Funding treatment for gambling addiction in Great Britain: ethical issues

Gambling is an activity that many people enjoy without significant risks to their health. For a minority, however, engaging in gambling can result in addiction. In the UK, for example, while 73% of the population (aged 16 years or over) participate in some form of gambling each year, the prevalence of problem gambling has been estimated to be 0.9% – between 342 000 and 593 000 adults (Wardle et al, 2011). While gambling addiction does not expose the addict to the physical risks of harm that those addicted to substances like alcohol and tobacco face, addiction itself is a serious psychiatric disorder. Addiction brings with it significant psychological problems which can impact negatively on all areas of a person's life (Morasco et al, 2006; Adams, 2007), and can also adversely impact on his/her family and the wider society. For these reasons the current scale of gambling creates a need for treatment of these problems.

There are two approaches that might be taken to deal with this need (both of which come in a variety of forms). On one approach gambling addiction is treated simply as a health problem and the resources for treating it are taken from whatever system is used to fund treatment for any other condition. An alternative approach is to take the fact that people are ill as a result of using the services provided by the gambling industry as being of prime importance. That industry, it would seem, is at least partially responsible for there being a need to treat gambling addictions and hence there may be grounds for holding it responsible for the costs of meeting that need. The industry has what Tom Scanlon (1988) called substantive responsibility – i.e. it is appropriate for it to pick up the bill.

This article highlights some of the ethical problems that arise with this second approach in the context of health care. In particular it argues that such a treatment system is ethically problematic as it is inequitable.

The system for funding (and delivering) research, education and treatment of gambling-related harm as it currently operates in Britain has three main elements. First, the Gambling Commission, set up in 2005, regulates gambling within Britain in partnership with the licensing authorities. Second, the Responsible Gambling Strategy Board, set up in 2009, has the role of developing strategy and priorities, and of advising the Gambling Commission and, via them, the government on strategic priorities to tackle gambling-related harm (Gambling Commission, 2011).

The final element, the Responsible Gambling Trust, was set up in April 2012 by merging the GREaT Foundation (which had responsibility for raising funds voluntarily from the gambling industry) and the Responsible Gambling Fund (which was the body that commissioned and distributed funds for research, education and treatment using the money raised by the GREaT Foundation). The new body combines the roles of its two predecessors and is an industry-led body but with a board of trustees that is evenly split between representatives of the industry and independent trustees.

An inequitable system

Because the system of funding treatment for gambling addiction in Britain is largely dependent on voluntary contributions from the industry, whether individuals will receive treatment or not depends to some extent on the goodwill and financial success of those in the gambling industry. Where times are hard in that industry less money, and hence less treatment, may be available. As such, this type of system may not always provide the funds needed to treat all those who are ill as a result of gambling. Indeed, in Britain voluntary contributions from the industry have not raised the money required to fund the strategy set by the Responsible Gambling Strategy Board (2011).

This dependence on decisions of a private sector industry is not a feature of the provision of health care for those suffering other types of ill health. While the NHS has to make decisions about what can be funded, those decisions are based squarely on the needs of the patient and on how effective various treatments are. Indeed, such a focus appears to be required by considerations of fairness.

There are two basic approaches to determining what fairness requires in health care: either the aim is to treat those with equal (or comparable) needs alike, or it is to treat alike those who have an equal (or comparable) chance of benefitting (Beauchamp and Childress, 2009). These two approaches, for example, lie behind the two strategies used to determine how to allocate scarce health-care resources fairly: help the worst off first (which rests on the idea that we should treat all those who are badly off with the same priority, and give a lower priority to those who are less badly off), or use our resources to produce the best outcome (which rests on the idea that we should treat with equal priority those who can benefit the most, and give a lower priority to those who would not get as much benefit).

Given the entirely different basis on which funding for gambling addiction is based in a system like that in place in Britain, this raises serious questions about whether those with gambling addictions are treated fairly – in terms of their access to services to treat their condition – compared to those suffering from other conditions. In particular this concern relates to those who are unable to access treatment funded by the industry (as a result of limitations on its provision depending on the funds available) but whose needs are nevertheless not considered by the health service more generally (on the grounds that this type of treatment is funded not by them but by the industry). This group of people has been effectively

abandoned by the health-care system and their needs are not given equal consideration within that system to those of others. Such a position is, according to either of the accounts of fairness outlined above, unfair.

Should industry pay?

It might be thought that this problem is raised by the voluntary nature of the contributions from the industry, and that moving to a compulsory levy would alleviate them. This, however, would be to move too quickly, because even if the funding provided voluntarily by the industry is insufficient to cover the costs of all those seeking treatment, it does not follow that those making the contributions are not contributing enough to cover the costs of harm that result from the use of their services. There are two reasons for this.

The first is that if the position is that the 'polluter pays', then any particular company should only be required to pay for the harm caused by its activities. Under a voluntary system not everyone will contribute, but even under a mandatory levy it may well be that not all providers of gambling pay their share. Some providers of gambling in any country, including Britain, are based offshore – for example, some providers of on-line gambling – and it may not be possible to raise money from them. If that is the case, even where the aim is that the industry pays to treat the health problems caused by its activities in practice this will not raise enough to cover all the harm caused by gambling. As such, there will remain those whose needs are not adequately considered unless they also have access to other forms of funding.

Second, in Britain, the government itself is a provider of some gambling services. As such, if the basis for charging the industry is that those who provide gambling services should pay for the harm caused by those services then the government ought to pay some of the costs to alleviate that harm. A failure to do so, while requiring other providers of gambling services to pay for the costs of that harm, would appear to be inequitable and to impose an unfair burden on those who are willing to contribute.

A move to a compulsory system would not alleviate these two problems. Requiring those on whom we are able to levy a fee to pay for the treatment of problem gambling, with no provision by the health service more generally, would be to impose a burden on them that is likely to be more than that which is justified by the requirement that they pay for the harm caused by their activities. What is needed is to complement the system that raises money from the industry, whether voluntarily or by means of a levy, with an adequate source of funding from the government. That is, an equitable system for health-care provision for those whose health has been harmed by gambling cannot in practice rely entirely on a polluter pays system that shifts the costs entirely onto the industry if it is to be a system that is fair to those suffering that harm (and to the industry itself).

Conclusions

This article has raised ethical concerns about the current dominant role that the gambling industry has in funding treatment of gambling addiction. These concerns do not arise so much from what the industry is doing (the funding it provides is to be welcomed), but from the fact that it is the main or principal source of funding. A better and more ethically acceptable funding system would supplement the industry's input with contributions from the government. **BJHM**

Tom Walker
Senior Lecturer in Ethics
School of Politics
International Studies and Philosophy
Queen's University Belfast
Belfast
Sanju George
Consultant in Addiction Psychiatry
The Bridge Substance Misuse Service
Birmingham and Solihull Mental Health
NHS Foundation Trust
Birmingham B37 7UR
(sanju.george@bsmhft.nhs.uk)

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KEY POINTS

- While gambling is an activity that many people engage in with no serious effects to their health, for a minority it creates significant health problems.
- In Britain, the gambling industry funds almost all of the treatment services through voluntary donations, which has significant ethical problems if relied on as the main source of funding.
- What is needed is to complement the system that raises the money from the industry, whether voluntarily or by means of a levy, with adequate funding from the government to ensure that it pays its share (given its role in providing gambling) and that the needs of those who are ill as a consequence of gambling are given proper consideration.