Gaming Machine Harm Minimisation Measures Consultation

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Submissions must be received by 5pm, Monday 16 January 2017.

Introduction
This submission has been prepared to inform the Gaming Machine Harm Minimisation Measures Consultation of the position of the Inner East Primary Care Partnership (IEPCP) in relation to the future operation of EGMs in Victoria.

This submission particularly focuses on the health implications of EGM gambling and ways in which a public health framework might apply to the future regulation and operation of EGMs. The IEPCP has worked for close to 10 years on projects to reduce harm from gambling. Initially this work was funded by the Department of Justice and then continued with funding from the Victorian Responsible Gambling Foundation. Most recently, IEPCP delivered the Chasing the Luck Program to reduce harm from gambling among the Chinese Speaking community in Melbourne’s East. The IEPCP also partners with local councils on their work to reduce gambling harm.

Primary Care Partnerships are a health platform set up and funded primarily by the Victorian Department of Health and Human Services. The PCP platform seeks to ensure that services and systems operate effectively in Victoria to maximise access to and outcomes from the primary health sector. The IEPCP operates in the local government areas of Monash, Boroondara, Manningham and Whitehorse and has over 30 members from the health, community and local government sectors.

The significance of the intersection between gambling and health is increasingly being researched and gambling is now being understood to be a major public health issue. As such, it demands an evidence based public health response. Harm from EGM gambling is serious and preventable.
IEPCP is informed by the latest research on harm from gambling. In particular, we rely on the comprehensive study commissioned by the Victorian Responsible Gambling Foundation which sought to assess and measure the impact of gambling harm in Victoria.

Key findings from this comprehensive study include:

- The burden of disease* from gambling is significant. It is just over two thirds the burden caused by alcohol harm or depression and higher than the burden from health conditions such as osteoarthritis or diabetes.
- Most of this burden is not experienced by “problem gamblers”. Indeed, this category of gamblers only account for 15% of the harm experienced.
- “Low-risk” gamblers account for 50% of the harm, or burden of disease cause by gambling.
- There are seven dimensions of gambling harm; health, financial, emotional or psychological, work or study, relationships, cultural harms and criminal activities.
- Most of the harm from gambling could be categorised as harm to self. Harm to others amounts to 13.8% of the harm.

The Gaming Harm Minimisation Measures Review Consultation offers the government significant opportunities to ensure that we build a Victoria free from gambling harm. The benefits of such an approach to the future health and prosperity of the State cannot be underestimated. However, the consultation is not broad enough in its scope to capture a range of evidence informed public health measures that might be most effective.

In addition to responding to the questions below, the IEPCP recommends that the government also consider a number of aspects of machine design and regulation in order to ensure that the burden of disease from gambling is reduced. We make this recommendation because many of the issues canvassed in your consultation do not address the fundamental driver of harm – dangerous machine design and accessibility. Until such time as these issues are addressed, we expect that high levels of harm from gambling will continue, not withstanding any changes that might come form the implementation of harm minimisation measures currently being explored by government.

**An evidence based public health approach must also consider the following:**

1. **Eliminate deceptive and misleading features from EGMs**

EGM design is such that many regular machine users will experience harm and addiction. The removal of the following features would be useful in reducing harm and the addictive nature of the machines.

a) Losses disguised as wins  
b) Fake “near misses”  
c) Note acceptors (South Australia has coin only machines)

We strongly recommend that the VCGLR apply much greater due diligence to new machines and technologies that it allows onto the market. EGM design over the last 20 years has

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* Burden of disease is a modelling technique that combines multiple data sources to count and compare the total fatal and non-fatal health loss from diseases and injuries in a population. Burden of disease quantifies the gap between a population's actual health and an ideal level of health in the given year. This gap is measured using the disability-adjusted-life-year or DALY. The more DALY associated with a disease or injury, the greater the burden. More than merely counting deaths and disease prevalence, the DALY takes into account age at death and severity of disease to count the years of healthy life lost from death and illness. It also attributes this burden to various risk factors. [http://www.aihw.gov.au/burden-of-disease/](http://www.aihw.gov.au/burden-of-disease/)
become more and more sophisticated and the VCGLR has not kept up with the advances in technology and the extent to which new technologies are able to create immersive and addictive experiences.

2. **Reducing maximum bets on Electronic Gambling Machines to one dollar per spin**

Based on the available evidence, it appears that a reduction of maximum bets to one dollar would have little effect on so-called 'recreational' gamblers and would have a positive effect for 'problem' gamblers who consistently bet at levels above one dollar. (Productivity Commission, 2010)

3. **Amend the Gambling Regulation Act 2003**

There are numerous improvements that should be made to decision making processes of the VCGLR. The Gaming Regulation Act 2003 should be amended to:

- Significantly increase the weighting that is given to local government evidence and experience
- Require decision-makers at the Victorian Commission for Gambling and Liquor Regulation (VCGLR) to consider the social and economic impacts of increasing densities of EGMs in vulnerable communities at the local level or census collection district level
- Require community benefits to be genuine and benefit those at most risk of harm from EGM gambling. The applicant would also be required to prove that there is a positive community benefit from increasing the number of EGMs, as opposed to the current ‘will not be detrimental’ test.
- Prohibit applications for new or increased numbers of EGMs in local communities (at suburb or statistical local area level) with below-average socio-economic indexes for areas scores where the EGM density is currently above, or will become above, the state average

4. **Reduce venue opening hours**

The Productivity Commission found that the four hour minimum closing period is insufficient to allow an adequate break in EGM use for problem gamblers. The minimum closing period should be extended from 4 to 8 hours for all venues.
We respond as follows to questions asked in the consultation.

Q.1. Is the current $200 per EFTPOS transaction limit appropriate? If not, what other regulatory measures would support the objectives of the Act?

The current $200 per EFTPOS transaction limit should be replaced with an enforceable personal daily limit of $200 in a gaming venue. This would affect very few casual gamblers, but would have significant positive effects on those with gambling problems.

We believe that of all the measures proposed as part of this consultation, this is the one that is most strongly backed by evidence. Accordingly, from a public health point of view, it should be the government’s highest priority.

Evidence: this position is strongly supported by findings from Hare, S. (2015)² which found that:

Problem gamblers reported accessing EFTPOS a significantly greater number of times for each gambling session (Mean=3.46 times per session) compared to non-problem gamblers (Mean=0.14 times) (t=3.85, p<.001). The same trend also applied to moderate risk gamblers (Mean=1.55 times) (t=4.63, p<.001), although the difference was not significant for low risk gamblers (Mean=0.98 times). In addition, results showed that, compared to non-problem gamblers, moderate risk (OR=13.02, p<.05) and problem gamblers (OR=34.95, p<.001) were significantly more likely to make EFTPOS withdrawals four times or more per session.

A very similar overall trend was observed for the mean amount of money withdrawn from EFTPOS (Figure 22). Problem gamblers withdrew a significantly larger amount of money per gambling session (Mean=$317.93) compared to non-problem gamblers (Mean=$65.56) (t=5.95, p<.001), as did moderate risk gamblers (Mean=$130.12) (t=3.69, p<.001). There was no difference between low risk and non-problem gamblers. Findings also showed that, relative to non-gamblers, problem gamblers were the only risk category significantly more likely to withdraw from EFTPOS over $200 per gambling session (OR=13.26, p<.05).

Q.2. Is the current $1,000 threshold for the payment of winnings by cheque appropriate? If not, what should be the limit and why?

The current threshold should be maintained.

Q.3. Should payment by EFT be permitted in addition to, or as a replacement for, payment by cheque?

EFT should be permissible and probably encouraged providing there is a 24-48 hour time delay between winnings being claimed and funds being available. This would give the same potential

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break in play as payment by cheque whilst maintaining the intent of the system to ensure that EGM users do not feed winnings immediately back into the machines.

A well implemented EFT proposal would also help overcome the practice of loan sharks and mobile cashiers exchanging checks for a lesser amount at locations near venues. The current $1000 threshold for payment of winnings by cheque could be supplemented with the option for an electronic transfer (using EFTPOS, bank deposit or other electronic deposit) to be processed with a delay of a day or two. This would keep the intention of the original legislation – that large winnings are not immediately available for further gambling (a behaviour which strongly indicates a gambling problem).

Q.5. Should venue operators be able to exchange personal cheques for cash?

No. Venues should not be able to exchange personal cheques for cash. Such a measure may increase harm and should therefore be prohibited. It is highly unlikely that recreational gamblers would be interested in cashing cheques in this way. The measure would be most likely to be used by people experiencing difficulties with EGMs, and would be likely to exacerbate harm.

In addition the practice of cashing cheques would allow cheques issued as winnings in one venue to be exchanged at another.

Other businesses (such as loan providers, pawn shops, and banks) should be prohibited from cashing these cheques on the same day as they were issued. These businesses should also be prohibited from advertising that they will cash cheques issued by gaming venues.

Q.6. If cashless gaming and or TITO is introduced, how should they be regulated so that they are consistent with other measures that limit access to cash? What harm minimisation measures should apply?

IEPCP recommends that cashless gaming and / or TITO not be introduced. New and emerging uses of technology must not be introduced without irrefutable evidence that they will reduce harm. Almost every technological advance that has been introduced by the gaming industry over the past 20 years has resulted in increased player losses and harm.

There is already a strong body of research demonstrating that those who use machines and experience problems lose track of the monetary component of their gambling while using machines. Further removal of tangible monetary indicators may intensify this problem and contribute to addiction.

This position is strongly supported by findings from Hare, S. (2015)\(^3\) which found that:

A range of studies have established that many gamblers will lose track of both money and time during gambling and are frequently unaware of whether they are ahead or behind in play (e.g., McDonnell-Phillips, 2006; Nower and Blaszczynski, 2010). For this reason, the study examined how often gaming machine players lost track of both money and time during play in the past 12 months. This was also measured in 2014 to permit a baseline for future follow-up after implementation of pre-commitment in Victoria (on December 1, 2015). Results are in Figure 23 and Figure 24. Consistent with findings of past studies (e.g., McDonnell-Phillips, 2006),

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\(^3\) Hare, S. (2015) Study of Gambling and Health in Victoria, Victoria, Australia: Victorian Responsible Gambling Foundation and Victorian Department of Justice and Regulation.
compared to non-problem gamblers, all at risk categories were significantly more likely to lose track of both money and time during gambling (Problem gamblers – Money t=11.38, p<.001).\(^4\)

Q.7. What opportunities are there to improve the way codes operate in Victoria?

Are there other models that would be more effective? If so, what are they?

Would a more prescriptive approach for all venue operators be better? Could the operation of codes be simplified?

Are there other matters that should be provided for in the Ministerial Direction for codes?

What requirements for loyalty schemes should be included in a code to promote responsible gambling?

Does the annual review process contribute to fostering responsible gambling? If not, why not?

Are there other options to ensure that the codes meet this aim?

Current codes are a weak form of self-regulation, and are not enforced in any meaningful sense.

In a number of public health fields, self-regulation has been ineffective in achieving improved health and well being outcomes. All significant public health successes in the past 20 years have been achieved through the introduction of stronger regulatory failures (ie Tobacco control, road safety). In those areas of public health practice where industries have argued for self-regulation, we have seen little or no improvement in public health outcomes (ie alcohol harm, obesity prevention and the food and beverage industries).

Furthermore, some key features of codes of conduct have been found to be ineffective. For example, there is no evidence that responsible gambling signage in venues is effective\(^5\). Despite this, such signage continues to be touted as an important initiative in codes of conduct.

The Victorian Responsible Gambling Foundation should be charged with writing a mandatory code of conduct which is informed by evidence. The Foundation has recently released a best practice guide which provides a comprehensive set of indicators which venue operators and staff should be aware of and act on, and a set of actions which follow from these.

In addition, there should be a significant investment in compliance officers to ensure compliance with the code and harsher penalties for compliance breaches. Our services hear repeated anecdotal stories of gaming venues paying lip service to codes of conduct and gaming venue staff being told by managers not to intervene in situations where patrons are clearly displaying signs of gambling addiction.

The Auditor General’s report of 2010 noted that there was inadequate auditing of codes. The report further noted:

The focus of auditing should be on confirming the actions taken by venue operators, not whether operators have made written commitments to take actions.\(^6\)

The more recent report currently being undertaken by the Auditor has not yet been released so we do not have formal information about the extent to which audit processes have


improved since 2010. However, our experience would suggest that much more work needs to be done in this area.

**Q.8.** Should the requirement to interact with customers who are showing signs of distress from gambling be part of codes, or should a separate offence be created for venue operators who fail to respond to suspected problem gambling?

There should be a separate offence for failure to respond to demonstrations of problem gambling. As operators of a high-risk and potentially harmful product, gambling venue operators have a duty of care to ensure that their customers are not harmed by their product. However, this duty of care does not absolve the government from its responsibility in licensing and regulating an essentially dangerous product. Indeed, there is a question to be asked about the extent to which it is helpful to focus on individual gaming venues and employees when the fundamental problem is with the product (EGM) itself. That said, at the current time, some venues facilitate, encourage and/or ignore gambling practices and behaviours that generate harm. Criminalising irresponsible provision of gambling may therefore be warranted.

Any offence created should cover all gambling venues in the state.

The Government should consider how this might be applied to non-venue based gambling offered within Victoria.

Penalties for offences considered by this consultation should be linked to venue losses. As a guide, one penalty offence should be equivalent to the average daily losses on EGMs in that venue.

Consideration should be given to the establishment of a Gambling and Liquor Ombudsman. This officer would be an avenue for complaints about the operation of gambling venues and services. This would make it easier for patrons to report instances where venues promote or allow gambling practices which generate harm.

**Q.9.** Are self-exclusion programs best administered by the industry or by another body?

**Q.10.** Should there be one self-exclusion program in Victoria?

**Q.11.** How could self-exclusion programs be improved?

A self-exclusion system should be simple and easy to use. It should allow a person to restrict themselves from as many venues as they require. This system should be covered by a single point of entry and administered by the Victorian Responsible Gambling Foundation.

Gamblers should not have to go near, or liaise with gambling venues, or the gambling industry in order to self-exclude.

**Q.13.** Should there be a separate offence for venue operators who knowingly allow self-excluded persons to enter or remain in the venue?
There should be a separate offence for venue operators who knowingly allow excluded gamblers to use gambling products.

This penalty should be similar to those applied to those who knowingly serve intoxicated or underage persons alcohol, and the breach penalty should accrue to the venue/operator.

Q.14. Should a new requirement to undertake advanced responsible service of gaming training be introduced?

The VRGF has worked on an extensive training program for gambling venue staff, implementation of which is to start from January 2017. It is our understanding that this program will have 2 modules; a preliminary online session which must be completed within one month of employment followed by module 2 which will be delivered by the Venue Support Worker program of Gamblers Help. This must be undertaken within 6 months of employment.

We are unclear why the Office of Gaming and Liquor Regulation would be considering further development of training at this time when the new model is yet to be implemented and is yet to be evaluated.

Q.15. If so, who should be required to complete the advanced training and what content should the training include?

As a principle, if there is more advanced training, we believe that this should be compulsory for all staff who work in the gaming room.

We note that training is only as good as its implementation. At the current time, we have significant reservations about the extent to which staff within many venues are enabled or encouraged to put into place the training they already receive. Until such time as this situation improves, there may be little point in introducing more advanced training.

Q.16. Who should be responsible for the development and provision of the advanced training?

Any further training should be developed and provided by the VRGF.
Q.17. Do you think regional caps and municipal limits should be maintained? Why?

Q.18. Should regional caps be extended beyond the existing capped areas and if so, why?

The IEPCP contends that the current system is not adequately protecting the areas that most require protection. We note that, of the municipalities we work closely with, the City of Monash is the council which has to most regularly respond to gambling industry applications for more EGMs. Current losses in Monash are not sustainable and are creating high levels of harm in that community.

The Productivity Commission, in its 1999 inquiry into Australia's Gambling Industries, found that “…there is sufficient evidence from many different sources to suggest a significant connection between greater accessibility—particularly to gaming machines—and the greater prevalence of problem gambling.”

More recently, Young et al (2012) have shown that there is an association between greater accessibility of electronic gaming machines (EGMs) and problem gambling, with EGMs being the form of gambling most often used by problem gamblers. Two commonly used measures of access to EGMs are density and proximity (e.g. distance to an EGM). 7

**Given the weight of this evidence, IEPCP contends that a system of municipal levels should be strengthened.**

It is more than ten years since the Regional Electronic Gaming Machine Caps Review (2005). At that time, the Panel found that capping the number of gaming machines in vulnerable communities should be “an important component of the Government’s ongoing harm minimisation strategy.” Despite this, action in this area has been weak.

Findings from the aforementioned Regional Electronic Gaming Cap Review recommended a universal cap to be set at 8.0 EGMs per thousand adults. The State Government did not follow this recommendation and set different densities for the different capped regions via the Order under Section 3.2.4(1) of the Gambling Regulation Act 2003 (Victorian Government Gazette No S 361, 20 October 2009).

Strengthening of the municipal limit system is important. IEPCP has reservations about the extent to which the existing system adequately protects vulnerable gamblers in any meaningful way. Indeed, the above review of the first round of caps found that:

the quantitative reduction of 406 gaming machines from four of the capped regions was too small to impact the accessibility of gambling opportunities.[...] the regional caps policy implemented in the first round was not of a scale and scope that would lead to a shift in the way gaming machines are distributed and, therefore, was unlikely to reduce accessibility to gambling opportunities. The findings of the study are supported by the evidence the Panel collected during its review. The majority of stakeholders indicated that they did not believe that regional caps would have an affect on existing problem gamblers. 8

Furthermore, there is an acknowledgement within community and government that more disadvantaged socio economic areas are seeing a concentration of EGMs:

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7 Young, M., Markham, F., & Dorna, B. (2011) Too close to home? The relationships between residential distance to venue and gambling outcomes International Gambling Studies Volume 12, 2012 - Issue 2 pp: 257-273

A statistical analysis of gaming machine densities in local government areas and the corresponding level of disadvantage shows that there is a significant relationship between the geographic concentration of gaming machines and an area's level of socio-economic disadvantage. Disadvantaged local government areas have a greater likelihood of having a higher than average number of gaming machines per thousand adults when compared with more advantaged local government areas.\(^9\)

A review of the limits system should be guided by the following principles:

**No further machines should be able to be placed in vulnerable communities, including at a suburb or municipal level. Vulnerable communities should be defined as those where:**

- Current EGM losses already exceed the average per capita losses in Victoria by 20% or more
- SEIFA indicates high levels of disadvantage (980 or below)

**There should be one uniform system of limits that is based on municipal areas and their profile**

The maximum limit for municipalities should be 8 EGMs per 1000 adults (as per the 2005 recommendation)

No suburb within a municipality should be able to exceed the established density by more than 25% (ie maximum suburb cap of 10 EGMs / 1000 adults)

Growth should not lead to an increase in EGM numbers

A stronger system of municipal limits would be welcomed by local councils and communities. It would take pressure off those municipalities that are often most under stress to deliver services and infrastructure. We note that most applications for more machines in recent years have been made in lower socio-economic, regional/rural and growth area councils. These are the municipalities that are already under most pressure to deliver important services and supports to their communities. As a result of applications for more machine numbers, these councils are diverting significant resources to responding to applications for growth in EGM numbers. Councils do not receive funding for this role and their capacity to adequately respond to applications is constrained.

Limiting machine numbers at current levels for any council where the per capita loss on EGMs is 20% or more above the statewide average would offer some protection to vulnerable area. This would provide genuine limits on EGM numbers for communities that are hardest hit by gambling losses. On current loss data, this approach would prevent additional machines being located in the following municipalities:

- City of Greater Dandenong
- City of Brimbank
- City of Maribyrnong
- City of Moonee Valley
- City of Latrobe
- City of Maroondah
- City of Monash
- City of Hume
- City of Warrnambool
- Shire of Central Goldfields
- City of Ballarat

This approach should be in addition to, rather than replacing any other limits. (ie municipalities that are already at a cap would still be protected.)

It is also worth noting that existing caps and municipal limits fail to protect areas at a suburb level. Some suburbs have EGM densities of 15 / 1000 adults. A new system as suggested above would ensure this does not happen.