The Case for a Statutory Gambling Levy

BRIEFING PAPER

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This paper, whose authors include senior NHS clinicians treating gambling addiction, makes the case for introducing a statutory levy on the gambling industry, to be overseen by a new independent board led by the Department of Health and Social Care. The paper surveys the current voluntary system of industry funding for harm reduction. It finds that the voluntary system is structurally flawed and has failed in its approach.

CONCLUSIONS

- The Department for Digital, Culture, Media and Sport has resisted repeated calls from a wide range of expert stakeholders to introduce a statutory levy
- The current voluntary funding system lacks consistency, transparency, and accountability
- £100m has been pledged by the gambling industry to a single charity, GambleAware, but funding is not being properly integrated with the NHS or research councils
- There is no long-term strategy of prevention and recovery within the current framework
- There is no clear target for harm reduction (in terms of quantity, timescale or cost)

The paper sets out the alternative regime that policymakers should put in place in order to provide better support for harm reduction.

RECOMMENDATIONS

- The Secretary of State should introduce regulations which would require operators to pay an annual levy to the Gambling Commission, as provided for in the 2005 Gambling Act.
- The creation of a Joint Advisory Levy Board to be given oversight over the levy paid to the Gambling Commission. This would be a formal cross-government working group led by the Department of Health and Social Care.
- The new Levy Board should oversee a comprehensive assessment of the evidence base of gambling-related harm and the limitations of the current voluntary system.
- To help achieve this, the industry should reallocate the £60 million pledged to GambleAware for 2023 to the Gambling Commission, under the oversight of the Levy Board.
- Having carried out its assessment of gambling-related harm, the Levy Board should calculate the costs of this harm and establish which parts of the industry contribute to that harm more than others. This calculation, which should be carried out in 2023, would enable a 'smart' levy to be introduced based on the 'polluter pays' principle from 2024.
- The Joint Advisory Levy Board should establish a clear target for harm reduction by a fixed date, against which the efficacy of the statutory levy can be evaluated. This target should be a reduction in gambling-related harm by 50% within 5 years.

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INTRODUCTION AND RECOMMENDATIONS

The Government is on record as stating that gambling harm is a public health issue, yet there is no statutory or formal function for the funding of services that would reduce this harm within an integrated health system. Instead, an informal arrangement exists whereby the gambling industry makes voluntary contributions to a list of approved service providers, with the bulk of funding given to a single charity, GambleAware. There is no framework for the integration of NHS services, no clinical modelling, no evaluation of the long-term impact of the current treatment system, no independent regulation via the Care Quality Commission, no coordinated oversight from research councils over the research into harm, no consistency in funding decisions, and serious questions have been asked about the independence of this funding from the influence of the gambling industry. Furthermore, decisions about the funding of healthcare services are not overseen by experts at the Department of Health and Social Care, as would be expected, but rather officials at the Department for Digital, Culture, Media and Sport.

Section 123 of the 2005 Gambling Act allows for the Secretary of State to make regulations requiring gambling operators to pay an annual levy to the Gambling Commission, including the option to determine the amount of the levy by reference to a percentage of operators' profits. This provision is echoed in the Government's Gambling Act Review, which states in its call for evidence that if the industry's voluntary contributions fail to deliver on funding needs, the Government will look at the case for alternative mechanisms, including a statutory levy. Section 123 of the Gambling Act does not make reference to hypothecated taxation. Instead, it provides for a system of funding – which could be either voluntary or statutory – drawn from industry revenue and allocated to specific functions.

Dozens of academics, leading clinicians and parliamentarians from across the political spectrum have called for an end to the current voluntary arrangement and the introduction of a statutory levy. GambleAware itself and the advisory board to the Gambling Commission have also called for the introduction of a statutory levy – a levy which is already provided for in the existing legislation and which is within the gift of the Secretary of State to introduce. Yet despite these calls, and the overwhelming consensus for change, the voluntary arrangement between DCMS, GambleAware, and the gambling industry remains in place.

This paper lays out the case for the introduction of a statutory levy drawn from the revenues of the gambling industry to fund the prevention, research, education, treatment and long-term reduction of gambling-related harm.

We argue that:

- The Government has ignored repeated calls from a wide range of stakeholders to introduce a statutory levy, despite provision for a levy already being included in the existing legislation.
- The current voluntary funding system lacks consistency, transparency, and accountability.

- Significant funds (in excess of £100 million) have already been pledged by the largest gambling operators to provide counselling and treatment services, yet these funds are not being distributed in a fully independent or efficient manner.
- Despite repeated calls from parliamentarians, clinicians, and the academic community for a better understanding of gambling-related harm, some of the evidence base has been impeded by inadequate and inaccurate research into prevention and treatment, including research which is not wholly independent from the gambling industry.
- At present, there is not a formal framework that harmonises the commissioning of services and the provision of those services (for example, the Department of Health and Social Care has limited oversight over healthcare services funded by the current voluntary system).
- A long-term strategy of prevention and recovery is not properly integrated within the framework for the funding of research, education, and treatment.
- At present, there is no clear target for harm reduction (in terms of quantity, cost, or timescale).

The paper will make the following six recommendations:

1. A statutory levy is already provided for in the existing legislation and there is widespread support from almost all major voices in the gambling reform debate for a levy to be introduced. Furthermore, the largest operators currently active in Great Britain have already made a voluntary pledge of up to 1% of their Gross Gambling Yield (GGY) towards the funding of research, education, and treatment (RET) – money which should be distributed through a formal framework rather than informal arrangement. There is no reason for the Government to oscillate any longer on this matter, or to use the ongoing review of the 2005 Gambling Act as a reason for further delay in introducing a formal framework for RET funding. ***We therefore recommend that the Secretary of State makes a commitment to use their power to introduce regulations which would require operators to pay an annual levy to the Gambling Commission, as stipulated in Section 123 of the 2005 Gambling Act, and that this commitment should be included in the Gambling Act Review white paper***.
2. The current system allows for a levy in the context of the Department for Digital, Culture, Media and Sport's oversight of gambling legislation and regulation. Yet treatment done by healthcare professionals requires expert oversight by the NHS and the Department of Health and Social Care, while academic research benefits from the support structures of universities and the research councils. Despite the need for a formal framework that could combine these different organisations and public agencies, RET funding is instead channelled through a voluntary system of informal arrangements overseen by a government department which lacks, by definition, the research and treatment expertise needed to integrate them properly. ***We therefore recommend the creation of a Joint Advisory Levy Board to be given leadership and oversight over the levy paid to the Gambling Commission: a formal cross-government working group which is led by the Department of Health and Social Care, acting in consultation with academics, clinicians, independent service providers, the relevant***

research councils, the Gambling Commission and its advisory boards, lived experience and stakeholders from the Department for Digital, Culture, Media and Sport and the Department for Education. The creation of the Joint Advisory Levy Board would not diminish the roles of either DCMS or the Gambling Commission in other aspects of gambling legislation and regulation, and would be possible within the parameters of the 2005 Gambling Act.

3. In 2019, the main gambling operators currently active in Great Britain entered into a voluntary arrangement to provide £100 million over a four-year period (with 1% of GGY pledged for the final year in 2023, equating to around £60 million) for treatment and counselling services. A single charity, GambleAware, is the beneficiary of this arrangement, despite the fact that NHS services have been underfunded during the same time period, that GambleAware acknowledges the need to "develop" its evidence base and has itself called for the introduction of a mandatory levy. We argue that £100 million is a significant amount of money – and authority – to give to a single charity when it is widely agreed that resources are needed to integrate the work of the NHS, public agencies, and local authorities within a formal framework of harm reduction. Without a sufficient understanding of gambling-related harm, an adequate framework to achieve harm prevention, and without full independence, these funds risk being spent inefficiently. ***We therefore recommend that the first priority of the new Joint Advisory Levy Board should be to oversee a comprehensive and independent assessment of both the evidence base of gambling-related harm and the limitations of the current voluntary system.*** It makes no sense to allow the current four-year funding arrangement between the gambling operators and GambleAware to continue while such an assessment is being carried out. In practice, this means that the operators should be encouraged to reallocate the £60 million pledged to GambleAware for 2023 to the Gambling Commission under the oversight of the Joint Advisory Levy Board. This would ensure maximum efficiency (and accountability) in the distribution of those resources, while maintaining existing treatment programmes until a new framework has been developed.
4. At present, funding is directed to projects which contribute to the Research, Education and Treatment (RET) of gambling-related harm. Yet research shows that both prevention and long-term recovery are also essential components in reducing that harm in society. We argue that the current framework of RET needs to fully integrate long-term harm Prevention (P) and Recovery (R). ***We therefore recommend that the Government and the Gambling Commission change future references about 'RET' in official documents to 'PRETR' (Prevention, Research, Education, Treatment, and Recovery), and that the Joint Advisory Levy Board's assessment of the evidence base is based on this same principle***.
5. There has been a debate over whether the levy should be set at 0.1% or 1% of GGY (or somewhere in-between), whether it should be a hypothecated tax, and whether it should be a fixed industry-wide percentage or instead be subject to a 'smart' assessment of harm based on the 'polluter pays' principle. ***Having carried out its assessment of the evidence base of gambling-related harm and***

the limitations of the voluntary system, we recommend that the Joint Advisory Levy Board then assesses the costs of this harm and calculates which parts of the industry contribute to that harm more than others. This calculation, which should be carried out in 2023, would enable a 'smart' levy to be introduced based on the polluter pays principle from 2024. We do not anticipate in this paper whether the levy would remain at the current pledge of 1% or would increase or decrease according to the Levy Board's calculation of need, harm, and cost. And we recognise that it is of course possible that if harm is reduced over time, the rate of the levy which meets the costs of that harm would reduce also. However, we also recognise that the integration of both prevention and long-term recovery as part of the existing RET strategy would, in likelihood, require a financial commitment that is equal to the current voluntary pledge of £60 million per year. The role of the Levy Board will be to determine the basis on which the levy will be set.

6. Finally, ***we recommend that, with the introduction of a smart levy in 2024 and the anticipated regulatory changes from the Gambling Act Review, a clear target should be set to reduce the quantity of total gambling-related harm. This target should be a reduction in gambling-related harm by 50% within 5 years.*** The Joint Advisory Levy Board should have responsibility for achieving this target, with independent evaluation carried out by DHSC in 2030, in order to inform future regulatory change.

WHY A STATUTORY LEVY?

Gambling-related harm is recognised by the UK Government to be a public health problem. In December 2021, the minister responsible for gambling, Chris Philp, gave a keynote speech at the annual GambleAware conference in which he said that "the Government considers gambling-related harm to be a health issue and a public health issue, and preventing harm is an essential objective of our gambling regulation."[1]

In this paper, we shall examine some of the questions around harm in more detail. It has been claimed in a World Health Organisation report on the epidemiology and impact of gambling disorder that the burden of gambling harm appears to be of a similar magnitude to alcohol misuse and major depression, and "substantially higher than harm attributed to drug dependence disorder".[2] Together with real life stories about the destructive effects of this harm on individuals and families featuring in the media almost every day, as well as concerns over the number of gambling-related suicides in the country each year,[3] there is a renewed focus in government on reducing gambling harms as part of its review of the 2005 Gambling Act – a review which "recognises the essential public health elements to any discussion of gambling", while stating that "the Department for Health and Social Care will continue work to expand and improve the treatment of gambling-related harms alongside other addictions like drugs and alcohol."[4]

One of the principal ways to achieve this aim has been the funding of research, education, and treatment. As outlined in the Advisory Board for Safer Gambling's 2020 report on a statutory levy, RET funding has been facilitated for a number of years via voluntary contributions from the gambling industry to a nominated charity, GambleAware, which has a "framework agreement" with the Gambling Commission to deliver the National Strategy to Reduce Gambling Harms.[5] Resources from these contributions have been distributed across a wide range of third sector organisations, academic institutions and two NHS providers, with a benchmark set for the industry to contribute 0.1% of Gross Gambling Yield,[i] equating to around £10 million a year. In 2018/19, GambleAware received £9.6 million in donations, with just over half of this spent on treatment.[6]

Since 2020, the Social Responsibility Code of the Licence Conditions and Codes of Practice (LCCP) has required licensees to make an annual financial contribution to one or more organisations on a list approved by the Gambling Commission. Specifically, operators must make a contribution to each of research, prevention, and treatment, ensure that these donations go to organisations on the approved RET list, and ensure that they have no connection to the recipient organisation. The Gambling Commission states that it does "not specify an amount which may be contributed as this could be seen as imposing a levy, which is a power reserved for Parliament."[7] In addition, some operators unilaterally give funds to preferred research organisations, charities, and

[i] GGY is a metric used to calculate the revenue of the industry by deducting the total of any prizes or winnings owed by an operator from the total of any stakes (as well as any amounts accrued) paid to the operator. See https://www.gamblingcommission.gov.uk/about-us/guide/page/definitions-of-terms

service providers, and in 2019 the largest operators currently active in Great Britain pledged £100 million to counselling and treatment over the course of four years, with GambleAware nominated the recipient of this money in 2020.

We argue that this current arrangement is too informal and unpredictable to provide sustainable solutions to the problem at hand. The voluntary nature of contributions has meant that individual operators vary in what they donate, with some offering risible amounts. In an oral evidence session with DCMS officials at the House of Lords Select Committee, Lord Butler raised the point that "it has been said in the House of Lords that last year some of the companies gave insultingly small amounts. Best Bets gave £5 and another company, GFM Holdings, gave £1. Is there any other way of interpreting that other than cocking a snook at the levy?" The response to this question from DCMS' Head of Gambling and Lotteries was that "they do not appear to want to commit funds to GambleAware; that is true. They may be making some other contributions; they may not. But, yes, it means they are saying they do not want to pay the levy that GambleAware has asked them to pay."[8]

The voluntary nature of the system also allows the gambling industry to decide not only how much to donate, but also when to donate and to whom. The resultant lack of stability in funding means that recipients cannot effectively plan for staffing, budgets and projects to reduce gambling harms. While the major operators have committed additional funds to the system until 2023, these funds are not measured against adequate metrics of harm, and the figure is likely an underestimation of what is required. The unpredictability of the voluntary system means that the industry maintains a degree of inappropriate control over funding, which diminishes the independence and agency of those service providers who are in receipt of its contributions.

This is an important point: when we say that the current system makes true independence impossible, we are not casting aspersions on the individual integrity of those who work for third sector organisations and service providers. Rather, we are highlighting a structural problem that is inherent to the voluntary system. As long as funding remains unpredictable, inadequate, or dependent on decisions made by gambling operators and their representatives, the system cannot be described – structurally speaking – as independent from the gambling industry.

An example of this structural problem is the £100 million recently pledged by the largest gambling operators to GambleAware. This pledge was negotiated between the five biggest operators in the UK in 2019 — GVC (now Entain), William Hill, Flutter, SkyBet and Bet365 – and the Culture Secretary at the time, Jeremy Wright, and was made to a new charity founded by Lord Chadlington, Action Against Gambling Harms.

Wright announced the pledge in Parliament, saying that "today, five of the biggest gambling companies have agreed a series of measures that will deliver real and meaningful progress on support for problem gamblers… These companies, together, represent about half of the British commercial gambling industry". He continued, "I know that Members across the House have argued for a mandatory, statutory levy to procure funds for treatment and support in connection with problem gambling. I understand that argument. However, as the House knows, legislating for this would

take time – in all likelihood, more than a year – to complete. The proposal made this morning will deliver substantially increased support for problem gamblers this year… The Government reserves the right to pursue a mandatory route to funding if a voluntary route does not prove effective."[9]

The main reason given by Wright for endorsing this voluntary arrangement was because introducing a statutory levy would, in his words, "take time – in all likelihood, more than a year – to complete". Yet a year after the pledge was made, the Betting and Gaming Council (BGC) announced that these same funds were being withdrawn from Action Against Gambling Harms and reallocated to GambleAware instead, stating that "ensuring that GambleAware are the main beneficiaries of this announcement recognises their independence, their links with the Department of Health and Social Care and health professionals and their acknowledged expertise as a commissioning body."[10] The BGC's decision reneged on an agreement that had been announced in Parliament – leading campaigners to call it "an unexpected change of heart" which "proves the industry has too much influence on how the money is spent."[11] The decision raised serious questions at the time about the focus of the research programme, and demonstrated how the industry remains in a position to choose – and change – what it funds, who it funds, and how.

Again, we recognise that GambleAware was not responsible for the BGC's reneging on a commitment that had been announced in Parliament. But that should not prevent us from pointing to the fundamental flaws in a voluntary system that allowed the industry to renege on their commitments in the first place. In the words of an open letter written by several dozen leading academics to the Government at the time and published in the *BMJ*, the BGC's change of heart "exemplifies the long-standing weakness of a funding system that allows the gambling industry to regulate the availability and distribution of vital funds to address gambling harms across our communities."[12] It is precisely for this reason that the National UK Research Network for Behavioural Addictions (NUK-BA) has recently written in *The Lancet* that "funds should not be held or administered by any organisation that has potential conflicts of interest in relation to the gambling industry, such as dependency on the industry for the existence and future of its organisation."[13]

In addition to these questions over independence and consistency, concerns have also been raised about the efficacy of the voluntary system. Gambling-related harms are recognised by the Government to be a health problem. Yet for gambling treatment, the voluntary levy bypasses the Department of Health and Social Care and NHS England, together with all the essential governance that goes along with treating health problems within integrated care systems. As a consequence, the treatment system, mostly funded by GambleAware, has systemic limitations. For example, only 2-3% of those with gambling problems come forward for support.[14] Annual statistics for the National Gambling Treatment Service for 2020/21 show that the majority of referrals (93%) were self-made, with less than one per cent (0.7%) being made by GPs[15] – a reliance on self-referrals which demonstrates how gambling has not been embedded as part of the wider health system. Furthermore, there is little in the way of intervention for low- to moderate-level harms (due to cases not being identified early enough), little in the way of aftercare for what is a relapsing problem, no competency

framework or accredited training for frontline staff, no accredited training for frontline staff in gambling disorder and evidence-based practice, no overseeing to ensure evidence-based practice, no evaluation of the long-term impact of the current treatment system, and no independent regulation via the Care Quality Commission.

In other words, the current voluntary system is defined by indeterminate expectations and unpredictable contributions, with some operators volunteering the bare minimum, some operators favouring certain providers, and others giving significant resources to a single charity, GambleAware. There is an inherent lack of consistency, transparency, and accountability in the current voluntary system, leading the advisors to the Gambling Commission, the ABSG, to declare that the current model of funding "is no longer fit for purpose." We agree. It is time for the Government to introduce a statutory levy.

The Government's Review of the Gambling Act 2005 presents the opportunity for a statutory levy as follows: "Separately from licence fees paid to the Gambling Commission, gambling duties are collected by HMRC and payable to the Exchequer. These amounted to around £3bn in 2019–20. The Government also has a power in the current legislation to place a levy on operators payable to the Gambling Commission, which it could use to fund projects related to gambling related harm or its wider regulatory work. The Government has always been clear that should the industry's voluntary system for supporting projects and services related to problem gambling fail to deliver the level of funding necessary, it would look at the case for alternative funding mechanisms and all options would be considered, including a levy."[16]

The mention of "power in the current legislation" is a reference to Section 123 of the 2005 Gambling Act, which allows the Secretary of State to make regulations requiring gambling operators to pay an annual levy to the Gambling Commission, including the option to determine the amount of the levy by reference to a percentage of operators' profits.[17] According to the Act, money received by way of the levy would be used to provide financial assistance for projects related to addiction to gambling, other forms of harm or exploitation associated with gambling, or any of the licensing objectives – with the Commission allocating these funds "with the consent of the Treasury and of the Secretary of State". Section 123 of the Gambling Act does not make reference to hypothecated taxation. Instead, it provides for a system of funding – which could be either voluntary or statutory – drawn from industry revenue and allocated to specific functions.

In other words, the introduction of a statutory levy would allow for the following:

- A levy would be spent on projects related to addiction, harm, and/or the licensing objectives
- The amount of a levy could be tied to a percentage of industry profit or an alternative formula
- The allocation of a levy would involve the consent of both DCMS and the Treasury
- The levy would be treated as if it was part of the annual fee (see Section 100 of the Act[18]), meaning that a licence would be revocable if the levy was not paid

- The levy would raise revenue to meet a specific cost caused by the activities of that industry without placing an additional burden on wider tax structures. The gambling levy is not a hypothecated tax
- The Secretary of State should consult the Gambling Commission before making regulations to introduce a levy

The Gambling Commission is advised by the Advisory Board for Safer Gambling, which has proposed that "a voluntary system to fund prevention and treatment of gambling harms is no longer fit for purpose. A statutory levy would be able to address many of the issues surrounding transparency, independence, equity and sustainability, and public confidence. It would also have the potential to raise significantly greater levels of funding needed to address gambling harms across Great Britain."[19] The view of the Commission has been that "some form of statutory levy, providing reliable finance to underpin these activities, is the right way forward".[20] Similarly, GambleAware itself "continues to advocate for a mandatory levy to fund research, prevention, and treatment services" due to the fact that the "voluntary nature of the current arrangements results inevitably in uncertainty of funding year to year and significant variations in cash flow within the year."[21] In an opinion piece published in *The Times* last month, GambleAware trustee Baroness Armstrong wrote that "gambling is a serious public health issue" and that for the work of the National Gambling Treatment Service to be maintained, "sustained funding is needed which can only be provided through the introduction of a mandatory levy."[22]

This groundswell of support for a statutory levy is echoed in Parliament. Politicians from all major parties have called for a levy, and the Lords Select Committee on the Social and Economic Impact of the Gambling Industry made a recommendation that "ministers should forthwith exercise their powers under section 123 of the Act to require the holders of operating licences to pay to the Gambling Commission an annual levy sufficient to fund research, education, and treatment, including treatment provided by the NHS", adding that "it is beyond belief that the Government have steadfastly refused to exercise the powers they already have to impose a mandatory levy on the industry. They must drag their feet no longer."[23] In fact, such is the overwhelming consensus for a levy from academics, clinicians, service providers and parliamentarians, that those few stakeholders in the gambling industry and elements of government who do *not* support that call have become increasingly conspicuous in their opposition to this consensus.

In this context, we argue that there is no reason for the Government to oscillate any longer on this matter, or to use the ongoing review of the 2005 Gambling Act as a reason for further delay in introducing a formal, integrated framework for RET funding. A statutory levy is already provided for in the existing legislation and there is widespread support from almost all major voices in the gambling reform debate for a levy to be introduced. Furthermore, the largest operators currently active in Great Britain have already made a voluntary pledge of up to 1% of their GGY to counselling and treatment services – money which, we argue, should be distributed through a formal framework rather than an informal arrangement. The legislation is in place, the funding has been pledged and the support for a levy is widespread. The only thing left is the political will to make it happen.

We therefore recommend that the Secretary of State makes a commitment to use their power to introduce regulations which would require operators to pay an annual levy to the Gambling Commission, as stipulated in Section 123 of the 2005 Gambling Act, and that this commitment should be included in the Gambling Act Review White Paper.

With a statutory levy introduced, who should have oversight of it? At present, we have a system in which decisions about the commissioning and funding of gambling-related health harms are not under the responsibility of the Department of Health and Social Care. There are no universally recognised clinical guidelines for the treatment of gambling harm, and gambling addiction has not been given parity with other addiction services. There is a debate over the diagnosis and measurement of harm – currently defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-V) and the Problem Gambling Severity Index (PGSI) – and the extent to which harm is experienced beyond the individual by wider networks. Until recently, only one specialist gambling clinic existed in the country. A pledge was made by the Government to integrate gambling within the wider NHS addictions strategy, but it seems that this plan has not yet seen meaningful progress. DHSC has no formal role in terms of RET funding and harm reduction yet, during oral evidence sessions at the Lords Committee inquiry, DCMS officials referred back to their DHSC counterparts when asked the question, "how does a government department judge that effectiveness?" Furthermore, there are no formal targets for harm reduction and no way of assessing the impact of government interventions.

Clearly, this is not good enough. As a result, in recent years some academic experts and campaigners have called for the wholesale transfer of governmental responsibility of gambling from DCMS to DHSC. We do not go as far as that. We recognise that gambling legislation and regulation involves elements which do not relate to the question of health harm and which belong under DCMS. But at the same time, it is self-evident that a clearly-defined role must be established for DHSC when it comes to responsibility for gambling-related harm. We argue that the introduction of a statutory levy would be the appropriate mechanism for this role.

The current system allows for a levy in the context of DCMS' oversight of gambling legislation and regulation. Yet treatment done by healthcare professionals requires expert oversight by the NHS and DHSC, while academic research benefits from the support structures of universities and the research councils. There is a need for a formal framework that can combine these different organisations and public agencies, overseen by a government department which has the expertise required to integrate them properly.

We therefore recommend the creation of a Joint Advisory Levy Board to be given leadership and oversight over the levy paid to the Gambling Commission: a formal cross-governmental working group which is led by the Department of Health and Social Care, acting in consultation with academics, clinicians, independent service providers, the relevant research councils, the Gambling Commission and its advisory boards, lived experience and stakeholders from the Department for Digital, Culture, Media and Sport and the Department for Education.

Numerous examples of this kind of formal cross-governmental collaboration already exist. These include the Special Educational Needs and Disabilities (SEND) review of disagreement resolution led by a Department for Education and Ministry of Justice jointly-chaired advisory group,[24] the Ministerial advisory group on mental health strategy, and the Cross-Government Working Group on Employment Status, which has reviewed the rules for employment status across government and considered options towards agreed employment status principles – a joint working group which includes HMT, HMRC, DWP and the Office of Tax Simplification.[25]

Crucially, the creation of the Joint Advisory Levy Board would not diminish the roles of either DCMS or the Gambling Commission in other aspects of gambling legislation and regulation, and would be possible within the parameters of the 2005 Gambling Act.

MEASURING GAMBLING HARM AND COST

Gambling disorder is a diagnosable – and treatable – health condition characterised by persistent and recurrent maladaptive patterns of gambling behaviour, leading to substantial functional impairment and reduced quality of life.[26] Different terms are used to describe this condition, including 'problem gambling', 'pathological gambling' and 'disordered gambling'. While the diagnosis, measurement, and treatment of this disorder has been a cause of debate within both the academic community and public policy forums, the Government makes use of broadly-accepted criteria when making decisions about the prevention of harm; in the words of a Department of Health and Social Care official at the Lords Committee inquiry, "there is an awful lot we do not know, but we start from a position where we have a reasonable estimate of problem gamblers that is based on the Diagnostic and Statistical Manual of Mental Disorders and Problem Gambling Severity Index scores".[27]

The Diagnostic and Statistical Manual of Mental Disorders and the Problem Gambling Severity Index are two screens used by the Gambling Commission to measure gambling disorder. These two screens measure harm in different ways. The PGSI was developed to assess the general population, while the DSM is used to assess gambling disorder within a clinical context. Both the DSM and PGSI were used as measurements in the British Gambling Prevalence Surveys of 1999, 2007 and 2010.

The PGSI screen consists of nine items assessed on a four-point scale in response to a list of questions (for example, "*has gambling caused you any health problems, including stress or anxiety?*" and "*when you gambled, did you go back another day to try to win back the money you lost?*"), with possible answers being: *never*, *sometimes*, *most of the time*, and *almost always*, and responses given the following scores:

- never = 0
- sometimes = 1
- most of the time = 2
- almost always = 3

These scores give a total which ranges from 0 to 27. According to the developers of the PGSI and the Gambling Commission, a PGSI score of 8 or more represents a problem gambler. The criteria are as follows: [28]

- 0: Gamblers who gamble with no negative consequences
- 1-2: Gamblers who experience a low level of problems with few or no identified negative consequences
- 3-7: Gamblers who experience a moderate level of problems leading to some negative consequences
- 8 or more: Gambling with negative consequences and a possible loss of control

The DSM-V screen is used by clinicians to diagnose gambling disorder among gambling addicts rather than the general population. Like the PGSI, it assesses gambling disorder on a sliding scale. The questions included in DSM-V ask whether gamblers:

- Need to gamble with increasing amounts of money in order to achieve the desired excitement
- Are restless or irritable when attempting to cut down or stop gambling
- Have made repeated unsuccessful efforts to control, cut back, or stop gambling
- Are often preoccupied with gambling (e.g., having persistent thoughts of reliving past gambling experiences, handicapping or planning the next venture, thinking of ways to get money with which to gamble)
- Often gamble when feeling distressed (e.g., helpless, guilty, anxious, depressed)
- After losing money gambling, often return another day to get even ("chasing" one's losses)
- Lie to conceal the extent of involvement with gambling
- Have jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling
- Rely on others to provide money to relieve desperate financial situations caused by gambling

A threshold of meeting at least four of these criteria in a 12-month period is used to diagnose a gambling disorder which could be described as mild (if 4-5 criteria are met), moderate (if 6-7 criteria are met) or severe (if 8-9 criteria are met).

The questions asked in both the PGSI and DSM-V screens are designed to establish the degree to which an individual is engaged in, exposed to, or at risk of gambling-related harm. The definitions of harm drawn from these screens are focused on the individual gambler. At the same time, three of the questions in the DSM-V screen (including "lie to conceal", "have jeopardized or lost a significant relationship, job, or educational or career opportunity" and "rely on others to provide money") also ask gamblers whether this harm affects their wider networks.

There is a debate over the degree to which gambling-related harm is an individual disorder or whether it extends to wider networks — in particular, families, peers, and communities – through a range of complex causal and correlative relationships. For Heather Wardle, gambling harms are "the adverse impacts from gambling on the health and wellbeing of individuals, families, communities and society, affecting people's resources, family and social relationships, occupational and educational opportunities and physical and mental health."[29] Harm is defined by four categories:

- Individual
- Families and social networks
- Community
- Societal

Within this "framework for action", measurements of gambling harm are different from clinical diagnoses of gambling disorder. Harms are the outcomes of disordered gambling, and can affect individuals, family networks, communities and wider society in a range of ways. Individual harm is defined by individual characteristics such as life events, personal history, and cognitive characteristics that influence the potential

experience of harm (for example, early gambling experiences). Harms affecting families and social networks involve actors within an individual's closest relationships, such as family, partners and peers that influence experience of harm. Harms in the community are defined by cultural characteristics within local spaces or broader social groups, like schools and workplaces, that may influence experience of harm. And societal harm is defined by policy, regulatory, and corporate norms and practices that may influence the experience of harm (for example, ineffective regulation).[30]

The notion of extended harm, developed by Wardle and others, is broadly accepted within both the clinical and academic community, and raises questions about how the measurement of harm can be calculated in terms of cost. This question has also been explored in recent years by public policy experts. In 2016, the Institute for Public Policy Research (IPPR) published a report assessing the fiscal costs of gambling disorder to the Government. Drawing on the 2010 British Gambling Prevalence Survey, the IPPR report proposed a taxonomy of harm which develops an "initial understanding" of some of the interactions associated with gambling disorder from data collected by treatment providers including the National Problem Gambling Clinic, Gamcare, Gordon Moody and Gamblers Anonymous.

These interactions fall into the following categories:

- health problems
- housing problems
- crime
- financial difficulties
- work and employment difficulties
- relationship problems

In terms of direct costs to the state, IPPR examined the burden of gambling disorder on health, employment, housing, and criminal justice, and concluded that "while the quality of data for different areas of interaction is highly variable, and therefore the methods for estimating excess incidence and unit cost are not directly comparable across different interactions… taken together, the sum of our findings would imply that the identifiable excess fiscal cost associated with people who are problem gamblers for the whole of Great Britain is in the region of £260 million to just over £1.16 billion."[31]

Since the publication of the IPPR report, the Gambling Commission has launched a National Strategy for reducing gambling harms which makes explicit reference to the question of extended harm beyond the individual. The Commission states that "we know that gambling-related harms take many forms, with negative impacts possible on peoples' resources, relationships and health and include those experienced by other people, not just the gambler – including families, children of gamblers, employers, communities and society more generally" and, echoing the language of DSM-V, adds that "harms can be temporary, episodic or longer term in nature, and can occur at all levels of gambling participation."[32]

Acknowledging both the methodological challenges and the paucity of evidence at play when it comes to quantifying complex causal relationships between individual behaviours and their social, cultural and economic effect, the National Strategy has

attempted to develop a way to measure the harms caused by gambling and the costs of these harms to society. This has produced two key reports: a "data scoping study" written by academics David McDaid and Anita Patel, and *Measuring Gambling-Related Harms: a Framework for Action* published by the Gambling Commission, ABSG and GambleAware. The first of these two reports considered different methodologies for estimating the social costs of gambling-related harms, while the second presented a preliminary working definition of gambling-related harms and adapted models of how those harms sit within a broader societal context.

McDaid and Patel's data scoping study provides a literature review, some expert interviews and the findings of an online survey. The study examines the question of harm measurement in several countries including the UK, USA, Australia, the Czech Republic, Germany, Macao, South Korea, Switzerland and New Zealand. Both the expert interviewees and survey respondents echoed the view that harm can extend beyond the individual, with 20% of survey respondents and interviewees pointing to the impact of harm on mental health, and 19% pointing the impact on partners, families, and relationships.[33]

McDaid and Patel also examine the question of the causality of harm. They argue that "more can still be done with cross-sectional datasets, including asking questions to determine whether adverse life experiences such as poor mental health or financial debt are a precursor to or consequence of gambling", and cite the Problem and Pathological Gambling Measure used in studies in Canada, Finland and US, the Adult Psychiatric Morbidity Survey and other survey data collected by the Gambling Commission, the Health Survey for England, the Scottish Health Survey and the Scottish Crime and Justice Survey as examples of instruments that might identify direct attribution between gambling and other types of associated harm.

At the same time, they state that "there is a considerable degree of variation in methods used to measure and value the costs of gambling" and "there are major challenges in attributing social harms to gambling" – adding that "causality may not be linear", and that "better longitudinal data is critical to address this issue."[34] The study concludes with a list of recommendations on what needs to be done in terms of methodology, research and reporting, including the need to:

- Make use of methodologies that deal with the issue of causality
- Highlight all relevant impacts of gambling-related harms and not just those that can more easily be measured monetarily
- Invest in simulation modelling (that is, estimating the costs of *not* taking action)
- Make use of opportunities to generate data for future longitudinal analysis
- Be transparent
- Measure and report on the distribution of harm (for example, the socioeconomic impact)[35]

The second of these papers, *Measuring Gambling-Related Harms: a Framework for Action*, outlines two main objectives: first, to "provide a working definition of gambling-related harms and situate this within a new framework for policy and regulatory action"; and second, "drawing on this definition, to outline a range of

measures and metrics which relate to these harms and identify which could robustly be built into a framework for measuring the social costs of gambling-related harms."[36]

The working definition of harm proposed by the paper is that "gambling-related harms are the adverse impacts from gambling on the health and wellbeing of individuals, families, communities and society". These impacts can be both short-lived and durable, and can exacerbate existing socioeconomic inequalities. Over 50 different metrics of harm are identified in the paper, with some attributed to a societal cost. Mirroring the categories of cost outlined in the IPPR report, they include the following:

- loss of employment
- experience of bankruptcy and/or debt
- loss of housing/homelessness
- crime associated with gambling
- relationship breakdown/problems
- health-related problems
- suicide and suicidality

This is also echoed in the 2021 Public Health England (PHE, now the Office for Health Improvement and Disparities) study commissioned by DHSC, which expands on similar categories of harm to provide estimated costs, including the cost of homelessness and suicide. PHE concludes that the annual economic burden of gambling in England can be estimated at £1.27bn (in 2019-2020 prices).[37]

However, PHE also highlight the fact that certain risk factors remain impossible to identify, that there is still an insufficient longitudinal understanding of the causal links between these risks, vulnerabilities and harm, and "it is not possible to say with confidence the extent to which [a factor] may cause or exacerbate the issue". As a result, it is argued that the gaps in the evidence base mean that the true scale of the economic burden of gambling harm is underestimated[38] – an assertion echoed by Wardle, Reith and Langham in their written evidence to the Lords Select Committee, which argues that "the number of people harmed from gambling is very likely to be far higher than the number of people who are categorised as problem gamblers."[39]

This exemplifies the problem at hand: extending a taxonomy of harm to accommodate both individuals and wider networks enables government to establish a more detailed *definition* of harm but hinders government from establishing a more accurate *measurement* of that harm. It means that we know more about the 'what' of harm but less about the 'how'. It means that we know that more people are harmed by gambling than are currently accounted for, but we do not have an accurate understanding of either the quantity or quality of that extended harm – a gap in the evidence which sits (through no fault of the academic authors themselves) at the heart of each one of the reports cited in this paper.

In other words, the body of research recognises the extension of harm from individuals to networks and the fact that this harm has a cost, but acknowledges the limitations of the existing evidence base and the need for further research to understand more about the relationship between harm and cost. This is why IPPR include the caveat in their

report that "the quality of data for different areas of interaction is highly variable", it is why McDaid and Patel highlight the fact that "there are major challenges in attributing social harms to gambling", and it is why the PHE report states that "it is not possible to say with confidence the extent to which [a factor] may cause or exacerbate the issue".

This problem was summed up by Lord Watts in an oral evidence session of the Lords Select Committee, when he challenged DCMS officials by arguing that the current system of researching and funding gambling-related harm is "almost a sticking-plaster exercise because, first, you do not know the numbers of problem gamblers and, secondly, you do not know the social implications of that. If you knew the answers to those first two questions, you could say how much the levy should be. You would then have to open a dialogue with the whole industry to find the money required to address this." In response, the DCMS official answered that "I agree with a lot of that, but I do not think the assessment of the social and economic costs tells you how much you need to cover prevention services and treatment services" — while her counterpart at DHSC acknowledged that "we do not know what the best range of services is to meet their needs, and we have to be very honest here. I think it is going to be a leitmotif of this session that we would like to know more and we do not know as much as you would like us to know."[40]

With this in mind, it is clear that while there is widespread support for a statutory levy from academics, clinicians, parliamentarians, campaigners, and leading voices within both the NHS and the third sector, there is a broad recognition among these advocates of the need for a stronger evidence base to define, categorise, measure, and reduce gambling-related harm. Specifically, it is clear from the existing evidence base that the priorities for future research should include the following:

- To date, the majority of reports which examine the question of gambling-related harm are essentially reviews of secondary research, meaning that there is a risk of these reports being caught in a pattern whereby a series of literature reviews refer to and reinforce each other. Caught like this, the evidence base does not move forward. There is a need for primary data, based on clinical observation, verification, and empirical experimentation – including randomised controlled trials on psychological interventions and pharmacotherapy for gambling disorder.
- This primary data needs to include longitudinal data, as called for in the Lords Select Committee Report and the recent article by the National UK Research Network for Behavioural Addictions in *The Lancet*. We argue that existing funds should prioritise putting together the structures necessary for such a longitudinal study to begin.
- As well as clinical data, research must also be dedicated to understanding "non-tangible" harms. By definition these will be difficult to identify. In this respect, we agree with McDaid and Patel that "causality may not be linear", and that "better longitudinal data is critical to address this issue". As Wardle and others have argued, "the metrics rated as having the best potential for attributing social costs to the harms of gambling are those with more concrete outcomes, such as job loss, relationship loss, crimes committed or loss of life.

> A challenge is how to value those with less tangible outcomes, but which are nonetheless, deeply impactful, such as loss of life opportunities and loss of family or community support and cohesion".[41]

We argue that a renewed focus on these three priorities – on primary data, on longitudinal data and on questions of causality – would ensure that existing funding pledges are efficiently used to provide support to the wider aims of the Gambling Commission's National Strategy, which states the "need to develop a way to comprehensively measure the harms caused by gambling and their cost to society. This will allow us to understand the scale of the issue and whether we've successfully reduced harms, and more effectively target interventions".[42]

As we have discussed in this paper, a single charity, GambleAware, is the sole beneficiary of the BGC's £100 million funding pledge for counselling and treatment services up to 2023. This is despite the fact that NHS services have been underfunded during the same time period, that GambleAware acknowledges the need to "develop" its evidence base and has itself called for the introduction of a mandatory levy. We argue that £100 million is a significant amount of money – and authority – to give to a single charity when it is widely agreed that resources are needed to integrate the work of the NHS, public agencies and local authorities within a formal framework of harm reduction. Without a sufficient understanding of gambling-related harm, an adequate framework to achieve harm prevention, and without full independence, these funds risk being spent inefficiently.

We therefore recommend that the first priority of the new Joint Advisory Levy Board should be to oversee a comprehensive and independent assessment of both the evidence base of gambling-related harm and the limitations of the current voluntary system. It makes no sense to allow the current funding arrangement between the gambling operators and GambleAware to continue while such an assessment is being carried out. In practice, this means that the operators should be encouraged to reallocate the £60 million pledged to GambleAware for 2023 to the Gambling Commission under the oversight of the Joint Advisory Levy Board. This would, we believe, ensure maximum efficiency (and accountability) in the distribution of those resources, while maintaining existing treatment programmes until a new framework has been developed.

In terms of this assessment, it is important to note that while 'Research, Education and Treatment' has long been the established terminology of the voluntary system, 'RET' is not used in the 2005 Gambling Act itself but rather was introduced as part of the Gambling Commission's regulation of LCCP. Furthermore, when the new LCCP Social Responsibility Code requirement came into force requiring operators to direct their annual financial contribution to one or more organisations on a list maintained by the Gambling Commission, references to 'Research, Education and Treatment' were changed to 'Research, *Prevention* and Treatment' (although the Commission still uses the acronym 'RET'). This change was, in the words of the Commission, "a result of the Commission's review of the RET arrangements in February 2018 which concluded that the current voluntary system was falling short of its objectives. The Commission was concerned that RET contributions were disparate and uncoordinated and that some

recipients of RET contributions had no clear link to the research, prevention, or treatment of gambling harms."[43]

This shift in terminology makes sense: prevention before an addiction has taken hold is preferable to treatment afterwards. And there is little point in talking about short-term treatment without talking about the longer-term recovery from and amelioration of the addictive disorder. We therefore argue that it is essential that both long-term prevention and recovery are enshrined in the Joint Advisory Levy Board's assessment of harm and the subsequent implementation of the statutory levy.

We argue that the current framework of RET needs to fully integrate long-term harm Prevention (P) and Recovery (R). **To this end, we therefore recommend that the Government and the Gambling Commission change future references about 'RET' in official documents to 'PRETR' (Prevention, Research, Education, Treatment and Recovery), and that the Joint Advisory Levy Board's assessment of the evidence base is based on this same principle.**

THE POLLUTER PAYS – WITH A TARGET

In this paper, we have argued that the answer to the inadequacies of the current voluntary system lies in the introduction of a statutory levy – and that only through a statutory levy can the formal structures be established which would allow consistency, transparency, and accountability to be achieved.

In order to achieve this, we have recommended the creation of a new Joint Advisory Levy Board, led by the Department of Health and Social Care, to have strategic oversight over the levy paid to the Gambling Commission. We have argued that the first priority of the new Joint Advisory Levy Board should be to undertake a comprehensive and independent assessment of both the evidence base of gambling-related harm and the limitations of the current voluntary system, accommodating measurements of longer-term prevention and recovery, in order to establish the necessary causal and correlative links between the determinants of gambling activity and gambling harm, as well as the elements of gambling activity (for example, the characteristics of certain products) which contribute to that harm. And we have recommended that this exercise should take place between the creation of the Joint Advisory Levy Board in 2022 and the end of the current BGC funding pledge in late 2023, with resources from the £60 million BGC pledge in 2023 being allocated to this purpose.

Having established an adequate assessment of harm, the question is what kind of levy the Joint Advisory Levy Board will then implement from 2024. When thinking about this, it is vital that we unpick terms which have become increasingly unclear in the debate. Would the levy be applied at 1% of GGY across the gambling industry? How would the levy be assessed according to need? Is the levy a type of hypothecated tax? How would the levy be applied according to the 'polluter pays' principle?

Much of the debate over the levy has risked conflating these different questions. For example, when Jeremy Wright announced to Parliament in July 2019 the gambling industry's £100 million pledge and the creation of more clinics, he was asked by Hugo Swire, "will the Secretary of State say a little more about how he envisages these clinics? Will they be sustained on a long-term basis? What is the geographical spread? Will the money be hypothecated? Critically, will the NHS match the money from the five companies to date? I welcome the move today, but I have to say that I am not convinced that we will not need some kind of mandatory levy in the longer term." To this question, Wright answered that "he is right to be sceptical: we are all sceptical and remain sceptical in government about this... In answer to my right honourable friend's point about hypothecation, I should say that it has been made clear that £100 million of the money announced today will be reserved for treatment over the four-year period. We will want to make sure that the requirements for treatment are met via this contribution and those that we expect the rest of the industry to make."[44]

This announcement made it clear that the pledge of £100 million by the industry was the reason that the Government was holding back from introducing a statutory levy, on the basis that the funds met the treatment needs: "if a voluntary route does not prove effective", Wright said to Parliament, "the Government reserves the right to pursue a

mandatory route". In other words, the voluntary arrangement agreed in 2019 was conditional on it being effective.

As we have shown in this paper, there are no clear models of measurement which would demonstrate what "effective" means, but Wright's announcement indicated two ways in which the effectiveness of the voluntary pledge would be judged. First, it would be judged by whether the money "means substantially more help for problem gamblers." Second, it would be judged by whether this help is given "more quickly than other paths we could take," adding that "as the House knows, legislating for [a statutory levy] would take time – in all likelihood, more than a year – to complete. The proposal made this morning will deliver substantially increased support for problem gamblers *this year*" [our italics]. Yet as we have shown in this paper, the BGC reneged on its agreement with the Action Against Gambling Harms charity a year after Wright's announcement and redistributed those funds elsewhere, thus undermining the benchmarks of effectiveness used by the Government to delay the introduction of a statutory levy.

It is impossible to overstate how damaging this episode was at the time to the credibility of the voluntary arrangement struck between the former Culture Secretary and the gambling industry, and it is beyond belief – to use the language of the Lords Select Committee – that despite the Government's own criteria for "effectiveness" being undermined in this way, a statutory levy has still not been introduced.

Furthermore, Wright said that "in answer to my right honourable friend's point about hypothecation, I should say that it has been made clear that £100 million of the money announced today will be reserved for treatment over the four-year period", implying that the ring-fenced nature of this funding meant that a more formal type of hypothecated tax was not necessary. This makes sense. The purpose of an industry levy is to raise revenue to meet a specific cost caused by the activities of that industry without placing an additional burden on wider tax structures. The gambling levy – whether statutory or voluntary – is not a hypothecated tax. Indeed, during a Lords Select Committee oral evidence session, one DCMS official stated, in reply to the point that the Government does not rule out bringing in a statutory levy if the voluntary levy was not effective, that "no, government does not rule it out, and of course… there would be other ways of funding it. If the Government decided that a tax on the industry was a necessary way of providing public funding, there would be other regimes, other means of taxation to do it. A hypothecated tax would not be the only way of providing that public funding."[45]

One of the arguments against hypothecation is that the amount of spending on a particular service should be calculated depending on circumstances affecting that service at any given time (the need), rather than being fixed (for example, at 1% of GGY) in a way that allows less flexibility to spend more (or less) if circumstances demand. The argument is that hypothecation limits the Treasury's flexibility to determine overall patterns of public expenditure,[46] meaning that the Government has less scope to allocate funds elsewhere if needed (leading to the risk of inefficiency and waste) and is less resilient to fluctuations in the market. As Richard Murray of the King's Fund argues, Treasury orthodoxy has long opposed full hypothecation. "The

larger the part of public expenditure to which hypothecation applies," he writes, "the harder it is to deal with the inevitable cyclical downturns in the economy, and indeed with structural ones of the sort that followed the 2008 financial crash – where output is lost permanently, rather than temporarily."[47] This limits the decision-making ability of the Government. In the words of a Treasury Select Committee report on hypothecated environmental taxes in 2008, "setting taxes is one decision facing a government; spending this revenue is another, separate decision."[48]

Furthermore, hypothecation does not integrate an assessment of need in the way that a more calibrated 'polluter pays' approach does. When applied to the question of a gambling levy set at 1% of industry GGY, this means that if the need for funds from research and treatment providers is greater than the amount drawn from that 1%, then the levy does not meet the need; if the need is less, then the money risks being spent inefficiently or wasted.

Additionally, a fixed 1% of GGY would make no distinction between different sectors of the industry, regardless of the market realities facing each sector and the link between those realities and harm. A bingo hall catering to local people in a small town or a casino catering to tourists in London's West End would face the same demand for a fixed percentage of its GGY as a remote operator of online casino games based in Gibraltar. This would risk creating imbalances, particularly if an assessment of gambling harm demonstrates clear differences between types of activity, product and venue, and would – according to industry figures – risk "decimating" parts of those sectors by placing a disproportionate burden on certain land-based venues.[49] It would also be on top of existing asymmetries in the wider tax demands already placed on land-based venues compared to their online counterparts (for example, Remote Gaming Duty is set at a flat rate of 21%, while taxes imposed on land-based casinos can reach up to 50% on every marginal pound of income).

For this reason, we agree with those economists who caution against more formal routes of hypothecated taxation and we recognise that a future levy must be equipped to go beyond the restrictions of a fixed percentage of industry GGY. Instead, it must be developed based on the assessment of need – an assessment that DCMS officials themselves said that they would "look at" during the Lords Select Committee oral evidence session[50] and which would, in the words of Jeremy Wright, reflect the link between gambling-related harm and the financial contribution needed to reduce that harm.[51]

In other words, a statutory levy should be raised fairly and spent efficiently. We argue that this means the introduction of a smart levy based on the polluter pays principle.

The polluter pays principle is an established mechanism used to measure the impact a corporation has on the individuals and environment engaged in and exposed to the consumption of commodities or services provided by that corporation. It has long been used to regulate corporations associated with environmental pollution – for example, aviation, plastics, agricultural waste, oil, and gas – and has been embedded in both successive OECD recommendations[52] and the EC Treaty, which states that policy on the environment "shall be based on the precautionary principle and on the principles

that preventive action should be taken, that environmental damage should as a priority be rectified at source and that the polluter should pay."[53]

We understand that such a principle raises questions about causality and responsibility. As industry analysts Regulus Partners have pointed out, "it is far from clear what, specifically, the 'pollution' is where disordered gambling is concerned. If a factory pumps chemicals into a river, it ought to be relatively simple to work out the nature, cause and necessary remediation of the pollution; but matters are apt to be more complicated when it comes to mental health. Given its prevalence amongst people with gambling disorder, we might assume that depression is an example of 'pollution'; but what if (as is often the case) the depression precedes – and perhaps contributes to – the disordered behaviour? Then there is the question of identifying the 'polluter'. How should we allocate costs where – as is also common – the person suffering from gambling disorder also has an alcohol dependency or substance use disorder?" Regulus conclude, "identifying the 'pollution' is far from an exact science."[54]

We agree that this is a valid concern. A smart levy would be achieved by establishing sufficient data on gambling activity and harm, before allocating funds based on identified need. At present, the Gambling Commission publishes figures on the GGY of the remote sector as a whole, on online casino games including specific products like online slots (described as "dominating the sector"), and on remote betting, led by football and horse betting. The Commission also publishes figures on the number of "problem" and "at-risk" gamblers.[55] However, it does not publish more detailed information about the relationship between GGY, consumer spend, product and harm, or establish how that relationship would translate into the calculation and allocation of a specific levy amount on a particular operator.

Regulus Partners point to the fact that "no-one has managed to produce any detailed spending plans for the money to be raised by a levy... A strategy without a budget is unlikely to have an operational plan in which case it is not in fact a strategy. In 2017, the Responsible Gambling Strategy Board indicated that funding for research, prevention and treatment might need to rise to as much as £76 million a year but this was more a high level guesstimate than a detailed budget." Regulus conclude that "discourse on the levy has generated considerable heat over recent years but precious little light in terms of assessment of need." We agree – and argue that the opportunities for such an assessment have been limited because of the inadequacies of the voluntary arrangement.

As we have argued in this paper, the inadequacies of the current voluntary system of RET funding have also meant that:

- There is no agreed definition or measurement of harm on which a successful research and treatment programme can be developed
- The largest operators have been able to withdraw funding and reallocate it elsewhere, disrupting the consistency of service provision and making independent assessment of those services impossible

- There are no formal structures of clinical commissioning or accepted clinical guidelines; as a result, there are no accepted clinical standards against which the cost of treatment can be assessed
- There is no integrated framework of long-term prevention and recovery alongside research, education and treatment

This is precisely why the introduction of a statutory levy requires an adequate assessment of gambling activity and harm. **We therefore recommend that the Joint Advisory Levy Board, having carried out its assessment of the evidence base of gambling-related harm, then assesses the relationship between this harm and consumer spend, products and industry GGY, in order to calculate which parts of the gambling industry contribute to that harm more than others and to allocate the levy accordingly. This exercise, which should be carried out in 2023, would enable a 'smart' levy to be introduced based on the polluter pays principle from 2024.**

We do not anticipate in this paper whether the levy would remain at the current benchmark of 1% or would increase or decrease according to the Levy Board's calculation of harm, need and cost. And we recognise that it is of course possible that if harm is reduced over time, the rate of the levy which meets the costs of that harm would reduce also. However, we also recognise that the integration of both long-term prevention and recovery as part of the existing RET strategy would, in likelihood, require a financial commitment that is equal to the current voluntary pledge of £60 million per year.

Finally, having carried out an assessment of harm and introduced a levy based on the polluter pays principle, we argue that it is vital for the Joint Advisory Levy Board to establish a clear target for harm reduction by a fixed date, against which the efficacy of the statutory levy can be evaluated.

The current lack of a proper framework for evaluation and targets has been raised in Parliament. In an evidence session with the Lords Select Committee, Lord Watts asked the question, "most companies that pay a voluntary levy pay it to GambleAware. Others pay it in to research, education and treatment. How can we judge the effectiveness of that levy and how the money is spent without having knowledge of all the details of how much is being put into the system and how it is being spent? How does a government department judge that effectiveness?" Responding to this question, a DCMS official said that "I might turn to my colleague from the Department of Health and Social Care here" — despite the fact that DHSC has been given no formal role by DCMS in the current voluntary funding arrangement — adding, "we have focused on trying to understand what the needs are and what impact the services in place are having, rather than matching it to different sources of funding."[56] Another DCMS official replied that "the Advisory Board for Safer Gambling has published a framework on how we can measure harms. That is work that is in progress. The Gambling Commission has commissioned the London School of Economics to scope out more work on how harms can be measured."[57] Yet, neither the ABSG nor the LSE report arrived at conclusions which provide a model – or the primary data – needed to enable a proper evaluation of impact. Rather, both reports pointed to what needs to be done in order to establish such a model: namely, recommendations for "how to strengthen

the evidence base" (LSE) and statements that "issues in treatment provision, outcome measurement, independent quality assurance and sustainable independent funding remain unresolved" (ABSG).

It is important to note that this is not the fault of either the LSE or ABSG. The evidence is lacking, and the authors of these reports have reached the conclusion that further research is required in order to fill the evidence gap. That is a reasonable position to take. What is less reasonable is when such research is cited in response to questions about the effectiveness of the voluntary funding arrangement and the evaluation of harm reduction.

The current system lacks the primary data and the clear target needed to enable a proper evaluation of harm reduction. This lack of a target has been referred to in the ABSG's Progress Report on the National Strategy to Reduce Gambling Harms, which recommended that the Gambling Commission should consider establishing key baseline metrics from which to set targets and measure progress.[58] These include establishing goals for a percentage reduction in the baseline of the following aspects of gambling-related harm, namely:

- Gambling-related debt, bankruptcy and other financial harms
- Gambling-related homelessness
- Gambling-related loss of employment
- Gambling-related domestic abuse and partner violence
- Gambling-related crime
- Gambling-related mental health
- Gambling-related suicides

Such benchmarks are typical in other sectors and parts of healthcare. For example, the NHS Five Year Forward View published in 2014 had performance goals for Clinical Commissioning Groups and mental health providers. The World Health Organisation has benchmarks to reduce mental health harms by a third by 2030. The United Nations has aimed to end AIDS by 2030[59] and the Medicines Safety Improvement Programme established a target to reduce medicine administration errors in care homes by 50% by March 2024.[60] The 2019 Clean Air Strategy has a target to reduce people's exposure to pollutants and an aim to reduce particulate matter emissions by 46% by 2030.[61] Similar pledges exist for carbon emissions. It is interesting to note that 2030 is a recurring date for many of these targets.

We recommend that a similar target should be set for the reduction of gambling-related harm. With the introduction of a smart levy in 2024 and the anticipated regulatory changes from the Gambling Act Review, a clear target should be set to reduce the quantity of total gambling-related harm by 50% within 5 years. The Joint Advisory Levy Board should have responsibility for achieving this target, with independent evaluation carried out by DHSC in 2030, in order to inform future regulatory change.

ENDNOTES

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