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Dear Secretary,

**Re: Inquiry into Poker Machine Harm Reduction Tax (Administration) Bill 2008**

Thank you for the opportunity to comment on the Poker Machine Harm Reduction Tax (Administration) Bill 2008.

Please see below our submission which focuses specifically on a case for continuing the ban on poker machines in community hotels in Western Australia. Indeed the arguments also apply for a similar ban Australia-wide.

Sincerely

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**A case for keeping poker machines out of the WA community.**

**Abstract**

The numbers of Electronic gaming machines (EGMs) or poker machines have expanded in many parts of the world, particularly in Australia. Most States and Territories in Australia now have poker machines in casinos as well as in numerous community clubs and hotels (bars). Australia now has the largest number of EGMs per head of population. The amount of money lost and the extent of gambling related problems have increased in relation to the increases in EGMs. Western Australia (WA) is the only State that has legislation forbidding EGMs in community clubs and hotels. Consequently it has the lowest rate of gambling related problems in the country. Public health advocates have had to work hard over several years to convince politicians that lifting the ban would result in significant community costs related to increased gambling rates.

This paper documents the case for maintaining the ban on EGMs in the WA community. The case is presented within the context of a decision making model.

## **Introduction**

Gambling associated with Electronic Gaming Machines (EGM's)(poker machines), has become a serious public health problem in many States in Australia. Western Australia (WA) is the only State that has legislation preventing EGM's being installed in hotels and clubs. Consequently, it has avoided the scale of gambling related problems compared to other parts of the country where they have been introduced.<sup>1</sup> However, the Australian Hotels Association and Licensed Clubs' Association continue to lobby the WA Government for permission to introduce EGMs to their premises.

A coalition of community groups (the Coalition Against Pokies {CAP}) has advocated against these vested interests. The opponents to EGMs argue that there is a strong case against this form of gambling on public health, social and economic grounds. As with any issue that is the target of advocacy campaigns, it is imperative that the advocates ensure that solid evidence exists to support their stance.<sup>2</sup>

This paper illustrates how a decision making model was used to provide a structure for describing the case for opposing poker machines in Western Australia.<sup>2</sup>

It also provides information to illustrate that problem gambling associated with poker machines is an escalating problem that warrants more serious consideration by public health officials and policy makers. This threat exists wherever EGMs currently exist, and wherever their introduction is planned.

Evidence over the last decade has been accumulating to indicate that gambling problems related to EGMs could pose a significant health and social problem in Australia. A systematic analysis of this information was carried out by using the steps recommended by the PABCAR decision-making model.<sup>7</sup> Based on this analysis it was concluded that a strong case existed for advocating against their introduction in WA.

The PABCAR model was developed and refined through observation of decision-making in public health settings, interviews with public health practitioners, and the application of the model to public health problems.<sup>7,8</sup>

The PABCAR model requires the practitioners to consider data and information in five steps (see Figure 1):

1. What is the problem and is it significant?
2. Is it amenable to change?
3. Are the intervention benefits greater than costs?
4. Is there aceptance for the interventions?
5. What actions are recommended?

*Insert Figure 1 about here*

The first step requires the identification of the problem and its significance to the community. This includes a description of the incidence of the problem, information about the target group/s and the costs to the community. An assessment of the community's perceptions regarding the problem and the identification of how it impacts upon their lives is part of this step.

The second step involves the assessment of the problem's amenability to change. If the data indicates that the problem is amenable to change then the practitioner moves to the next step. However, if there is little evidence of changeability, the option is to discontinue or to carry out research to find ways to increase the changeability.

The third step is an assessment of the benefits and costs of implementing the intervention/s. The impact upon the target group and the community; ethical considerations associated with the intervention; economic costs and the efficacy of the interventions are considered. Social and ethical consequences, which may result from the implementation of the change, are also assessed.

Part of the assessment of the benefits and costs associated with the interventions needs to include an economic benefit and cost analysis. Some of this data is gathered during the first two steps when examining the costs associated with the burden of illness or the public health problem, and the costs of implementing various interventions and their associated benefits.<sup>9</sup>

After weighing up the evidence presented in this step, it should be possible to decide whether the potential benefits of the advocated policy or intervention are greater than costs. If the benefits are greater than the costs then it is recommended that the decision-making be taken to the next stage, where an assessment is made of the level of acceptance or likely acceptance of the advocated measure. If the benefits are less than the costs it is suggested that the proposed advocacy be discontinued. If the answer is unclear, then it might be appropriate to advocate for pilot testing or a trial of the proposed measure.

The fourth step examines the acceptability of the proposed measure by relevant groups or individuals including the target group, the community, politicians, and industry representatives. It is likely a wide range of views maybe evident, requiring the public health practitioner to frame the issue for consideration by key stakeholders.

The final step of the PABCAR model is action and monitoring. If there is not a significant level of acceptance for the proposed measure then substantial lobbying is recommended. This advocacy should be targeted towards those blocking the implementation of the measure, as well as towards those who support the intervention to ensure that they continue to advocate for its implementation. In addition, ongoing media advocacy aimed at the general public is recommended. If there is a significant level of acceptance then the measure should be implemented by the appropriate authorities.

### **Analysis of the impact of EGM's based on the PABCAR model**

The first step of the PABCAR model (see Figure 1) is the clear identification of the problem. This includes reviewing epidemiological evidence, information about the target group (number of people affected and social context of the problem) and the cost of the problem.

### 1. What is the problem?

Australians lose over 14 billion dollars a year on gambling with electronic gaming machines (EGMs) being responsible for more than half of this loss.<sup>1,10,12</sup> Australia has 21% of the world's EGMs with over 180,000 machines. During the period 1972 to 1998, the per capita spending (over the age of 18 years) on gambling increased from \$300 (in 1998 prices) to \$800 in Australia with much of the growth attributed to EGMs. This makes Australians the heaviest gamblers in the world, spending twice as much on average as residents in Europe and North America.<sup>1</sup>

Gambling is not necessarily unhealthy. It can provide enjoyment to many people with few adverse effects. However, there is increasing evidence that excessive gambling by an increasingly larger proportion of some communities is having substantial social and health consequences.<sup>1, 11,13, - 17</sup> In the United States and Canada an estimated 2% of adults are pathological gamblers and an additional 2% to 4% are classed as problem gamblers. Similar prevalence rates are estimated for Australia and New Zealand.<sup>18,19</sup> The prevalence of gambling related problems has increased substantially in all these countries in association with the expansion of legalized gambling, especially EGMs.<sup>19, 20, 21</sup>

Western Australia (WA) is the only State in Australia where EGMs are not permitted in hotels and clubs. In WA they are confined to the Burswood Casino. The Australian Hotels Association and Licensed Clubs' Association for the introduction of EGMs into their premises initiated a campaign in 1997. They formed the Independent Gaming Corporation specifically to lobby for the EGMs and since that time have undertaken an advocacy campaign.

#### Target groups for the 'problem'

The groups in Western Australia that are most affected by EGMs are:

- Primary target group - Potential problem gamblers
- Secondary target groups - The gamblers' families and friends
- The community that pays for the negative consequences outlined below

*{Problem gambling is described by a variety of definitions but most emphasize two aspects in particular. Firstly there is usually a lack of control by the gambler over her or his gambling behavior, and secondly there are usually adverse personal, economic and social impacts, which result from the gambler's actions}.*<sup>1</sup>

#### Epidemiology

About 2.3% of adults in Australia are afflicted with a significant gambling related problem, with 140,000 people experiencing severe problems. Problem gamblers contribute disproportionately (over 25%) to gambling revenue.<sup>1, 22</sup> The highest rate of problem gamblers is in New South Wales (NSW) and the lowest rate in Western Australia, which reflects the availability of gaming machines.<sup>1</sup> Evidence from South Australia, NSW and Queensland indicates that as EGMs have become more available there has been an escalation of problem gambling.<sup>16, 23</sup> Statistics indicate that West Australians are involved in gaming activities at similar rates as other Australians.<sup>1</sup> Therefore it is unlikely that West Australians have any other factors apart from

the absence of EGM's which account for them having the lowest rate of problem gambling in Australia.

It is estimated that 5000 people in Western Australia are problem gamblers, with another 10,000 suffering some problem associated directly with gambling.<sup>23</sup> However, reports from community based welfare groups indicate that the extent of the problem is grossly under-reported.<sup>24</sup> In Australia there was a 50% increase in gambling related caseloads of counselling services during 1997-1998 and an estimated 8000 people obtained treatment for gambling problems in the last year.<sup>1</sup> The majority of these people reported problems associated with EGMs. Western Australia contributed relatively little to this pool of problem gamblers, probably due to the limited access to EGMs. However it is estimated that if EGMs were introduced widely into WA, the number of new problem gamblers would increase by more than 100%.<sup>1</sup> There is limited data about gambling characteristics of adolescents, but reports from the USA suggest that up to 6% to 7% of this group may have gambling problems.<sup>25, 26</sup> As EGMs are confined to licensed premises, this form of gambling is unlikely to have direct impact on teenagers. Any negative consequences are more likely to emanate from older family members, particularly parents' betting on poker machines.

### Cost to the Community

One problem gambler affects at least five other people.<sup>1, 13, 17, 22</sup> Grief, stress, breakdown of family relationships, financial difficulties, stealing from family members, loss of household income, increased crime and study difficulties are common to the problem gambler and their families. Problem gamblers' spouses often report similar physical and emotional problems of the gambler. Many gambling problems are associated with a desperate desire to recoup losses. These problem gamblers can suffer numerous physical and mental health problems including substantially increased risk of suicide.<sup>1, 27</sup> Reports revealed that 10% of problem gamblers and 60% of gamblers undergoing counselling contemplated suicide.<sup>1, 14</sup>

Evidence indicates that in South Australia, NSW and Queensland there has been an escalation of problem gambling which is associated with the expansion of EGMs.<sup>1, 16, 22</sup> It is acknowledged that as has happened in other States, the introduction of EGMs in WA is likely to impact more on the poorest and most vulnerable members of the community.<sup>24, 28</sup>

The information presented above indicates that gambling produces a significant problem for at least 2.3% of Australian adults with a further 11.5 % of Australians being adversely affected by the gambling

### 2. Is the problem amenable to change?

The next step in the PABCAR Model is to assess if the problem is amenable to change. This step utilizes evidence from previous interventions. If it is unclear whether the problem is amenable to change then further research is recommended.

Evidence suggests that the availability of EGMs directly relates to the size of the gambling problem. Therefore a very effective intervention is to minimize the availability of EGMs to the public. The following interventions could be considered as part of the response to reduce the problems associated with EGMs.



Potential employment opportunities may also be lost due to a moratorium on EGMs for social workers, welfare agencies, undertakers and health professionals who would be needed to deal with the victims of excessive gambling. The State Government may also be deprived of an additional source of taxes.

Licensed premise owners would not obtain a percentage of profits from the EGMs that might be used to upgrade their facilities and to subsidize meals. However, patrons, especially younger people are likely to be deprived of entertainment such as live bands that would be displaced by EGMs should they be allowed into hotels.<sup>31</sup>

Community charities may be deprived of funds from the profits of EGMs. On the other hand, the introduction of EGMs can lead to a reduction in fund raising income from charitable gambling such as bingo.<sup>16,32</sup> Also, retail outlets in the vicinity of premises with EGMs report loss of income since the introduction of EGMs.<sup>16</sup> Reports in 1998 from other parts of Australia where there has been an increase in the number of EGMs corroborate that evidence. Costs of health, welfare and crime prevention services may also increase due to the introduction of EGMs (Refer to Figure 2).

*Insert Figure 2 about here*

#### Efficacy of the intervention

*The recommended intervention, a moratorium on the introduction of EGMs in WA, based on current evidence, is likely to have a significant positive effect on the health and welfare of the WA community. The intervention requires little effort and cost to implement and monitor.*

#### 4. Is there acceptance for the interventions?

If the benefits from implementing the intervention are greater than the costs it is appropriate to consider the next step of the Model, the acceptability of the measure.

There has been strong support from the target group, the general community, and many politicians for a moratorium on new EGMs in WA. However, there has been some opposition from selected industry groups.

#### Target group

Increasing numbers of the target group (potential problem gamblers; the gamblers' families and friends; and the community that pays for the negative consequences of EGMs) support the intervention.<sup>1</sup>

#### Community

Evidence indicates that the community in WA has a high level of acceptance of the measure. Substantial media coverage of the gambling issue helped increase awareness of the problems associated with excessive gambling. Surveys indicate that as many as 92% of the public oppose an increase in gaming machines.<sup>1</sup>

#### Politicians

Many politicians tend to follow the feelings of the community rather than lead when it comes to health-related policy. In WA, the political leaders of the major parties have publicly stated their opposition to the introduction of EGMs. However, some Members of Parliament continue to be vulnerable to the lobbying of the vested interests of the Australian Hoteliers and Licensed Clubs Associations.<sup>1,2</sup>

### Industry

The Australian Hotels Association and Licensed Clubs Association are the main proponents for the introduction of EGMs into their premises. They believe that EGMs would increase patronage of their facilities, and hence, increase profits. Reports in 1998 indicate that the Independent Gaming Corporation was successful in gaining the support of some sporting clubs such as bowling and football, to back their campaign for the introduction of EGMs to their premises. It was assumed that the potential negative effect of EGMs was not adequately communicated to those club members. On the other hand members of the retail industry expressed concerns about the potential loss of income due to customers spending substantial funds on EGMs.<sup>1,16</sup>

### 5. *What actions are recommended?*

The final step of the PABCAR model is action and monitoring.

If there is a significant level of acceptance then the measure is likely to be implemented

In the case of EGMs in Western Australia, there is very strong community support for retaining the status quo. People in WA became aware of the negative ramifications of the large numbers of accessible EGMs in other States. The majority of State Members of Parliament were also made aware of problems associated with EGMs, along with the public's opinion on the issue. Consequently, the WA Government policy, and that of the Opposition Liberal Party, is to maintain a moratorium on any change to the numbers of EGMs in the State.<sup>2</sup>

Based on the evidence outlined above, the decision to advocate for a ban on new EGMs is well founded, and supported by the PABCAR decision making process. The Government's decision to support the ban is similarly based on sound evidence.

### **Conclusions**

The justification of a public health decision is complex and to a degree dependent upon the beliefs of the individuals, their interests and values. Public health professionals need to be able to justify their decisions when advocating for a measure or policy. The PABCAR Model leads the advocate through a series of questions and steps, which requires consideration of the problem from a broad perspective. Importantly, it helps ensure that public health professionals have considered relevant evidence prior to advocating for measures.

The evidence is clear that there is a very strong case for a continuing ban on poker machines in hotels and clubs in Western Australia. Any change to this policy would therefore be inappropriate and irresponsible.

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<u>Benefits</u>	<u>Costs</u>
<p><u>Social</u></p> <ul style="list-style-type: none"> <li>• Intangible savings of grief of family and friends of potential suicide victims</li> <li>• Reduction in the number of victims of crime committed by gamblers.</li> <li>• Less strain on social welfare services.</li> </ul>	<ul style="list-style-type: none"> <li>• Loss of potential social services supported or subsidised by taxes collected from EGM revenue</li> </ul>
<p><u>Ethics</u></p> <ul style="list-style-type: none"> <li>• The number of problem gamblers in WA would not increase by 100%</li> <li>• Decrease, or at least, no increase, in the general harm to the community from problem gambling</li> <li>• Increase in the freedom of the community due to lower crime rates. i.e. the society as a whole is likely to be the beneficiary</li> </ul>	<ul style="list-style-type: none"> <li>• Loss of freedom of a minority of gamblers who may be deprived of their choice of gambling formats.</li> <li>• Loss of freedom of members of the Australian Hotels' Association to market a revenue earner</li> </ul>
<p><u>Economic</u></p> <ul style="list-style-type: none"> <li>• Less public revenues required to promote harm minimization campaigns about gambling</li> <li>• Costs of health, welfare and crime prevention services would not increase due to EGMs.</li> <li>• If EGMs did not exist, the resources would be used to create similar levels of alternative employment to that funded by the gambling.</li> <li>• Patrons, especially younger people would not be deprived of entertainment such as live bands that would be displaced by EGMs should they be allowed into hotels</li> <li>• Community charities including charitable gambling such as bingo would not have to compete with EGM gambling.</li> <li>• Retail outlets would not have to compete with EGM gambling.</li> </ul>	<ul style="list-style-type: none"> <li>• There would be no increase in revenue from clients who might be attracted to licensed premises to play the EGMs. This may affect employment in the hospitality industry.</li> <li>• Profits from the EGMs would not be available to licensed premise owners to upgrade their facilities and to subsidize meals</li> </ul>

**Figure 2. Are the *benefits* of preventing expanded access to EGMs greater than the costs?**