Gambling and health: uncomfortable bedfellows
Max W Abbott

Gambling has been a leading growth industry for 20 years, particularly in countries such as New Zealand where electronic gaming machines (EGMs) and urban casinos were widely introduced.\(^1\) Approximately NZ$2 billion was spent (lost) in New Zealand on major forms of gambling last year—$5.5 million per day.

Like alcohol, gambling is Janus-faced. Among other things it deals entertainment, pleasure, companionship, distraction, and dreams with one hand. And it dispenses financial ruin and a trail of personal, family, and social devastation with the other.

No comprehensive cost-benefit analysis of gambling has been undertaken in New Zealand. Studies elsewhere weight health impacts (on the cost side of the equation) heavily, particularly those related to problem gambling. Like gambling, problem gambling has a long pedigree. It is graphically portrayed in novels by Dickens and Dostoevsky. However, it was not until 1980 that ‘pathological gambling’ entered the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-III).

Although having features in common with substance dependence and misuse, pathological gambling is classified as a disorder of impulse control.

Essential characteristics of pathological gambling include:

- A continuous or periodic loss of control over gambling.
- A progression, in gambling frequency and amounts wagered, in the preoccupation with gambling and in obtaining moneys with which to gamble.
- Continuation of gambling involvement despite adverse consequences.

Adverse consequences occur in many spheres—mental and physical health, family and interpersonal relationships, work, education, and recreational pursuits. Because money is the primary currency of this ‘addiction’, financial hardship and ruin are commonplace, as is criminal activity to finance gambling and gambling debt. In New Zealand prison surveys, 15% of males and 26% of females report offences of this type.\(^2,3\)

The first (1991) New Zealand gambling survey estimated that 0.9% to 1.6% of New Zealand adults currently experienced serious gambling problems (probable pathological gamblers).\(^4\) A similar number had less serious problems. Males, young adults, and marginalised groups (Maori, Pacific, unemployed, low income) had particularly high prevalence rates. Few reported seeking help. Those who did turned to friends, family members, and Gamblers Anonymous.

A second national survey was conducted in 1999.\(^5\) Since 1991, casinos had been opened in Christchurch and Auckland, EGM numbers increased markedly, and total gambling expenditure doubled. A national gambling helpline was established (1993) and counselling services developed (from 1994) in major centres.
Contrary to expectation, the 1999 study did not find a prevalence increase. While Māori and Pacific people remained at high risk, the profile of problem gamblers had changed.

In the investigators’ words, problem gambling “had aged, feminised, and gone a bit upmarket.” A substantial increase was found in help-seeking. Informal sources remained important, but almost as many consulted specialist gambling services, health professionals, and alcohol and drug services. Nevertheless, most did not seek help of this type, including those with serious problems.

Since 1999, four more casinos have been established, EGM numbers further increased and additional forms including Internet gambling introduced or expanded. Total gambling expenditure has again doubled. What is the impact of this on problem gambling and related gambling harms?

Before returning to this question, it is worth noting that New Zealand was the first country to conduct a national problem gambling survey and develop nationwide problem gambling services. It has retained its pioneering role with the Gambling Act 2003. This far-reaching legislation arose out of concern about loose control in the gambling environment and gambling-related harms. It places gambling within a public health framework and seeks to contain growth and minimise harm. Implementation is the joint responsibility of the Department of Internal Affairs (regulation) and the Ministry of Health (prevention, treatment, research, and evaluation).

From 1999 to 2003, strong growth continued in specialist gambling service consultations. However, in 2005, new helpline callers reduced by a third; and new counselling clients by a fifth. Reasons are not established, but the Gambling Act 2003 and Smokefree Environments Act 2004 are probably implicated. Gambling expenditure, particularly on non-casino EGMs, also decreased for the first time. Similar changes occurred in Victoria, Australia following the introduction of a smoking ban and some other regulatory measures.\(^6\)

The Ministry of Health reports:

…It remains to be seen, however, whether the decreases are the start of a new trend, a transient period of consumer and industry adaptation, or simply an outlier in the established increasing trend… (p4)\(^7\)

Although cautionary caveats are in order, this rapid decline in help-seeking occurred while specialist services were being further expanded and promoted. Change of this magnitude is without precedent in the addiction or mental health fields. Certainly it would be a novelty if we were considering hip replacements! It would be helpful to know what is going on.

While expenditure and help seeking provide some information, their relationships with problem gambling are complex. Unfortunately there has been no national prevalence survey since 1999, although one is planned. This should help clarify whether problem levels have changed during the past decade.

Two articles in this issue of the Journal make important contributions to our understanding of problem gambling and underline its significance for GPs and other health professionals.
Mason and Arnold analyse gambling data from the 2002/03 New Zealand Health Survey. Half the problem gamblers smoked daily and two-thirds reported increasing smoking while gambling—a possible explanation for the impact of smoking bans in EGM and other gambling venues?

More than half of the gamblers studied engaged in hazardous alcohol consumption. Problem gamblers also reported worse health across a range of domains. Risk factors were similar to 1999, confirming the changes since 1991. Regrettably the study used a non-standard problem gambling measure that precluded comparison with the 1991 and 1999 surveys.

Sullivan and colleagues surveyed patients from 16 GP practices and found 7.5% experienced gambling problems. About twice as many said they were affected by another person’s gambling. Both groups had significantly elevated depressive symptoms. Māori, Pacific, Chinese, and ‘other ethnicity’ patients were at high risk. This implies previous methodologies might not have been sufficiently sensitive to problems among some Asian and recent migrant groups. There was a high level of participation in the study and apparent acceptance of GPs as a potential source of help. This suggests that primary health providers could effectively offer screening, referral, and a range of interventions to assist the majority of problem gamblers and concerned others who do not currently access specialist services.

The two studies, while showing robust associations with a range of health measures, do not indicate temporal sequence or causation, for example whether depression contributes to or results from gambling problems. For screening purposes this does not matter. However, advancing scientific understanding and informing public health and clinical interventions requires more sophisticated examination of these connections. Prospective studies are particularly important in this regard and, while few, are starting to help untangle the complex web of relationships between the agent gambling, other environmental factors, and individual psychology and biology.

There are indications that progress is being made with the Gambling Act 2003 and related initiatives to reduce gambling-related harm. However, agent, environment, and ‘host’, like rust, never sleep. And not only problem gamblers are addicted to gambling—so too are governments and communities that receive significant gambling revenue. The true measure of public health resolve comes when it is sustained in the face of reduced rents (taxes, levies and grants) to the beneficiary.

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References:


