated to develop the existing programme,
- £50k be made available for a web-based information source, such as Gambleaware.co.uk,
- Money should be allocated for the provision of a national telephone helpline,
- Activity is needed to deliver a programme of awareness raising among front-line professionals (GPs and debt counsellors etc) to help improve signposting to treatment and ensure these professionals form an important part of the 'care pathway'. Approximately £500k for this area of priority, and
- An additional £350k for piloting and evaluating preventive education activities.

Therefore altogether the Review proposed that for the 2009 / 10 financial year £1.05m be allocated for preventive education activities, with the longer-term target being £1.4m.

5.2 Problem gambling service delivery in the United Kingdom

Responsible Gambling Strategy Board and community education

The RGSB 2010 Strategy highlights that the RGSB is aware that a number of service providers are carrying out prevention work at a local level and that more work needs to be put into gathering information about such initiatives as it will inform their understanding of risk and vulnerability factors and will also offer the potential to refine and recommend the expansion of local programmes on a national scale (Responsible Gambling Strategy Board, 2010). Furthermore, it is noted that non-gambling focused frontline agencies that offer help etc to individuals who may be, are known to be experiencing or are at risk of experiencing gambling-related harm can also provide information and models of working that will assist in developing targeted prevention and education initiatives.

The Strategy also identifies working with regulators and the industry as a key method of promoting prevention and education initiatives. The Prevention and Education Panel (which is part of the RGSB) has also identified, with the help of stakeholders, some specific vulnerable groups who might be focused on in relation to targeted prevention and education initiatives. Vulnerable groups include, homeless people, people with mental health problems, young professional sports players, substance users, certain cultural and ethnic groups etc.

Furthermore, work is already underway on a parents, carers and young people initiative. The aim of that initiative is to explore whether community leaders can engage with families in understanding the risks and early prevention issues associated with gambling. The project is being carried out in two locations and the results will be available later in 2011.

The RGF is also funding a project by the English Healthy Universities Network, which is exploring whether gambling-related risks, particularly those associated with debt, can be minimised by providing information and support that is specifically designed and targeted for tertiary students.

The Prevention and Education Panel is also looking at the role that the Internet has in the prevalence of problem gambling. The Panel also identified that the internet offers new prevention opportunities and as such it is important that the right level and format of information about gambling is available to children and young people on the internet.

5.2 Problem gambling service delivery in Canada

Problem gambling system overview

In Canada, gambling operates exclusively under the control of the provincial and territorial governments.

In June 2001, the Responsible Gambling Council (RGC) sponsored a national forum that brought together a group of stakeholders to identify issues and actions to further the aims of responsible gambling in Canada. As a result of that meeting a diverse group of representatives from several provinces established a founding steering committee and have pursued the creation of a national member-driven initiative to provide services to members in support of responsible gambling research, education and policy development.

The steering committee has translated this vision into a formal initiative – the Canadian Partnership for Responsible Gambling. The Canadian Partnership for Responsible Gambling is a collaboration of non-profit organisations, gaming providers, research centres and regulators working to find and promote effective ways to reduce the risk of problem gambling.

The RGC's programmes have grown and expanded almost continuously since 2001, including:

- Within Limits: Problem Gambling Prevention Month now travels to 45 communities and reaches three-million Ontario households. This is one of Canada's largest problem gambling prevention programmes,
- Yearly high school drama tours have reached over 190,000 students since its inception, expanding into other provinces including Nova Scotia, New Brunswick, PEI and Newfoundland,
- Since 2001, Know the Score, the RGC's interactive touring programme for university and college students, is in five Canadian provinces and New York State, and
- In 2005, with funding from the Ministry of Health Promotion, the RGC launched two social marketing campaigns – friends4friends targeting the friends of young adults who are at risk of developing a gambling problem and Gambling & You, an awareness campaign targeting the spouses of people with a gambling problem.

Problem gambling system overview

Statistics show that in 2009, 3.2% of Canadian adults were affected by moderate to severe problem gambling. In September 2009, there were 13 problem gambling help lines located in each province and territory in various provinces in Canada.

In 2008 / 09, across Canada overall, at least 44,682 helpline calls were made and at least 15,970 individuals sought treatment from problem gambling counselling services. Additionally in 2008 / 09, across Canada there were a total of 82 on-site support centres, which was more than triple the number reported in 2007 / 08 (27).

Ontario

Since 2002, Ontario has allocated a portion of its gambling revenue to allow for the funding of substance abuse treatment recognising the existence of high rates of co-morbid gambling and substance abuse disorders.

Ontario supposedly spends the most of any Canadian jurisdiction on the resourcing of its problem gambling strategy. The Responsible Gambling Council of Ontario has also established the Centre for The Advancement of Best Practices, which aims to promote the identification and adoption of best practice to reduce the prevalence of problem gambling in Ontario.

Section 6 – Service Delivery Model

Section 6 – Service Delivery Model

6.1 Introduction

Introduction

In the Preventing and Minimising Gambling Harm: Six-year strategic plan 2010 / 11–2015 / 16 the Ministry stated their *'commitment to identifying opportunities to increase efficiency and alignment of service delivery and management, including the possible devolution of services to DHBs'* (Ministry of Health, 2010). In the same document, the Ministry indicated potential benefits of DHB devolution as including:

- Efficiencies from aligning problem gambling and mental health and alcohol and other drug services
- Improved access to services and outcomes for people presenting with coexisting mental health, alcohol or other drug issues.

One of the five objectives of this review was to assess the appropriateness of the current structure for delivering problem gambling intervention and Public Health services.

An appropriate delivery model is a fundamental driver of the VfM of problem gambling services. The cost of changing the structure and accompanying risks would be substantial. Therefore a full, robust strategic options analysis would be required before sufficient evidence could be collected, sufficient to make the decision on changing this structure.

In this review, we have been able to undertake a high level preliminary analysis by identifying three alternative service delivery models. For each model, an initial review enabled high level advantages and disadvantages to be identified.

The status quo is for 24 NGOs to be funded by the Ministry on an FTE basis. The alternative models identified are:

1. Devolution to District Health Boards
2. Consolidation of service providers
3. Output/outcome based at-risk funding of providers.

We recommend that further work be undertaken to:

- Define the three alternatives (excluding the status quo),
- Analyse the advantages and disadvantages of each of the four models in detail, and
- Analyse the fiscal impact of the four alternatives.

A robust strategic analysis is essential given the broader structural changes possible in the wider health sector in coming years.

6.1 Preliminary analysis of alternative Service Delivery Models

Status Quo – 24 service providers funded by the Ministry on an FTE basis

Status Quo – 24 service providers funded by the Ministry on an FTE basis

The current model consists of 24 service providers (of which 22 are NGOs) contracting directly with the Ministry. The current model is described in detail in Section 3.1 context.

Advantages

- Can deliver (in certain situations) an integrated service to address client co-morbidities as certain providers either offer or are co-located with other health & social services
- Maintains Iwi mandate as Maori service providers are regional (rather than national)
- Supports government aspirations to contract with the NGO sector more
- Results in greater accountability as funding is administered centrally from a single entity (The Ministry) - resulting in greater accountability for funding
- Ensures that FTE are employed for front-line services as funding is based on FTE inputs
- Streamlines reporting processes as service providers report to one entity – the Ministry
- Controls application of problem gambling strategy as funding is administered by one body
- Provides visibility and management of problem gambling services over the entire country allowing services to be targeted to areas most in need
- Maintains consistent service delivery as funding and contracting model are centralised
- Provides consistency in service delivery due to central funding and contracting model
- Improves communication and engagement with Minister through central administration.

Disadvantages

- May reduce economies of scale. 15 providers have contracts for less than $200k. We question whether this allows for economies of scale given the fixed costs each contract service providers will incur. Examples of these include Premises, utilities, insurance, reporting to the Ministry (Ministry of Social Development, No date).
- Creates perception that NGOs have limited influence on service delivery model and restricted ability to innovate
- Does not deliver services to address co-morbidities (in some situations). Certain service providers are dedicated to, or mainly provide problem gambling services and do not offer other services
- Reduces Ministry control over areas such as staff competency or political neutrality as NGOs are autonomous entities
- Lacks incentives for NGOs to collaborate inter-regionally or cross-sector.

Conclusion

The key strength of this model is the centralised management and funding of the problem gambling programme with the Ministry. This results in streamlined reporting, greater accountability for funding and greater control over how funding is applied.

The key weakness is the reduced economies of scale.

6.1 Preliminary analysis of alternative Service Delivery Models

Alternative 1: Devolution to District Health Boards – Services are devolved to DHBs

Alternative 1: Devolution to District Health Boards – Services are devolved to DHBs

This alternative explores the option for services to be devolved to DHBs. The exact model of service delivery under this option needs to be determined. DHBs may elect to deliver services themselves by employing their own addiction health promoters or counsellors or alternatively they may contract with existing or new problem gambling providers (NGOs) to deliver services. Stakeholders also suggested that in practice, DHBs may collaborate to deliver services on a regional basis. Our advantages and disadvantages provided below encompass both possibilities.

Advantages

- May be more responsive to community needs as DHBs have strong knowledge of issues affecting people within their regions
- Integrated better with other health / social services
- Maintains Iwi mandate as Maori DHBs are regional (rather than national)
- Makes use of administrative and management structures already in place to create efficiencies
- Requires high-levels of accountability and political neutrality as DHBs are public entities.

Disadvantages

- Certain DHBs would receive small levels of funding. Would this be adequate to deliver services?
- DHBs may prioritise funding to other areas of health over problem gambling services
- Reporting to 20 DHBs may be onerous if existing national service providers, for example the Problem Gambling Foundation or The Salvation Army are contracted
- May$_{be}$ poorly$_{inte}$ grated and inconsistent nationally
- May have a lower profile with the Minister and media if administered under the decentralised model devolved to DHBs
- DHBs may develop contracts with service providers to different specifications. This may create regional variations and inconsistencies in service delivery
- May reduce the transparency of levy funding as reporting on outputs and outcomes will be more challenging
- Less control over how funding is spent i.e. the proportion spent on Public Health vs. Intervention services.

Conclusion

The key strength of this model would be the integration with other addiction services and primary healthcare with current service providers.

The key weakness is the loss of centralised administration and management of funding.

6.1 Preliminary analysis of alternative Service Delivery Models

Alternative 2: Consolidation of providers Status Quo with fewer service providers

Alternative 2: Consolidation of providers Status Quo with fewer service providers

This alternative explores the option of retaining the current model whereby services are controlled by the Ministry but services are contracted to fewer providers.

This is essentially the current model adapted to focus on four to eight providers which would deliver services nationally. It is anticipated that several of these providers would deliver dedicated Maori and Pacific services.

Advantages

- Make use of economies of scale in the larger consolidated providers by reducing FTE payments. This is based on the underlying assumption that economies would be achieved in larger contracts through reduced overheads
- Less demand on contract managers as they will be managing fewer contracts. It may be possible to reduce contract management costs
- Greater cohesion and collaboration
- Stronger sector voice than the current model with 24 service providers
- Streamlined reporting with four to eight reports received by the Ministry rather than 24
- Greater consistency is service delivery
- Greater consistency in ‘brand’ and message for problem gambling services Less demand on contract managers as they will be managing fewer contracts. It may be possible to reduce contract management costs

Disadvantages

- May shift balance of power / influence more heavily to service providers. This may negatively impact the political neutrality of service providers
- May lack Iwi mandate due to larger national service providers
- Elevated risk to the Ministry is greater under this model as greater reliance is placed on a small number of providers.

Conclusion

The key strength of this model would be the cost-efficiencies that could be obtained from consolidation of providers

The key weakness is likely to be the loss of localised Iwi mandate. Service providers would need to place significant effort on developing these relationships and this support.

6.1 Preliminary analysis of alternative Service Delivery Models

Alternative 3: Output/outcome based funding Service providers funded based on performance

Alternative 3: Output / Outcome based funding

This alternative explores the option of retaining aspects of the current model whereby services are controlled by the Ministry but altering the funding mechanism so that payments are based more on outputs and outcomes. The exact model of service delivery under this option need to be determined. We provide below a series of potential outcome measures that KPMG is aware of being considered internationally.

Potential output / outcome measures (Intervention services):

- Number of sessions / clinical hours delivered
- Improvement in gambling screen scores post treatment

Potential output / outcome measures (Public Health)

- Volume of first-time clients attending services
- Diversity of clients attending services
- Community-level prevalence over time

For output / outcome measures to be implemented, further work needs to be undertaken to measure the effectiveness of service delivery. We are aware of two service providers, Odyssey House and Woodlands Trust who currently report on the effectiveness of their intervention treatment services.

Several providers commented that they would be interested in the high-trust, risk based or 'earned-autonomy' contracts implemented by other government departments.

Advantages

- Incentivises providers for performance and to achieve targets
- Incentivises greater productivity and greater VfM
- Encourages less productive staff and providers out of sector
- Rewards service providers that can increase outputs within resourcing
- This funding mechanism encourages supply to match demand, services that have high demand would hire practitioners to match this demand
- Incentivises providers to innovate and develop their own cost-efficiencies (within contract)

Disadvantages

- Providers may become financially unstable if demand falls
- May incentivise finding clients rather than treatment outcomes (Quantity vs. Quality) if outcome measures are unable to be assessed
- May encourage inter-provider competition for clients and accordingly funding
- Would have major implications on the problem gambling levy whereby the formula includes a weighting based on client presentations
- Presents a significant challenge in establishing causal relationships between outcome measures and the delivery of Public Health services
- Elevates risks relating to data integrity. An incentive would exist to create fictious clients, accordingly more regular audits of data integrity would be required
- May create a perception that service providers are too focused on 'recruiting' clients
- Outcome based funding can create a perverse incentive for service providers to select clients based on the likelihood of a positive outcome.

Conclusion

The key strength of this model would be the development of incentives for service providers to deliver real benefits – outputs / outcomes.

The key weakness is likely to be inter-related, with the potential for this incentivised approach to shift the focus to delivery of sessions, with the potential for less emphasis on client outcomes. This will require robust measures of treatment effectiveness. Measuring the effectiveness of Public Health services will still be a key issue.

Appendices

Appendix A
Stakeholders consulted through this review

Stakeholder introduction

The table below identifies the 51 stakeholders engaged with as part of this review.

In terms of service providers, this represents 80% of all service providers and 94% of problem gambling funding by value (by 2010 / 11 contract value).

Table 6: Stakeholders consulted with during this review

Name	Organisation
Prof. Max Abbott	Auckland University of Technology
Dean Adam	Ministry of Health
Graham Aitken	Problem Gambling Foundation of New Zealand
Jerry Banse	Te Roopu Tautoko Ki Te Tonga
Dr. Maria Bellringer	Lifeline Auckland
Lloyd Bezett	Department of Internal Affairs
Lisa Campbell-Dumlu	The Salvation Army of New Zealand Trust
Martin Cheer	Pub Charity
Rebecca Coombes	Auckland University of Technology
Hannah Crump	Health Sponsorship Council
Epati Fale	Tupu Pacific Alcohol, Drugs and Gambling Services
Dr Vicki Fowler	Woodlands Trust
Andrew Gaukrodger	SkyCity
Anthony Hawke	Hapai te Hauora Tapui
Zoe Hawke	Hapai te Hauora Tapui
Ruth Herd	Researcher
Major Lynette Hutson	The Salvation Army of New Zealand Trust
Karen Jones	New Zealand Lotteries Board
Christine Kalin	Odyssey House
Sean-Paul Kearns	Ministry of Health
Mike Knell	New Zealand Community Trust
Dr. David Korn	University of Toronto
Natu Levy	Ministry of Health
Eru Loach	Nga Kete Matauranga Pounamu Charitable Trust
Shirley Lammas	Te Rangihaeata Oranga
Layla Lyndon-Tonga	Nga Manga Puriri
Sherona Mariner	Tupu Pacific Alcohol, Drugs and Gambling Services
John Markland	Department of Internal Affairs
Colin Mason	Lifeline Auckland
Denis McLeod	Te Herenga Waka o te Ora Whanau
Matt McMillan	Te Kahui Hauora o Ngati Koata Trust
Laurie Morrison	Te Kahui Hauora Trust
Michelle O'Loughlin	The Salvation Army of New Zealand Trust
Sharna Lee Packer	Nga Tai o Te Awa
Bobby Pairama	Raukura Hauora o Tainui
Alison Penfold	Abacus Counsellng ,Training and Supervision Limited
Carmela Petagna	Ministry of Health
Adrian Portis	Ministry of Health
Graeme Ramsey	Problem Gambling Foundation of New Zealand
Grant Reihana	Raukura Hauora o Tainui
Gus Rieper	Clubs New Zealand
Bruce Robertson	Hospitality Association of New Zealand
Dion Rogan	Nga Tai o Te Awa
Iva Singsam	Raukura Hauora o Tainui
Bernie Smulders	Woodlands Trust
Sean Sullivan	Abacus Counsellng ,Training and Supervision Limited
Bob Tamehana	Best Care (Whakapai Hauora)
Geraldine Nickel	New Zealand Racing Board
Derek Thompson	Ministry of Health
Dr. Phil Townshend	Problem Gambling Foundation of New Zealand
Aux Captain Gerry Walker	The Salvation Army of New Zealand Trust
Darren Walton	Health Sponsorship Council
Francis Wevers	Community Gaming Association
Michael Wemyss	New Zealand Racing Board

Listed in alphabetical order (by surname)

Appendix B
Literature Review - Bibliography

- Australian Government - Productivity Commission. (1999, November 26). Australia's Gambling Industries - Inquiry Report. Retrieved January 20, 2011, from http://www.pc.gov.au/projects/inquiry/gambling/docs/finalreport
- Australian Government - Productivity Commission. (2010, June 23). Enquiry Report - Gambling. Retrieved November 18, 2010, from http://www.pc.gov.au/projects/inquiry/gambling-2009/report
- AUT Gambling and Addictions Research Centre. (2010a, July). Evaluation of problem gambling Intervention services. Auckland: AUT Gambling and Addictions Research Centre. Retrieved November 29, 2010, from Problem gambling research programme 2007 to 2010.
- AUT Gambling and Addictions Research Centre. (2010). Focused Literature Review for the Problem Gambling Programme. Retrieved November 18, 2010b, from Health Sponsorship Council - Research Publications: http://www.hsc.org.nz/researchpublications.html
- AUT Gambling and Addictions Research Centre. (2005, November). Literature Review to Inform Social Marketing Objectives and Approaches and Behaviour Change Indicators, to Prevent and Minimise Gambling Harm. Retrieved November 18, 2010, from Research Publications: http://www.hsc.org.nz/researchpublications.html
- Bergin, A. E., & Garfield, S. L. (1994). Handbook of Psychotherapy and Behaviour Change (4 ed.). New York: John Wiley & Sons, Inc.
- Department of Internal Affairs. (2008). People's Participation in, and Attitudes to, Gambling, 1985–2005: Final results of the 2005 survey. Wellington.
- Department of Justice, Victoria, Australia. (2009, March). Problem Gambling Community Awareness and Education Strategy. Retrieved January 25, 2011, from http://www.pc.gov.au/__data/assets/pdf_file/0005/87872/sub205-attachment3.pdf
- Department of Justice, Victoria, Australia. (2006). Taking Action on Problem Gambling. Retrieved January 25, 2011, from http://www.pc.gov.au/__data/assets/pdf_file/0004/87871/sub205-attachment2.pdf
- Francis Group. (2009, April 9). Informing the 2009 Problem Gambling Needs Assessment: Report for the Ministry of Health. Retrieved December 7, 2010, from Publications - Problem Gambling: http://www.moh.govt.nz/moh.nsf/indexmh/problemgambling-publications
- Gamble Aware. (No date). About this website. Retrieved January 25, 2011, from http://www.gambleaware.co.uk/about-this-website
- Gamcare. (2010). Annual Review 2010. Retrieved January 21, 2011, from Gamcare Publications: http://www.gamcare.org.uk/publications.php
- Gamcare. (2010, September). Briefing Paper 1 - Who we are. Retrieved January 25, 2011, from http://www.gamcare.org.uk/data/files/Briefing_papers/BRIEFING_PAPER_1_v3.pdf
- Gamcare. (No date). Residential Treatment. Retrieved January 25, 2011, from http://www.gamcare.org.uk/pages/residential_treatment.html
- Gamcare. (2010). Statistics 2009 / 10. Retrieved January 21, 2011, from Gamcare Publications: http://www.gamcare.org.uk/publications.php
- Gravitas Research and Strategy Ltd. (2007). Problem Gambling TVC Concept and Brand Testing. Auckland: Gravitas Research and Strategy Ltd.

Appendix B
Literature Review - Bibliography

- Health Sponsorship Council. (2010, September 24). Activity Areas - Problem Gambling. Retrieved January 20, 2011, from http://www.hsc.org.nz/problem-gambling.html
- HP Consulting. (2006, December 1). Review of Problem Gambling Service Plan Costings and Formula for Levy Calculation. Retrieved December 7, 2010, from Gambling Commission - Other Publications: http://www.gamblingcommission.govt.nz/GCwebsite.nsf/wpg_URL/Reports-Publications-Proposed-Problem-Gambling-Levy-(December-2006)!OpenDocument
- Jackson, A. C., Thomas, S. A., Thomason, N., & Ho, W. (2002). Longitudinal Evaluation of the Effectiveness of Problem Gambling Counselling Services. Melbourne: Victorian Department of Human Services.
- Korn, D., & Shaffer, H. (2002). Gambling expansion in North America: a Public Health perspective. APHA Annual Conference. Philadelphia.
- KPMG. (2010). Fraud and Misconduct Survey 2010. Retrieved February 25, 2011, from KPMG Forensic Services: https://www.kpmg.com/NZ/en/IssuesAndInsights/ArticlesPublications/Pages/Fraud-Survey-2010.aspx
- Matua Raki. (2009). Stocktake of Alcohol and Other Drug Treatment Services in New Zealand. Wellington: Matua Raki.
- Ministerial Council on Gambling. (2008, December 31). Progress Report to Council of Australian Governments on implementation of the National Framework for problem gambling 2004-2008. Retrieved January 20, 2011, from Publications & Articles: http://www.fahcsia.gov.au/sa/gamblingdrugs/pubs/progress_report_NFPG/Pages/default.aspx
- Ministry of Health. (2009). Draft Problem Gambling Service Plan 2010 – 2013 Psychosocial Intervention and Support Services - Memo to Barbara Phillips.
- Ministry of Health. (2009). In-depth Spending Review of Ministry of Health and District Health Board Public Health. Wellington: Ministry of Health.
- Ministry of Health. (2009). Internal Memorandums to support establishment of service plan. Wellington: Ministry of Health.
- Ministry of Health. (2007). New Zealand Health Survey. Wellington.
- Ministry of Health. (2010, May). Preventing and Minimising Gambling Harm: Six-year strategic plan 2010/11–2015/16. Retrieved October 13, 2010, from Problem Gambling Publications: http://www.moh.govt.nz/moh.nsf/indexmh/preventing-minimising-gambling-harm-6-yr-service-plan
- Ministry of Social Development. (No date). Costs of running an NGO. Retrieved February 11, 2011, from https://www.msd.govt.nz/what-we-can-do/community/good-practice-funding/integrity/costs-of-running-an-ngo.html
- National Research Bureau Limited. (2007). Gaming and Betting Activities Survey 2006 / 07. Auckland: National Research Bureau Limited.
- New Zealand Public Service Association. (2008). Allied Health, Public Health and Technical. Retrieved January 21, 2011, from New Zealand Public Service Association: http://www.psa.org.nz/YourWorkplace/HospitalsAndHealthServices/HealthAPT.aspx
- New Zealand Treasury. (2009, November). Guidelines for Contracting with Non-Government Organisations for Services Sought by the Crown. Retrieved February 14, 2011, from http://www.treasury.govt.nz/publications/guidance/mgmt/ngo

Appendix B
Literature Review - Bibliography

- PriceWaterhouseCoopers. (2009, November 20). Review of Levy Calculation. Retrieved December 3, 2010, from Gambling Commission - Other Publications: http://www.gamblingcommission.govt.nz/GCwebsite.nsf/wpg_URL/Reports-Publications-Proposed-Problem-Gambling-Levy-(November-2009)!OpenDocument
- Queensland Department of Employment, Economic Development and Innovation. (2010b). Evaluation of the Queensland Responsible Gambling Strategy. Retrieved January 25, 2011, from http://www.olgr.qld.gov.au/resources/responsibleGamblingDocuments/Qld_Responsible_Gambling_Strategy_Evaluation.pdf
- Queensland Department of Employment, Economic Development and Innovation. (2010a, March). Problem gambling - Results from the Queensland household gambling survey Fact Sheet. Retrieved January 25, 2011, from http://www.olgr.qld.gov.au/resources/responsibleGamblingDocuments/FactSheetProblemGambling2008-09.pdf
- Queensland Government Treasury. (2002, February). The Queensland Responsible Gambling Strategy. Retrieved January 25, 2011, from http://www.olgr.qld.gov.au/resources/responsibleGamblingDocuments/RGStrategy02.pdf
- Queensland Office of Liquor and Gaming regulation. (2010, June). Responsible Service Inquiry. Retrieved January 25, 2011, from http://www.olgr.qld.gov.au/aboutUs/responsibleService/responsibleservicejune2010.shtml
- Responsible Gambling Strategy Board. (2009b). Frequently Asked Questions. Retrieved January 25, 2011, from http://www.rgsb.org.uk/faq/default.aspx
- Responsible Gambling Strategy Board. (2010, October). Responsible Gambling Strategy Board - Strategy 2010. Retrieved January 25, 2011, from http://www.rgsb.org.uk/publications/default.aspx
- Responsible Gambling Strategy Board. (2009a). Responsible Gambling Strategy Board. Retrieved January 25, 2011, from http://www.rgsb.org.uk/
- Smith, G., Hodgins, D. C., & Williams, R. J. (2007). Research and Measurement Issues in Gambling Studies. United States of America: Academic press (Elsevier).
- Statistics New Zealand. (2010, July). Consumer price index (inflation). Retrieved February 8, 2011, from Economic Indicators: http://www.stats.govt.nz/browse_for_stats/economic_indicators/CPI_inflation.aspx
- Synovate. (2008). Kiwi Lives Advertising Campaign Stage Two Concept Testing. Wellington: Synovate.
- Synovate. (2009, July). Kiwi Lives Advertising Stage Two - Campaign Effectiveness Measure and Review. Retrieved November 18, 2010, from Research Publications: http://www.hsc.org.nz/researchpublications.html
- The Quit Group. (2009). Monthly Monitoring Report - July 2009. Wellington: The Quit Group.
- The Quit Group. (2010). Quit Service Client Analysis Report. Wellington: The Quit Group.
- The Quit Group. (2010). Return On Investment in The Quit Group's smoking cessation support services. Wellington: The Quit Group.
- The Quit Group. (2010). Six Monthly Performance Monitoring Report. Wellington: The Quit Group.

Appendix B
Literature Review - Bibliography

- United Kingdom Gambling Commission. (2010). Industry Statistics 2009 / 10. Retrieved January 25, 2011, from http://www.gamblingcommission.gov.uk/pdf/Gambling%20Industry%20Statistics%202009%202010%20WEB%20-%20January%202011.pdf
- United Kingdom Gambling Commission. (2008, October 17). Review of Research, Education and Treatment. Retrieved January 25, 2011, from http://www.gamblingcommission.gov.uk/pdf/Review%20of%20research%20education%20and%20treatment%20-%20Oct%202008.pdf
- United Kingdom Gambling Commission. (No date). Who we are and what we do. Retrieved January 25, 2011, from http://www.gamblingcommission.gov.uk/pdf/Who%20we%20are%20and%20what%20we%20do%20-%20August%202008.pdf
- Victorian Auditor-General. (2010). Taking Action on Problem Gambling. Melbourne: Victoria Government Printer.
- Woodlands Centre Charitable Trust. (2010, August). Initial and Final Gambling Screens - PowerPoint Presentation. Christchurch, New Zealand.
- Woodlands Centre Charitable Trust. (2009). Statistical Information Pertaining to Woodlands Trust treatment Effectiveness for Problem gamblers 2008 to late 2009. Christchurch: Not yet published.
- Woodlands Centre Charitable Trust. (2006). Statistical Information Pertaining to Woodlands Trust Treatment Effectiveness for Problem Gamblers 2000 - 2006. Christchurch: Not yet published.
- Woodlands Centre Charitable Trust. (2010). Statistical summary of the change in the MOH Harm measure between the start of each Woodlands Trust one-day educational seminar and the 12-month follow-up. Christchurch: Woodlands Centre Charitable Trust.
- World Health Organisation. (1986, November 21). The Ottawa Charter for Health Promotion. Retrieved February 2, 2011, from http://www.who.int/healthpromotion/conferences/previous/ottawa/en/index4.html