Gambling, Prevention and the Statutory Levy

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Disclosure of interests

- HW has received funding for gambling from the Economic and Social Research Council, National Institute for Health Research, Wellcome, Gambling Commission (including regulatory settlement funding), Department for Culture Media and Sport, various Local Authorities (Greater Manchester Combined Local Authority, Middlesborough Lambeth, Blackburn with Darwen) and the Office for Health Improvement and Disparities. In 2018/19 HW worked on a project funded by GambleAware on gambling and suicide.
- CB has received funding from the Economic and Social Research Council, National Institute for Health Research, British Academy, Blackburn with Darwen Local Authority and Department for Culture Media and Sport to study gambling.
- GR has received funding from Economic and Social Research Council, National Institute for Health Research, British Academy. In 2017/18 GR worked on a project funded by GambleAware on gambling and advertising
- Disclosures for attendees: the majority of attendees had nothing to declare. Some (n=5) were in receipt of regulatory settlement funding. Two were in receipt of funding from a single philanthropic funder.

Commissioning context and disclaimers

- Between October and December 2023, the government issued a public consultation on various issues relating to the potential implementation of a Statutory Levy on gambling companies to fund research, treatment and prevention.
- In January 2024, the policy team leading the review of this consultation at the Department for Culture Media and Sport (DCMS) contacted Professor Wardle to discuss the possibility of colleagues at the University of Glasgow supporting further engagement with key stakeholders on prevention. Prof Wardle, Reith and Bunn (the team) suggested that a series of workshops with different public health-related stakeholders would be an efficient method to gain additional views within a short period of time.
- DCMS funded the Glasgow team to prepare, facilitate and report on findings from these workshops. The following report summarises the main themes which emerged from these workshops.
- The views represented in this report are those of the report authors. They do not represent the views of DCMS and do not reflect the government's policy position.

What was the scope of the project?

- To consult with a range of public health and related community stakeholders to:
  - ➢better understand existing funding mechanisms for prevention activity across similar public health areas;
  - ➢document the advantages and disadvantages of these approaches, and to;
  - ➢understand what public health experts believe a strong system for gambling prevention should look like, given the opportunity afforded by the Statutory Levy.

Methods

1. Third Sector and Civil Society

9 attendees:

3 representatives from groups with lived experience of gambling harms;

2 gambling reform agencies;

2 smoking civil society/prevention organisations;

2 alcohol civil society organisations

2. Local government

8 attendees:

2 from North West

2 from North East

1 from North – general

3 from London

3. Academics

8 attendees:

2 from tobacco

2 from drugs

2 from alcohol

1 public health (general)

1 from suicide prevention

4. Regional and national governments

7 attendees:

2 from Scotland

2 from Wales

1 from England

2 cross national

- Four consultation workshops held with different stakeholder groups.
- 32 participants
- Groups lasted between 1 to 1.5 hours
- DCMS staff attended in observer capacity
- Meetings recorded with permission and transcripts analysed to identify common themes and recommendations.

Key observations*

"the place to do prevention is in Parliament; it is in legislation; it is in regulations"

"it's not a leisure activity…it needs to be regulated as a health harming commodity"

"the industry has had too much influence in the past on this [prevention] for gambling"

"[a prevention system] has to be independent and what's really important is that it can speak truth to power"

"We must set expectations and right from the beginning say, '*this [the levy] is peanuts. It will make very little difference*' … but there are cheap, cheap legislative evidence-based levers that are available, if a government is willing to think that way."

"It's not [DCMS's] expertise…responsibility needs to be with the part of the system that is responsible for health."

*Select quotes from workshop participants illustrating common themes across the groups

The challenge

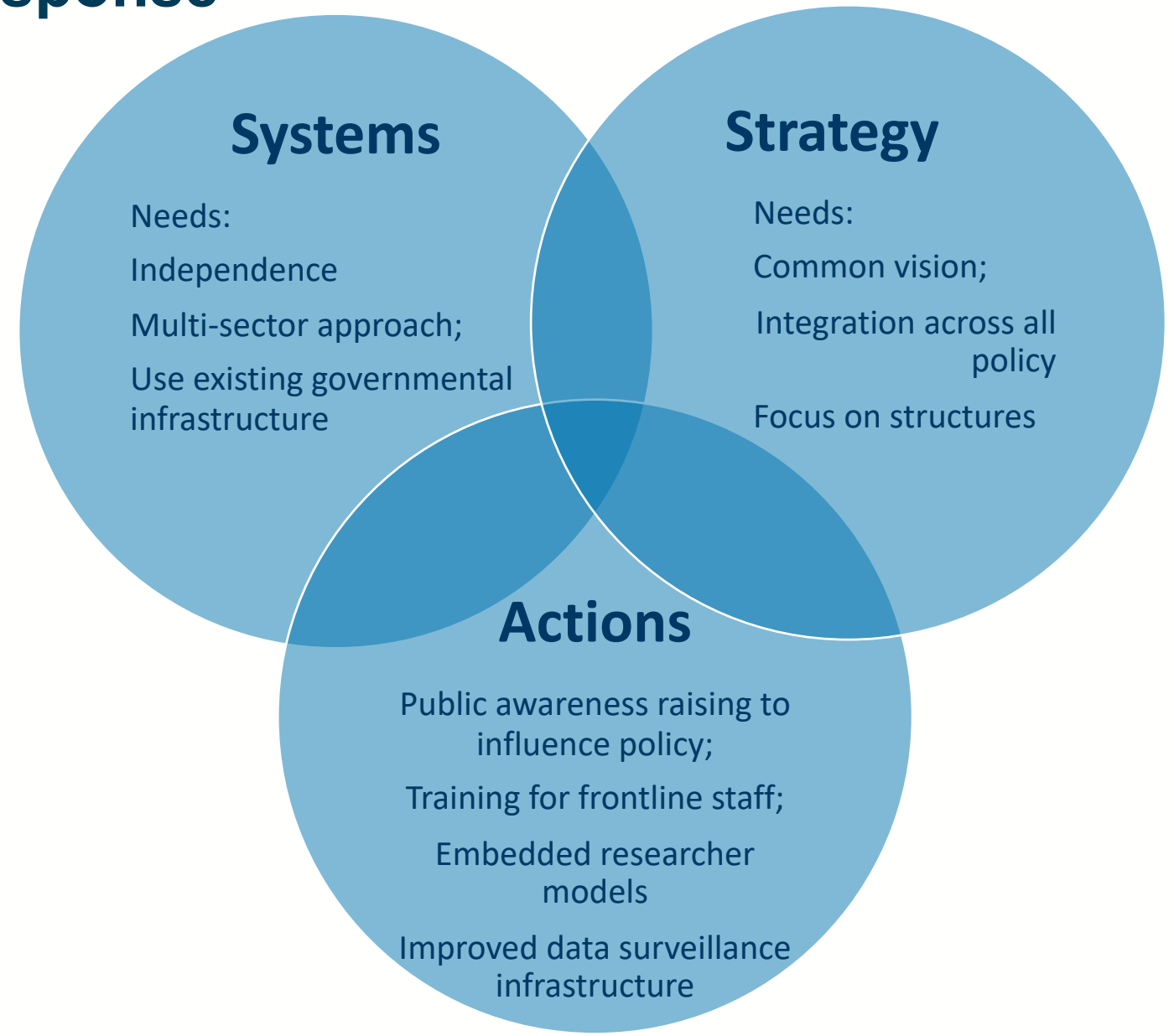
Effective prevention requires:	The White paper contains:
Strong range of upstream interventions focusing on commercial practices	Limited upstream interventions; greater focus on industry-led prevention
Restrictions on products and how products are promoted	Limited restrictions on products and their promotion
Clear focus on primary objective of protecting health	Dual focus on protecting the vulnerable and aiming to permit and grow the industry

An unresolved tension:

A prevention strategy to mitigate harms will lack efficacy if the underlying political basis and legislative framing does not support the implementation of measures most likely to be effective. This tension limits what the Levy can reasonably expect to achieve with respect to prevention.

The pragmatic response

There was widespread recognition that the current policy environment is not optimal for a fully realised public health prevention strategy. However, it was also recognised that there is an opportunity to start building towards this ambition, using the Levy to implement stronger, robust and independent systems and to start work in some priority actions areas whilst a more comprehensive and commonly-held Prevention Strategy was developed. The features of the systems proposed and the priority actions can be implemented now. In turn, they may generate impetus for political and policy change over the medium to longer term.



Primary recommendations: Systems

Systems

Ensure Independence

- Prevention strategy and its implementation needs to be designed and delivered by those with experience and competence in this area.
- Industry and those affiliated with industry should have no role in the development of the prevention strategy
- Prevention, policy and research needs to be insulated from industry influence.

Integrate multi-sectoral approach

- Health and social care professionals, third sector, researchers and all tiers of government need to be active in an effective prevention system
- At local levels, Local Authorities have experience and competence for multi-sector working both within local government and working with local community partners
- There are examples of effective regional multi-sectoral partnerships; though recognitions that all LA do not operate at the same pace.

Use existing governmental infrastructure

- There are existing governmental infrastructure and processes for the delivery of prevention activity in public health. Gambling should be integrated **within** these systems. This includes; local and regional activity organized through the Public Health grant (funds could give a ring-fenced supplement to the PH grant in priority geographical areas (see Smoking Cessation funds); or have opportunities for regional consortium bids drawing on models such as the Health Action Zones) and/or national activity led by organisations with competence for prevention delivery (i.e., DHSC/OHID, Public Health Wales, Public Health Scotland; recognizing that systems differ across Scotland and Wales to England) and partnership working with NIHR and other research councils to integrate research, prevention development and evaluation.
- Concerns that significant proportion of levy could be swallowed by costs of setting up new bureaucracy.

Primary recommendations – Immediate Actions

Immediate actions

Training for frontline staff

- Mobilise large network of existing frontline health and social care and range of other professionals (i.e. criminal justice etc) who intersect with the public by training them to identify and intervene to prevent gambling harm.
- Engage independent third sector, local government and researchers to develop and/or scale existing gambling harm prevention training packages.
- Have national co-operation and oversight to ensure consistency of key messages

Awareness raising

- Increase knowledge and understanding of gambling harms and how they are generated among the public through wide-ranging and co-ordinated awareness raising initiatives.
- This is a longterm route to more substantial change – build public support for legislative level prevention measures, increasing political will.

Embed research

- A reflexive and dynamic relationship between prevention activity and research is needed, with fast feedback loop where evidence generated as prevention is implemented.
- Embed researchers 'at the coal face' to work with health and care professionals, treatment providers and service managers to rapidly develop evidence and practice that supports gambling harm prevention. Draw on existing models for doing this, such as the NIHR School of Public Health model

Improve data infratructure

- Better data and data infrastructure is needed to drive evidence-based prevention. This includes developing systems for monitoring and surveillance of gambling across a range of functions. Should look to examples for alcohol and drug reporting to emulate. Levy funding could start to develop this system.
- Access to industry data, without compromising independence, needs to be prioritised.
- Coroners should uniformly implement a mechanism for recording gambling involvement in suicides.

Primary recommendations – Strategy

Strategy

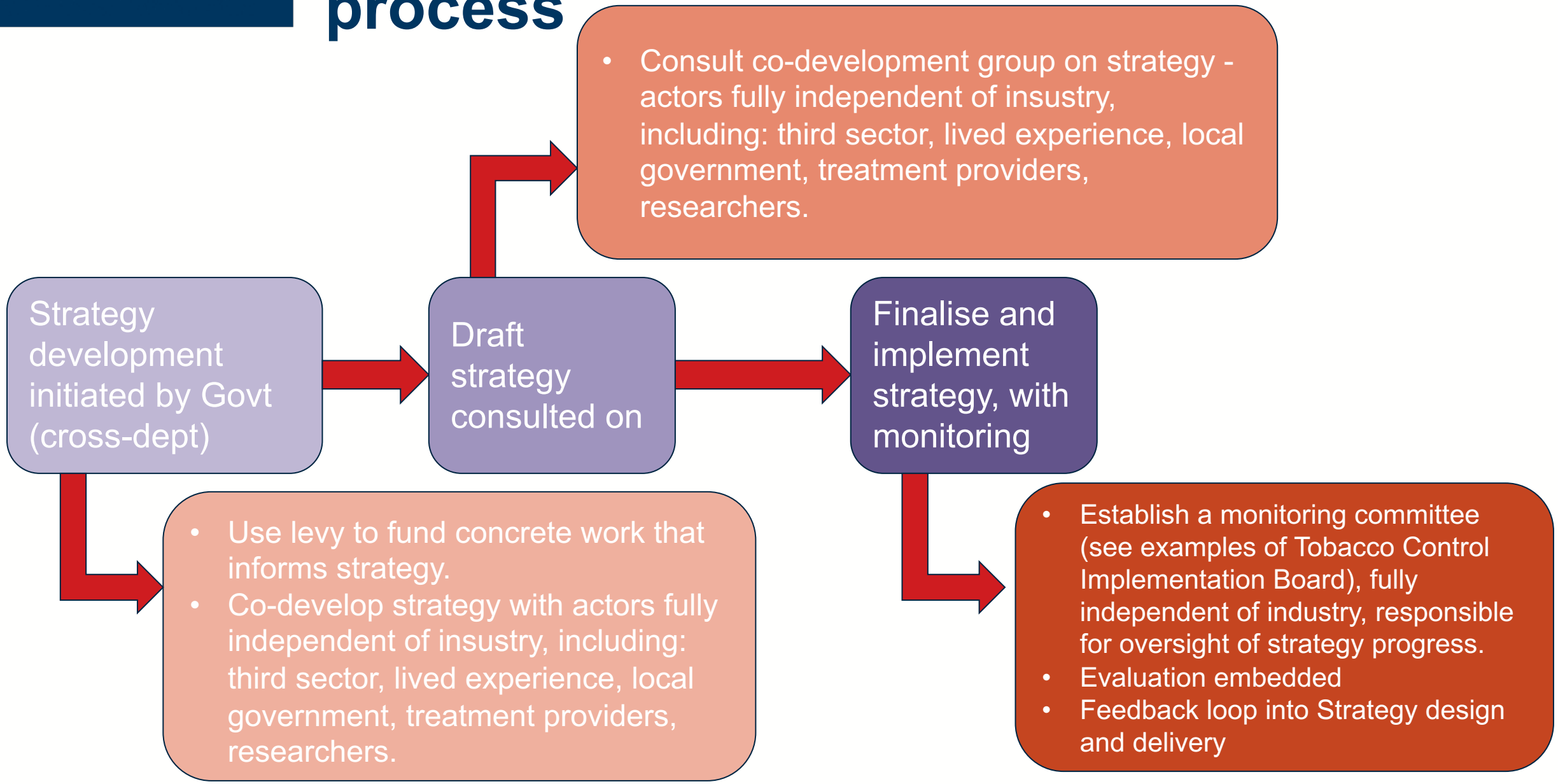
Vision	• Prevention strategies work best when there is unity of vision and purpose. • Vision needs to be clearly articulated and co-developed by a multi-sector, independent, community which is invested in gambling harm prevention. • There needs to be common goal so that everyone involved in the system knows they are working towards. • This strategy needs to be underpinned with clear understanding on how different activities contribute to strategy delivery with clear articulation of the short term, medium term and longer-term outcomes that mark progress towards success. • Fora for developing this community are important e.g. through cross-sector knowledge exchange conferences
Govn owned	• Government ownership of strategy by departments with competence for health, with co-ordinated working with devolved governments to achieve common ambitions
Integrated provision	• Gambling prevention should be integrated across all relevant policies at local and national levels. Gambling should not be siloed but built into working practices of a wide range of professional specialists. • A gambling harm prevention strategy needs to integrate horizontally – across sectors – and vertically – from national to local – with bi-directional flows of information and resource. • Potential model: regional tobacco control managers who monitor locally but also have systems of national level data reporting.
Wider determinants	• A gambling harms prevention strategy needs to be aligned with efforts to address wider determinants of health e.g. poverty, precarious employment, other forms of harmful consumption.

What matters for developing a successful gambling harm prevention strategy?

Government owned prevention strategy outlining common vision and goals

- Independence from industry
- Primary ownership with health departments but need cross-departmental buy-in for success (as exemplified by alcohol tax initiatives)
- Co-ordination and co-operation with devolved governments to have common goals and aligned working (as exemplified on smokefree generation work)
- Need multiple policies at multiple levels which generate synergistic effects. Education in isolation will not be effective.
- National strategy ownership embedded within existing local delivery mechanisms (i.e., relationships with local government, health boards etc; exploring existing mechanism through the Public Health Grant and ring-fenced supplements, like smoking cessation grants or Scottish/Welsh equivalents).

Strategy development: suggested process



Immaturity of existing system: what actions are needed now to build better systems and strategies going forward?

Immediate actions

- Training of professionals on gambling harms
- Awareness campaigns for gambling harms and how industry works
- Local area action (equivalent to Health Action Zones or Scottish/Welsh equivalents) to start to build practice and knowledge
- Embedded researchers models to improve the quality and quantum of evidence and insight
- Invest in building community of civil society engagement
- Prioritise getting better data e.g. mandatory coroner reporting; greater access to and scrutiny of industry datasets

leading to

part of strategy to:

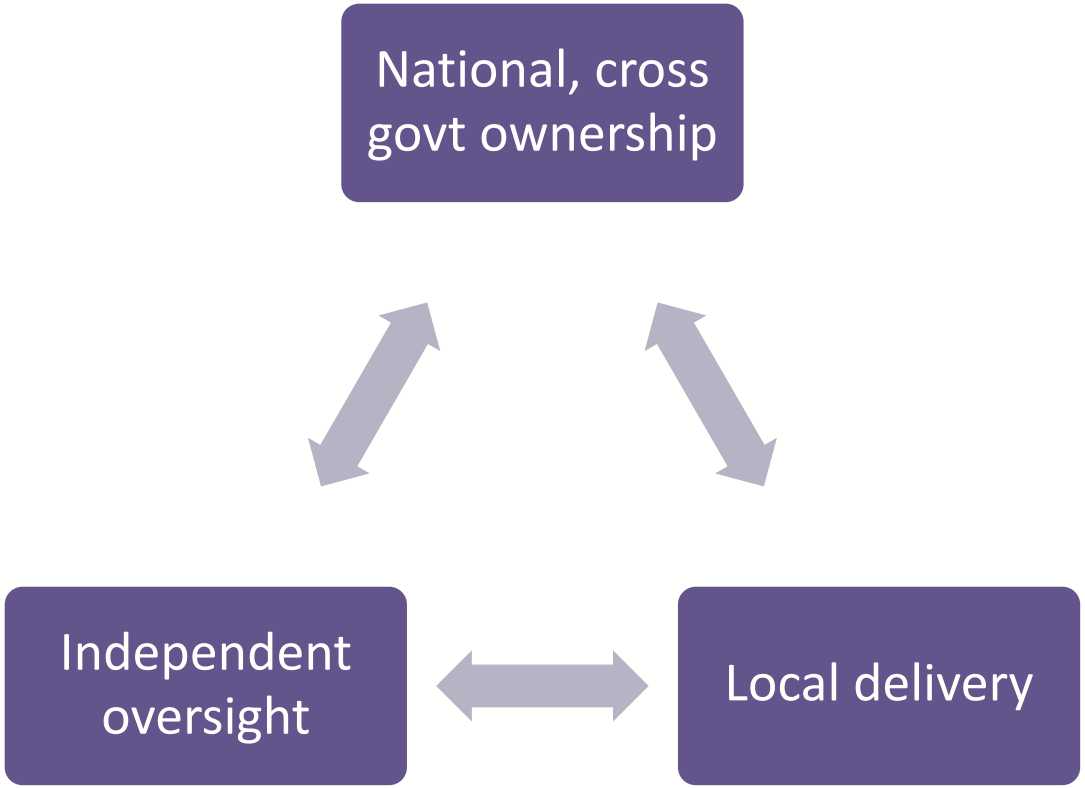
Longer term ambitions

- Increase awareness among professionals which builds support and requirements for joined up data monitoring systems
- Increase public awareness generates impetus for policy action, where prevention is in parliament
- Evidence from local area action supports widespread roll out and embedding gambling prevention with resource dedicated to producing this
- Civil society organisations act as conduit for knowledge translation and focus for accountability (see models such as Action on Smoking and Health, Alcohol Health Alliance).
- Improved surveillance data builds case and evidence for greater action

Challenges and opportunities

- **Quantum of funding:**
  - Recognition that quantum of funding currently anticipated unlikely to deliver meaningful results.
  - **Solutions?**
    - In short term, focus allocation based on need to achieve some results.
    - Develop sustainable exemplar projects and build capacity
    - Supplement prevention funding with regulatory settlements to boost quantum
- **Legislative levers currently unavailable:**
  - Working within a system where the major prevention levers are unavailable – even more so with gambling being reserved issue
  - **Solutions?**
    - Map local and regional level levers that could be implemented; draw on examples of local awareness campaigns (like North East Balance and alcohol harms campaign); training for professionals; embedding awareness and screening; national awareness campaigns to build public support for action – including focus on industry tactics.
- **Local authorities do not have enough oversight:**
  - Local authorities do not have contractual oversight of gambling harm prevention activity and are unable to co-ordinate efforts, except where delivery organisations choose to share information
  - **Solutions?**
    - Require all Levy funded activities to report scope and outcomes of work to local authority public health teams (or Scottish/Welsh equivalents)

Build from existing systems: Nationally owned; locally delivered; independence in oversight



Local authorities (or Scottish/Welsh equivalents) are best placed to co-ordinate localised and community prevention, with **vast experience** and systems from tobacco, drug and alcohol work. They need to be **empowered** to oversee prevention in their localities, supported by national (and devolved) government frameworks, and **independently monitored**. Civil society/third sector are essential for steering and delivering both localised and independent prevention.

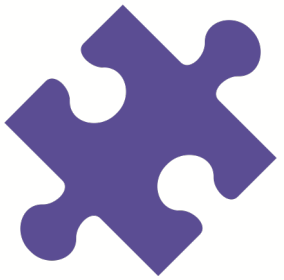
Key points

Counter

Powerful industry perspectives to ensure a truly independent system

Balance

Recognise that a fully realised public health prevention approach is not possible within current legislation but pragmatic steps can be taken now to improve systems and implement foundational actions



Join-up

Generate multi-sectoral approach to gambling prevention and research, embedded within working practices across local and national government levels, aligned around a common purpose

Thank you!

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