

CHAPTER 1

A PUBLIC HEALTH PERSPECTIVE

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One might question the need to have a chapter on public health in a book on the treatment of problem gambling, since treatment and public health are really two quite different enterprises. It is important, therefore, to state at the outset the aims of this chapter. They are to:

- inform those working in the treatment of gambling problems about the public health dimensions of gambling;
- describe how public health practitioners in New Zealand, who believe themselves to be at the cutting edge internationally, are beginning to do their work;
- foster an appreciation on both sides (treatment and public health) of the work done by each other.

The chapter begins with an overall consideration of what public health is and how it is interpreted in a gambling context. It then looks at basic ‘data’ used when taking a public-health-as-it-applies-to-gambling (PHG) approach – the overall health and well-being and societal scene with regard to gambling in New Zealand. Consideration is then given to current PHG action there. Following that an International Charter on Gambling is briefly discussed, since it has a strong public health component and is being spearheaded in New Zealand. Finally, the relationship of PHG to clinicians is considered briefly.

What is a public health approach to gambling?

In essence, a public health approach is about seeing health and well-being issues in their larger context and, as required, designing interventions that suit this ‘big picture’ approach. There are two broad levels.

The first is what could be called the ‘macro’ or ‘overview’ level, which involves a ‘bird’s-eye’ view of a field. With regard to gambling, this could involve statistics about usage, numbers of poker machines in different

regions, overall numbers of problem gamblers going through services, and so on. Often the action associated with this type of public health involves policy development. This dimension can also include a general overview of the service sector.

The second level could be called ‘meso’ or middle in its scope, with a focus on real people in their living contexts – for example, being aware of the family and cultural realities of people’s gambling, organising community action groups to lobby local authorities about poker machine outlets, or developing educational programmes for schools. Here the action tends to be more of an educational or community development nature, and is more concerned with localities or specific interest groups.

The macro view

With regard to the ‘macro’ view of public health, what is the scene with regard to gambling and problem gambling in New Zealand? Much of this information is probably familiar to clinicians, but it is this kind of information that PHG uses as the basis of everything it does.

In little more than a decade, gambling has increased more than tenfold in New Zealand. This increase is mainly associated with poker machines, which became legal only 14 years ago. Most damage done by gambling today is associated with poker machines. In 2001, New Zealand was reported as having “the fastest growth rate of licensed gaming machines per capita anywhere in the world” (Adams, 2001). This increase has continued at accelerating rates since then, although the 2003 Gambling Act has resulted in some reduction in the rate of increase.

There are huge amounts of money involved, with both the industry and government profiting from gambling, which makes it difficult to take meaningful action about the impact of gambling in society. In 2002/2003, New Zealanders spent \$11,600,000,000 on gambling, and lost over \$1,800,000,000 to gambling – almost unimaginable amounts of money to go out of people’s pockets, especially those of the poor, who are the biggest consumers. The Ministry of Health has estimated that the annual impact of problem gambling on health and quality of life could be as much as \$1.06 billion (Ministry of Health, 2004). By this author’s calculation, the New Zealand government is receiving direct and indirect benefit of around a billion dollars annually from gambling, but is paying out around \$1.5 billion for its health and social consequences (see Brown & Raeburn, 2001).

In 2002/2003 6,000 new cases were referred to problem gambling services. According to the records, 80% involved problems associated with poker machines. In December 2003, there were 26,868 machines in 2,137 locations, including the Chatham Islands and Great Barrier! This is one machine for every 116 people, close to Australia's record 1:110 (cf. USA's 1:400).

Both the government and the industry would have us believe that problem gambling afflicts only a very small proportion of the population. In Abbott and Volberg's (2000) population survey, less than 2% of the adult population reported having a current problem, although up to 3.9% reported having had a problem with gambling at some stage. The authors say that these findings are probably conservative, a view shared by most experts who have looked at the research. Some British research indicated that perhaps up to 7% of the adult population have or have had a gambling problem (GamCare, 1998) and, as reported below, the rates for adolescents may be more than that. (There are issues, of course, about how 'problem gambling' is defined.)

For every problem gambler, there are many more people affected negatively by gambling. This estimate varies between five and seven people per problem gambler (Australian Productivity Commission, 1999; Ministry of Health, 2004). Using the last census data (2001), if problem gambling is put at a conservative 2% of the adult population, and the estimated number of people affected by each problem gambler at a conservative five, 336,000 New Zealanders would be negatively affected by gambling. The actual figures could easily be double that.

These data are based on the adult population. There is current research which indicates that young people may have considerably higher problem rates than adults. Research in Alberta, Canada, found that of 12-17 year olds, 15% were 'at risk' from gambling problems, and 8% were problem gamblers (Alberta Alcohol and Drug Abuse Commission, 2001). New Zealand research is even more startling. Sullivan (2001, September) found in a small study of Auckland schools that perhaps up to 22% of students may have gambling problems. And at present it is not known whether these problems will disappear in adulthood, since they can disrupt crucial developmental processes.

It is not just youth who are endangered, but also a number of other groups who are of considerable political and social interest. These include Māori, Pacific and Asian populations, those on low incomes, and older

people. Māori and Pacific people are particularly at risk, with both groups being disproportionately represented in clients to treatment services. In 2002/2003, 26% of new clients were Māori, and 7% were Pacific people. The Problem Gambling Foundation has a whole Asian team working on gambling problems – even though gambling is part of Asian culture, it seems to have proliferated among recent migrant groups.

Gambling can have devastating effects on both individuals and families, as those working in the clinical area well know. These effects include family breakdown, debt, crime, the further impoverishment of already poor people, depression, suicide, and physical health impacts.

In addition to the direct negative impacts of problem gambling on people and their families, there are more general societal effects which are of concern. There is not space to cover these fully here. However, it is worth emphasising that since our New Zealand PHG action is focused on communities, the impact of gambling on communities can be quite severe. An example of this is the negative economic effects of poker machines on regional communities, from a study conducted in Victoria (Pinge, 2001). And since it is those on lower incomes who spend most on poker machines, the amount of poverty driven by this phenomenon must be of concern. There are also the distorting effects on community life of increasing amounts of leisure time and community funding coming from poker machines. On a wider scale, what does it say about our societal values when so much of our energy is put into chasing after money in this way?

Obviously gambling, especially the damaging form associated with poker machines, is a major new public health issue in our society. Effective public health action is needed to deal with this. The next section looks at what has been done with regard to this recently in New Zealand.

The overall model for public health action in gambling

New Zealand appears to be the first country in the world to adopt an explicit public health approach to gambling. This gives us the opportunity to design effective systems. In this section, the overall model developed so far for public health and gambling is briefly presented, and in the following section a description is given of recent work being done in the area.

Historically, traditional public health grew out of the need to control infectious diseases such as TB and smallpox, and more latterly, non-

communicable diseases such as cardiovascular disease and cancer. In more recent times, there has been ‘the New Public Health,’ as represented by the 1986 Ottawa Charter for Health Promotion. The New Public Health tends to emphasise the social determinants of health, such as poverty, ethnicity, employment, prejudice, housing, education, a state of peace or war, government policy, community well-being, and so on. In New Zealand, the Treaty of Waitangi is also seen as a central document in this context.

The scope of modern public health has moved beyond physical health to include mental health, well-being, and quality of life (e.g. Ellis & Collings, 1997; Ministry of Health, 2002). The attempt to apply the public health concept to gambling is an extension of this trend, and is quite recent (Korn & Schaffer, 1999). Indeed, in New Zealand ‘public health’ funding has only been available in the gambling area for the past year or so, although a certain amount of ‘health promotion’ activity has occurred for some years.

This author has argued elsewhere that PHG consists of two complementary and equal sectors of activity: health promotion and harm minimisation (Brown & Raeburn, 2001). Health promotion is a ‘people-centred’ and ‘bottom up’ enterprise, where people are empowered to acquire their own knowledge, skills and political influence so that they can have a measure of control over their own futures with regard to gambling. The aim is the development of ‘resilience’ or strength with regard to the powerful forces of gambling in society. Harm minimisation, on the other hand, is more ‘top-down’ and imposed. It relates to policy, regulations, warnings on poker machines, licensing restrictions, monitoring of activities, and so on, which are part of government’s and others’ responsibilities to ensure a safe and healthy environment with regard to gambling.

The Te Ngira approach to public health action

In 2003 this author had the opportunity to work with Ruth Herd of Hapai Te Hauora Tapui Ltd on a partnership contract to the Problem Gambling Foundation and Hapai, to produce a national work plan for public health workers funded by the Problem Gambling Committee – the first such workers in the world. This project involved consultation with both mainstream and Māori providers, and collaboration with Pacific and Asian providers and workers. The resulting document is called *Te Ngira*:

Gambling and Public Health – A Workplan (Raeburn & Herd, 2003). The Māori word *Te Ngira* in the title means ‘needle,’ and comes from the first Māori king, Potatau Te Wherowhero, whose vision was of multicoloured threads through the eye of a needle, representing different cultures working both independently and together in a common enterprise. The central tenet of the *Te Ngira* document was to put such a cultural vision at the forefront, which included acknowledging the critical role of biculturalism and a Treaty-based perspective.

One of the stated objectives of the contract for the work plan was to find a common approach for public health workers throughout New Zealand. This requirement obviously had to be balanced against the commitment to cultural self-expression implicit in the *Te Ngira* philosophy. The four main cultural groups involved in this exercise – Māori, mainstream, Asian and Pacific – achieved broad agreement on a basic operational model for going about this work. This is called the ABCDE approach, where A = Awareness-raising, B = Building networks and coalitions, C = Community development, D = Developing resources, and E = Evaluation.

The ABCDE approach was initially developed and trialled following the appointment of five public health workers to the Problem Gambling Foundation of New Zealand (PGF) in early 2003 – two Māori, one Pacific, and two European. These workers chose the title Health Promotion Advisor (HPA) for themselves, which reflects the domain they emphasise.

The first action taken by the HPAs was to choose several Auckland communities with which to work. The ABCDE model is now being applied in these communities. The first step, awareness raising, has involved HPAs contacting people with an interest in gambling in a given community, and meeting with them to inform them about gambling and its impacts, using much the same kind of information that was presented at the beginning of this chapter. Through networking processes, in due course a hui or community forum is held in that community, which major stakeholders and community people attend. This leads to the setting up of action groups to address local issues. Some of the first of these related to the new gambling legislation, where local authorities were required to consult with communities about the number of poker machines in venues. This shows that communities can have direct input into policy processes, and one of the aims of the ABCDE model is to foster community input into advocacy and policy – aspects of harm minimisation.

The next stage, C, is a more formal process of community development, with the aim of action groups moving towards setting up ongoing community-run projects to provide a better gambling environment, and a sense of control by that community over its gambling future. These projects are based on 'needs assessment' by the community of what the community wants for itself. The community development process, which is quite complex and takes a degree of skill by HPAs to facilitate, is based on the PEOPLE System. The PEOPLE System (where PEOPLE stands for Planning and Evaluation of People-Led Endeavours) has been widely used in New Zealand as a systematic planning model for community-controlled health promotion and development projects, and appears to have wide inter-cultural acceptance. Its theory and application is described more fully elsewhere (Raeburn, 1992; Raeburn and Rootman, 1998). The PEOPLE System provides a strong basis for sustainable self-determined community projects, and will hopefully lead to communities around New Zealand becoming capable of managing their own affairs and building capacity, with regard to gambling, in a way that is satisfying to them.

The D stage of the of the ABCDE model, developing resources, is aimed at capitalising on the learning of the early work of the HPAs, so that manuals and resources can be developed to help others to operate in a similar type of way if they wish to.

The final step in the ABCDE model, evaluation, is being undertaken in a variety of ways, mainly based on a goal attainment approach. Not only does one want community action to work, but it also needs to be sustainable, and the evaluations are designed to assess and support this. To date it is clear that communities are responding well to the process described here. It is also clear from this work that gambling is a latent but powerful issue of concern in these communities.

As stated, the Te Ngira approach seems to be acceptable across cultures, with Māori, Pacific, Asian and European HPAs all using it constructively. It is also seen as generally applicable across New Zealand by HPAs in centres other than Auckland, although some local variation will be required. Overall, the ABCDE and PEOPLE System approaches provide a simple and systematic framework for action, have a degree of self-evident common sense about them, and provide considerable room for creativity, cultural adaptation and local variation.

The International Charter on Gambling

As mentioned, New Zealand appears to be at the forefront of a public health approach to gambling. One manifestation of this was the staging of an international conference in Auckland in 2003 entitled ‘Gambling through a Public Health Lens,’ the first such conference in the world. This conference took the opportunity to go forward with an idea that had been simmering for some years, namely producing an international charter on gambling, mainly as an instrument directed at governments to point out their duty of care towards their citizenry with regard to gambling – the New Zealand government is by no means the only one getting significant revenue from gambling. The draft of a charter, provisionally named ‘The Auckland Charter,’ was presented at the conference and workshopped by participants. (Ngati Whatua, the tangata whenua of Auckland, have agreed to name the Charter in due course, so the present name is temporary.) The draft was based on work done previously by Peter Adams and Ralph Gerdelan, who took a harm minimisation approach, but it was expanded prior to the conference to include a health promotion dimension as well. It therefore reflects the model of public health for gambling written about in this chapter. A post-conference version of the Charter now exists, and the intention is that it be further worked on, especially from a cultural perspective, around New Zealand, and then taken to ‘the world’ – a process that may take some years.

The relationship of public health to clinical work

This is a topic that deserves a chapter in its own right. In essence, there seem to be a number of ways of looking at this. One is that public health workers and clinicians see themselves in partnership, and in particular as looking for areas of collaboration; for example in the area of early intervention. A second is for clinicians to see their work in a larger public health context. That is, clearly public health matters like legislation, access to poker machines, impacts on community economies, cultural effects, family impacts, community support systems, school programmes, and so on are very relevant to clinical work. A third aspect is that, especially in more rural areas, some ‘sole charge’ clinicians will have to do both clinical and public health work. Relevant to these considerations are the training systems available to clinicians in the gambling area, and this would seem to be a matter requiring urgent attention.

Conclusion

Public health as an identified practice in gambling was barely a year old when this chapter was being written. It will clearly evolve as time goes on, and the advent of the Ministry of Health's taking over the funding of public health and gambling in mid-2004 may change the landscape again. However, together with efforts going on in other quarters with regard to the harm minimisation aspect, there is reason to believe that there is a sound and innovative base for PHG thinking and practice already well in place. And so far public response seems to be favourable.

This chapter on public health and gambling was written for those concerned with the treatment of problem gambling. In the past there has been a feeling among at least some clinicians that public health and health promotion are difficult matters to relate to. I hope this chapter dispels any such feeling. The belief of this author is that treatment and public health are two essential and complementary aspects of the public good enterprise related to gambling, and that those working in each area stand to benefit greatly from one another, in an atmosphere of respect. It is not a matter of 'two solitudes.' Rather, it is a matter of two vitally important enterprises working together synergistically to help make a better world. If what is written here can contribute, then its mission has been successful.