A tale of missed opportunities: pursuit of a public health approach to gambling in New Zealand

Peter J. Adams & Fiona Rossen
School of Population Health, University of Auckland, Auckland, New Zealand

ABSTRACT

Aim This paper provides a critical overview a decade after the New Zealand Government announced its intention to formally incorporate a public health approach into its comprehensive revision of gambling legislation. Method The initial enthusiasm and the subsequent disillusionment with this approach are tracked. Four reasons for its lack of success are examined. Findings The New Zealand experiment with a public health approach to gambling is seen to have floundered in a network of vested interests. The pathways for influence included inappropriate industry input as well as community and government sector reliance on gambling profits. The new legislation neglected to set up systems for strong independent accountability, and this weakened the potential of public health initiatives. Conclusion As with tobacco control, the policy integrity of a public health approach to gambling requires close attention to ways of reducing vested interests in both government and community sectors and to establishing strong points of independent accountability.

Keywords Ethics, gambling industry, New Zealand, public health, vested interests.

INTRODUCTION

The Problem Gambling Foundation of New Zealand conference in July 2001 was an extraordinary event. Not only was each of its 3 days opened by different Cabinet Ministers, but the conference coincided with Cabinet discussions on the principles of a new Gambling Act; an Act that would provide the overarching framework for gambling regulation for decades to come. Conference organizers found themselves in the astonishing position of fielding regular phone calls from Cabinet officials regarding various aspects of the Act. On the third day the Deputy Prime Minister, Jim Anderton, announced:

We will therefore be developing a coordinated and consistent framework for all gambling modes which addresses the concerns of both the community and the gambling industry... I can indicate to you today that the Government will be adopting a public health model for problem gambling [1].

None of us had expected this announcement. Certainly, those of us involved in services had been advocating for such an approach, but past engagements had accustomed us to disappointingly weak responses from government. We sat stunned; just as stunned as the industry representatives and the ministry officials who sat alongside us. No country in the world had dared to officially declare gambling a public health issue, let alone make it a basis for policy and legislation. This announcement shook current arrangements to their core.

A brief overview of proceeding events helps in making sense of this unexpected volte face. Until the 1980s commercial gambling in New Zealand had been a low-key affair, made up mainly of non-continuous forms of gambling such as a national raffle and on-track horse betting, where there is a reasonable delay between a purchase and its outcome [2]. Then, in the mid-1980s, a series of neoliberal economic reforms ushered in an extended period of liberalization that expanded both the range and potency of gambling products: a national lottery was introduced, electronic gambling machines (EGMS—‘pokies’, ‘slots’, ‘fruit machines’) were legalized with increasing jackpots and availability, track betting was permitted by telephone, then on the internet, then internationally [3]. Shortly afterwards, in 1990, the Casino
Control of the spread of consumption has been the key aim in the strategy. This focus is consistent with the harm minimization framework which provided the base for the New Zealand alcohol and drug policy [14]: secondly, it outlined how longer-term solutions were going to require active, informed and empowered responses from communities; and thirdly, it recognized the need for political accountability that ensured responses were genuine. In a later paper [15] we described this as resembling the motion of a jaw, with harm minimization initiatives moving top–down from policy to intervention, health promotion initiatives moving bottom–up from empowered communities to managed environments and accountability initiatives seeking ways to ensure that the jaws had sufficient motive force within the political environment to bite onto its target.

TIMES OF OPTIMISM

On 12 September 2003 the new and comprehensive Gambling Act was finally passed and, indeed, four of its eight primary purposes appeared to be consistent with a public health approach: namely, ‘to control the growth of gambling’, ‘to prevent and minimise the harm caused by gambling’, ‘to ensure that money from gambling benefits the community’ and ‘to facilitate community involvement in decisions’ ([16], Section 3). A spirit of optimism spread through gambling services, concerned community organizations and some government agencies. At last we were not only going to address the needs of problem gamblers, but we were also going to tackle the whole gambling environment.

At first this optimism seemed justified. Changes in EGM regulations and smoking legislation led to the first significant levelling-off of rises in gambling consumption in 20 years [17]. Furthermore, the key agencies appeared to be undergoing major transformations. The Department of Internal Affairs, previously loose in its enforcement, became proactive and assertive in tightening-up how it monitored gambling venues, and it made progress in formulating a detailed harm minimization framework for future implementation [18]. The Ministry of Health, which for decades had dragged its feet on gambling, released a series of documents that outlined its broad commitment to a comprehensive response to gambling harm [19,20]. A number of organizations—such as Hapai Te Hauora Tapui, the Salvation Army and the Problem Gambling Foundation—undertook a range of initiatives that involved working alongside communities in raising awareness of gambling issues and in supporting ways for them to manage harm from gambling [21]. Progress was made in health promotion initiatives, community evaluation protocols, local government gambling policies and public health work-force development [22,23].

The optimism was contagious. For example, the agency charged with social marketing, the Health Sponsorship Council, described their activities as aiming to influence in both upstream and downstream directions.

Upstream changes include denormalising harmful gambling, by getting society to understand the question and issues around gambling harm, and building public support for measures that prevent and minimise gambling harms and create safer families, safer communities, and safer venues and gambling products ([24], p. 16).

In line with this, their early marketing campaigns focused on community ownership of the problem, with television advertisements and other forms of marketing claiming ‘Problem gambling: our communities, our families, our problem’.
A further key development was prompted by recognition that Māori (indigenous) and migrant populations faced specific challenges in the new gambling environment [25–28], and this led to a diverse and vibrant range of innovative projects aimed at strengthening cultural resilience. For example, some Māori initiatives focused on responding to gambling through Iwi (tribal) networks [29,30] and others by achieving an integration of public health and Māori-based approaches [31].

Accordingly, the first few years following the Act appeared very positive. Change was going to take time, but we were well on the way to being at the international forefront in developing an integrated whole-government approach to gambling.

**TIMES OF DISILLUSIONMENT**

A few years later, it soon became apparent that talk of a public health approach was struggling to translate into reality. Worrying signs were emerging that the rhetoric of change was disguising a ‘business-as-usual’ approach to industry development [32]. For example, while the Department of Internal Affairs was concentrating most its efforts on improving the enforcement of current regulations, they were making little progress with harm minimization initiatives. The Health Sponsorship Council campaigns were swinging away from community engagement and back to an individualized focus on problem gamblers (e.g. their slogan changed to ‘Choice not chance’). Most disappointingly, the Ministry of Health’s leadership of public health responses had become swamped by treatment service issues and sidelined into weakly framed prevention campaigns (e.g. their current strategic plan emphasizes ‘Government, gambling industry, communities and families/whānau working together’ [33]; see criticism [34]). Little was initiated in the way of policy or regulation changes that might address the ongoing misery still afflicting problem gamblers and their families.

Parallel to this, the gambling industries had become more organized and effective in pursuing their interests in political arenas. The casinos had positioned themselves successfully as good corporate citizens, EGM gambling was an increasingly accepted part of the entertainment terrain and community groups had grown progressively more dependent upon grants from gambling sources.

By 2008, few of the key players were speaking with any enthusiasm about a public health framework. Gone were the dreams of a whole-government, population-wide and integrated approach to the gambling environment. For those who supported gambling expansion this was too idealistic, too interventionist and too disruptive. For them it was time for a more pragmatic approach: gambling involves a fine balance of political and commercial interests. They viewed gambling as a significant force in national business activities which not only participates in an expanding entertainment industry but also returns sizeable profits to government and communities. In these difficult financial times, these contributions cannot be ignored; efforts are required to protect the source—a large part of which comes from problem gamblers [35,36].

The ultimate indicator of where matters stood occurred in June 2011, when the Prime Minister announced a deal with the Auckland SkyCity Casino in which the Casino agreed to invest NZ$350 million in a convention centre in return for a relaxation of gambling laws that would allow expansion of their gaming floors [37]. This occurred without reference to the public health purposes of the Gambling Act, thereby making a mockery of the years of effort put into its public health provisions.

Where does this leave the broader response to harm from gambling? We remain firmly convinced that a public health approach is the best way of tackling these issues. A major opportunity had come our way, but we had missed it. For the sake of future attempts, we need now to consider reasons why the opportunity passed us by.

**TIME TO REFLECT**

In hindsight, we can identify four aspects of the Gambling Act which impeded a public health approach and, acting together, doomed it from the outset.

The first mistake was obvious from the start. When the Act was being passed, in order to shore up a slim 62/52 majority in the House, late amendments were negotiated with a minor party that insisted upon, among other things, greater consultation with the gambling industry [37]. This opened the door for gambling industries to have significant input into key aspects of the ‘integrated problem gambling strategy’ ([16]; Section 318h). In particular, it obliged government officials to consult with industry leaders on sensitive areas such as research, social marketing and harm minimization initiatives. The mechanisms for such consultation were mainly through informal links, but formal processes included a consultative committee and visible representation on key panels. For example, a panel formed to review competitive bids for New Zealand’s largest research project, a repeat national prevalence study, included a leading figure in the EGM industry. Added to this, a number of government research contracts specified requirements for industry involvement and services were discouraged actively and, at times, punished for openly challenging industry practices. What emerged over time was a contrast between the government sector’s warm consultative engagement with industry leaders and either a minimal or a fractious involvement with leaders in gambling treatment or public health services.
The second mistake involved the effective separation of the different arms of a broad public health approach into different government agencies. In particular, while the Department of Internal Affairs was tasked with gambling regulation and harm minimization, the Ministry of Health was tasked with managing the broader ‘integrated problem gambling strategy’ that included initiatives such as health promotion, community awareness, treatment and research initiatives (Section 317). Despite attempts at coordinating efforts, responsibility for progress with the public health approach remained split and this, in effect, fragmented what could have been achieved by a combined group. As witnessed with tobacco control, the coordinated planning and implementation between regulatory measures, media campaigns and cessation services have played a significant role in reducing tobacco use.

The third mistake inherent in the Act concerned the way ‘benefits’ for communities were interpreted purely in terms of financial returns. This, we would argue, established the most solid and worrying obstacle to implementing a public health approach. Two of the five main forms of gambling, lotteries and EGMs, were set up to return significant amounts of money to community groups. For example, profits distributed from EGMs in bars and clubs rose from 151 million dollars (NZ) in 1999/2000 to more than 317 million dollars in 2005, approximately half of which was pumped into sports organizations [38]. Add to this another 100 million dollars (NZ) from lotteries [39]: the community sector was faced with having to absorb a sizeable amount of money. Unsurprisingly, it did not take long for many charities, sports clubs, churches, schools, arts groups and other recipients to begin viewing this funding as vital for their survival [40]. Moreover, once hooked into a long-term dependence on these profits, many recipients were transformed into active players in the gambling political arena. Their outrices could be heard far and wide whenever the slightest dips in gambling consumption led to reductions in their funding. This converted many community organizations into vociferous advocates for gambling, and they were not shy in voicing their support in the media, at select committees and within communities. Added to this, these allegiances penetrated deep into universities, research organizations, hospitals and community health services: places from which, in normal circumstances, voices of protest would be raised regarding community reliance on addictive consumptions—as occurs with alcohol and tobacco. In this way the New Zealand community landscape was transformed into a hostile environment for public health solutions, particularly solutions that might lead to reductions in gambling consumption.

The fourth and final mistake was the failure to specify a point of independent accountability to oversee the broader policy and regulatory environment. Problem gambling has the capacity to generate sizeable, easily acquired and unattached profits and, by whatever mechanisms these are managed, it is exceedingly difficult to prevent vested interests of all shapes and sizes from accumulating around points of transfer [41,42]. In New Zealand, signs of vested interests can be identified in political circles, in government departments, in community groups, in research organizations, in health services and in the media [43]. This network of interests makes it virtually impossible to locate a point of reckoning that might guard against initiatives degenerating into inept public relations exercises: token host responsibility programmes, weak harm minimization measures, disempowered community initiatives, minimally relevant research projects and gambler-blaming media campaigns [44]. However, to be fair, no country in the world that has engaged in widespread commercial gambling has found a way to address this issue adequately. Whether gambling provision is government-owned—as occurs in Canada or Sweden—or privately run—as occurs in most states of Australia and the United States—the scale of the profits from high-intensity commercial gambling has an unpleasant way of penetrating most political systems [45–47]. Some suggestions are emerging regarding ways to develop independent accountability [48,49], but in the New Zealand context this will probably require formation of a body that reports directly to Parliament—not through government ministers—and which is responsible for overseeing the integrity of all aspects of an integrated public health framework. Now, in New Zealand at least, arrangements such as this are very unlikely to occur.

THE TIME AHEAD

This cautionary tale of optimism turning to disillusion highlights how issues of vested interests and accountability can make or break concerted efforts to reduce gambling-related harm. Putting aside our disappointment, it is still reasonable to expect that other countries will seek to move beyond the addicted consumer and to develop overarching frameworks for addressing challenges in the wider gambling environment. We have watched how a broad and integrated public health approach can make significant inroads into reducing harmful tobacco and alcohol consumption [50,51]. It makes sense to apply what has been learnt here to gambling.

Added to this, gambling is faced with different challenges to other addictive consumptions. Its global expansion is more recent, so public awareness of its potential...
for harm tends to be low [52]. Harms are also difficult to quantify, both because they are actively concealed and because they occur within the privacy of personal lives and intimate relationships [53]. Consequently, gambling, as an international concern, has yet to register in global forums such as the World Health Organization. Most importantly, gambling is an activity that revolves entirely around transfers of money and, as such, its profit-generating capacity puts it into a league all its own [54]. A large proportion of these profits are derived from addicted consumers without requiring investment in the development and distribution of an agricultural product—as with alcohol and tobacco. Moreover, most products—particularly EGMs—possess considerable leeway in the way contingencies can be manipulated to maintain addicted behaviour. For skilled operators, this level of control opens up the prospect of returning escalating profits.

It is this yield that will pose the most difficulties for those nations in the process of bedding-down high-intensity commercial gambling. Once governments and communities become vested in the profits from gambling, in the absence of some form of strong and independent accountability, well-intentioned public health strategies will gravitate towards token and superficial programmes that give the impression of addressing issues but in reality cover up and disguise the true extent of harm from gambling.

Declarations of interest

The authors did not receive funding support for this work and, to their knowledge, have no relationship to any other activity that benefits directly from alcohol, gambling and other dangerous consumption industries. The authors have participated in research teams funded by a government-administered levy on gambling.

References

prepared for the Problem Gambling Foundation of New Zealand; 2005.


44. Adams P. J. Ways in which gambling researchers receive funding from gambling industry sources. Int Gambl Stud 2011; 11: 145–52.


