

Gambling harms can be reduced: public health meets politics

Charles Livingstone

There are, at present, about 116,000 people in Australia with a serious gambling problem, and another 279,000 with a moderate one. These people directly affect their children, parents, spouses, cousins, neighbours, employers, friends, lovers, colleagues and customers. More than three quarters of problem gamblers principally use poker machines. There are 185,500 high intensity poker machines scattered throughout Australia's suburban pubs and clubs (and another 12,300 in Australian casinos).¹

Gambling problems are significantly associated with physical and mental illness; financial ruin, the loss of family and corporate assets, and bankruptcy; relationship difficulties, family breakdown and divorce; crime, including fraud, theft, violence and deception; and suicide, self-harm and the neglect and abuse of children. Poker machines are disproportionately concentrated in already disadvantaged areas.^{1,2}

The Australian Productivity Commission (PC) found that "the greater the extent of the problem, the more likely it is related to EGMs." The likelihood of having a gambling problem is increased by as much as 17.5 times for those who use poker machines, compared to those buying a lottery ticket. Further, poker machine venues derive around 40% of their revenue from those with a serious gambling problem, and another 20% from those in the 'moderate risk' segment.¹

Key elements of a comprehensive reform of poker machine gambling in Australia were set out in the PC's report of 2010. They were twofold, emphasising changes to game and machine characteristics, overlaid by a pre-commitment system. Both of these major components are very likely to have a positive effect on the harm associated with gambling problems. However, of the two, it is most likely that addressing game characteristics, particularly via much-reduced maximum bets and prizes, would be effective and readily implemented. Modification of some key game characteristics is a key strategy to reduce intensity of use and thus harm.¹

Utilising unit record files from a Queensland gambling prevalence study, the PC discovered that 88% of recreational gamblers bet less than \$1 on poker machines, whereas 50% of problem gamblers do so.¹

The PC's analysis of these data is supported by other studies³⁻⁵ indicating that a reduction in bet size will not inconvenience recreational gamblers but will reduce the amount lost by problem or at risk gamblers. Other studies identify other game characteristics (e.g., the number of 'lines' that can be played or multiples of bets made per line) that are likely to exacerbate high levels of expenditure.^{6,7}

Poker machines are designed to facilitate instant and significant increases in the amount bet. The PC described this as 'the capacity of EGMs for high cost play and for players to ramp up spending 1000-fold, from 1 cent per button push to \$10 per button push every few seconds.'¹ A \$1 bet limit would significantly limit this.

The PC proposed that average losses would be in the range of \$120 per hour if a \$1 maximum bet were introduced, as opposed to current

maximum average losses of \$1,200 per hour.¹ However, outcomes for poker machines are highly unpredictable, in large part because of high maximum prizes.

Maximum prizes on Australian poker machines are relatively high by world standards. In the UK, most machines in clubs and pubs are limited to maximum prizes of £70 or less.¹ In Australia, maximum prizes are \$10,000 or more. The problem with large maximum prizes is that such extremely unlikely events, occurring not more than 1 in 10,000,000 games, distort the pattern of payouts. Most users actually spend their stake very quickly, increasing the likelihood that they will 'chase' losses or seek a 'reasonable' period of game time.

Livingstone and Harrigan⁸ demonstrated how this occurs using modified parameters on a computer simulation of an Australian poker machine game. Further research is necessary to develop precise design principles that accord with this approach, but the principle is well understood and achievable. Implementation of this measure would be inexpensive if phased in over the replacement cycle (around five years).

Reform of the regulation of gambling in Australia must begin by addressing the issues associated with poker machines. There is little doubt as to the efficacy of available solutions. As in many areas of public health, an effective upstream solution will affect the revenue stream of powerful vested interests. The recent response by the gambling industry to the possibility of reform illustrates this, in a manner highly reminiscent of the activities of 'Big Tobacco' in the past. At this point, the public health commitment to improved health and wellbeing acquires a political dimension. In Australia, that moment has well and truly arrived.

References

1. Productivity Commission. *Gambling*. Report No. 50, Canberra 2010
2. Department of Justice. *The Victorian Gambling Study – wave two findings*. Melbourne; 2011.
3. Blaszczynski A, Sharpe L, Walker M. *The Assessment of the Impact of the Reconfiguration on Electronic Gaming Machines as Harm Minimization Strategies for Problem Gambling*. Report for the Gaming Industry Operators Group, University of Sydney Gambling Research Group. Sydney; 2001.
4. Centre for Gambling Research. *Review of the ACT Government's Harm Minimisation Measures*. Commissioned by the ACT Gambling and Racing Commission; 2005.
5. Sharpe L, Walker M, Coughlan M-J, Enersen K, Blaszczynski A. 'Structural changes to electronic gaming machines as effective harm minimisation strategies for non-problem and problem gamblers'. *J Gambling Studies*. 2005; 21(4):503-20.
6. Australian Institute for Primary Care. *The Changing Electronic Gaming Machine (EGM) Industry and Technology, Final report*. Commissioned by the former Victorian Gambling Research Panel; 2006.
7. Rodda S, Cowie M. 'Evaluation of electronic gaming machine harm minimisation in Victoria', Report prepared for the Victorian Department of Justice. Melbourne, Caraniche Pty. Ltd; 2005.
8. Livingstone C, Harrigan K. *Submission to the Joint Select Committee on gambling Reform, Inquiry into pre-commitments scheme*. Submission No. 118 (principal and supplementary submissions). 2011. [cited 2012 Mar 15] Available from http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Committees?url=gamblingreform_ctte/precommitment_scheme/submissions.htm

Author

Charles Livingstone, School of Public health and Preventive Medicine, Monash University, Victoria

Correspondence

Charles Livingstone, School of Public health and Preventive Medicine, Monash University, Level 3, Burnet Tower, 89 Commercial Road, Melbourne, Vic 3004; e-mail: Charles.livingstone@monash.edu