Commonwealth Department of Health and Aged Care

to the

Productivity Commission's

Inquiry into Australian Gambling Industries

April 1999

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SUMMARY

The Commonwealth Department of Health and Aged Care welcomes the opportunity to provide a submission to the Productivity Commission's Inquiry into Australia's Gambling Industries.

This submission largely addresses terms of reference 3(d) the social impacts of the gambling industries; 3(g) the impact of gambling on Commonwealth, State and Territory Budgets; and 3(h) the adequacy of ABS statistics involving gambling. It concentrates on only a few of the issues raised by the Productivity Commission's *Issues Paper*: the definition of gambling; gambling as a health issue and the consequent costs to the Commonwealth; the need for governments to adopt a more active approach to preventing harm from problem gambling; the roles of government in relation to gambling, including hypothecation of gambling revenues to health related programs and projects; and, areas for further research.

Health care in Australia is financed by a mix of public and private funding arrangements. In 1995-96,[1] Commonwealth ($18.6 billion) and State ($7.9 billion) government outlays provided around 67 per cent, while the private health sector ($12.5 billion) provided around 33 per cent. Commonwealth outlays for 1998-99 are expected to be over $23.2 billion of which $165.6 million is directed to improving Aboriginal and Torres Strait Islander health.

Gambling is usually regarded as a responsibility of the States and Territories and the Commonwealth Department of Health and Aged Care has no policy position or direct role in relation to Australia's gambling industries. Yet the economic and social impacts of gambling intersect with all three sectors of the health system that finance health care in Australia: State, Commonwealth and private.

Definition of Gambling

The definition and description of gambling suggested by the Commission could be perceived to be too narrow to capture the scope of the issues set out in the Commission's *Issues Paper*.

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1 The most recent year for which there are comparative data.

Any attempt to define the experience of gambling needs to encompass not just the forms of gambling taxed by governments, but illegal gambling, and the more culturally derived forms of gambling, especially where they result in addictive behaviours or other negative social impacts.

Problem Gambling

Gambling can impact on the health and well-being of gamblers and their families and result in costs to the health system. In some cases it may be linked with mental health problems. Although there is continuing debate as to the cause of problem gambling, in the Australian context it would seem more useful to regard it as a social issue rather than a human pathology.

There continues to be a need for further work on identifying the causes, and more accurately defining the nature, of problem gambling and developing appropriate measurement instruments. Even so, it is suggested that at this time such further work may not be as productive as seeking to address problem gambling or prevent it from emerging

In view of this, for the present, the Department supports the definition and scope notes proposed by the Australian Institute of Gambling Research as follows:

> *'Problem Gambling' refers to the situation in which a person's gambling activity gives rise to harm to the individual player, and/or his or her family, and may extend into the community.*
>
> *'Harm' is essentially a value judgement made by individuals, by families and by the community. What is judged to be harmful for an individual will depend very much on social norms and will vary according to gender and to the lifecycle of the individual. … Where the individuals and families involved live in a society with diverse cultural values and expectations then it will be more difficult, for researchers and service providers to discern the nature and extent of 'harm' (AIGR, 1997, p.2).*

This has the potential to encourage a preventive approach similar to those adopted by the Commonwealth and State in relation to other addictions.

Impact of gambling on health and well-being

There is a lack of documented evidence about the impact of problem gambling on health and well being, especially in the Australian context. Symptoms identified by respondents in the *Queen of Hearts* study (Brown 1997) included: depression, stress, anxiety, lethargy, insomnia, poor nutrition, suicidal thoughts, increased caffeine and nicotine consumption, sweats, confusion, panic and ulcers. Overseas researchers have noted that high rates of affective disorders and suicidal ideation have been consistently reported among clinical populations of pathological gamblers (Blaszczynski and Farrell 1998; Black and Moyer 1998).

It is commonly accepted that many gamblers or members of their families may seek assistance from health workers but without naming gambling as a problem – they present for related health or mental health problems, such as those identified above.

Similarly, there is very little direct evidence on the impact of gambling on the health of Indigenous people. Evidence from a study of gambling in Kimberley Aboriginal communities describes a parallel between the factors associated with gambling and the socio-economic, social and cultural, and specific risk factors contributing to poor Indigenous health more generally. Even so, where gambling in Aboriginal communities is mostly restricted to card games, at least the money circulates within the community. Where electronic gaming machines are introduced, gaming shifts from a social to an individual activity and the money lost goes to the owners of the gaming licence – and probably out of the community.

Costs of gambling to the health system

No attempt has been made to estimate the health costs flowing from gambling related problems. Such costs are commonly regarded as falling on State and Territory social programs. Costs to Commonwealth, State and Territory, and private health funding are generally overlooked and there is no way of tracking these costs. There is no Medicare item for ‘problem gambling’. Hence, the claims of General Practitioners and private psychiatrists give no indication when patients are seeking help for health problems related to gambling or

when hospital services are accessed by attempted, or completed suicides relating to problem gambling.

It can only be assumed that there are costs to all sectors of the health system and that these vary from State to State depending on the approach to problem gambling counselling in each State. Costs are largely to the Medicare Benefits Scheme with some also accruing to the Pharmaceutical Benefits Scheme and hospital funding. In the United States there is increasing pressure for problem gambling to be defined as a 'disease'. This would seem to be driven more by desire to increase the willingness of health insurance companies to pay for the treatment of problem gambling, than by evidence that problem gambling is a medical condition.

The Department considers that the introduction of a Medicare mechanism primarily for quantifying demand for assistance with problem gambling is not appropriate. Problem gambling has not been conclusively identified as a medical problem. Nor is fixing problem gambling primarily a Commonwealth responsibility as would be implied by providing Medicare funding.

Preventive approaches

The Commonwealth, often in collaboration with the States and Territories, has adopted preventive approach to a wide range of health and well-being issues including drug and alcohol abuse, injury prevention, youth suicide, child abuse, and domestic violence.

More work is needed to develop a coherent preventive approach across Australia, one which encompasses strategies appropriate to differing sectors of the industry, types of venues, and types of consumers. Experience to date indicates that preventive approaches to problem gambling need to be wide-ranging. A nation-wide preventive approach might cover:

- the responsibilities of individual gamblers including measures that might improve understanding of gambling risks, to make it more likely that gambling is and informed

choice, eg, measures relating to promotion and marketing in the media and in gaming venues;

- community education and information that encourages gamblers to consider the risks to their families as well as themselves from excessive gambling;
- clarifying government roles;
- regulation;
- planning and location of venues;
- re-constructing the context of gambling; and
- training and rewarding gaming staff for taking a practical preventive role.

Governments and gambling

State and Territory governments have multiple responsibilities in relation to gambling including: legislation and regulation; licensing of operators; promotion of gambling; revenue raising; allocation of gambling revenue, including hypothecation to specific purposes; developing policies and programs to address the negative impacts of gambling, and commissioning research into the impacts of gambling. These functions may be vested in one or more departments.

Of particular concern to the public is the role of government in promoting a potentially addictive behaviour – a role which is in sharp contrast to the part State governments play in discouraging and preventing other addictive behaviours.

Revenue raising and hypothecation

Although gambling taxes provide only around 2% of national revenues, in the last five years States have become increasingly reliant on gambling revenues. In 1996-97 States collected $3.4 billion, or 11%, of their taxes from gambling.

In parallel with this major increase, States have increasingly earmarked the revenues for particular areas of government spending, including and estimated $1.179 billion to health and problem gambling related purposes (see Table 1 below). There is a risk that this

hypothecation is disguising the impact both of the revenue being raised and of the gambling activity being promoted.

Researchers have enumerated wide-ranging criticisms of hypothecation including issues around transparency and lack of budget scrutiny, increasing regressivity, increasing government dependency on sustaining gambling revenue, 'reshuffling' government spending and not producing certainty about future funding including through vulnerability to savings measures.

Earmarking, *per se,* does not necessarily result in the negative impacts. Rather, it is the way in which hypothecated funds are managed that is critical.

In relation to health-related activities and programs, two of the above issues are of concern to the public, to consumers of services and to service providers.

- *Earmarking does not necessarily produce greater certainty about future revenue sources*

  To claim that earmarked funds are vulnerable to savings measures implies that, in comparison, programs funded from consolidated revenue are protected from savings measures and changing government expenditure priorities. This is not necessarily so. It also assumes that hypothecated revenues are used to fund ongoing 'programs'.

  The pattern of health-related grants differs from State to State. Hypothecated revenue from lotteries in Victoria (35% to 36% of turnover), WA (16% of sales), and SA (net operating surplus, equal to around 33% of sales), is transferred to Hospital Funds and not distributed as direct grants.

  Other hypothecated funds are distributed as direct grants to community organisations or government departments either as one-off capital grants or to support service delivery:

- in WA and Queensland the majority of direct grants are for one-off capital grants to community organisations for renovations, furnishings, equipment and computers etc, with some larger capital grants to support medical research; and

- in NSW and Victoria hypothecated funds are more likely to support service delivery (including problem gambling counselling and preventive programs related to gambling), and research into gambling. Even so, the grants are usually time-limited (eg, piloting innovative approaches) and the overall total of health and gambling related grants comprise a relatively small portion of the total funds distributed.

Overall, for the four States considered above, the degree to which service deliverers are dependent on hypothecated funds has been minimised. In addition, in none of these States are hypothecated funds used for entitlement programs.

- *Earmarking 'merely reshuffles government spending and revenues rather than increase[s] resources for the funded social programs' and may even reduce overall funding as earmarked resources may be taken into account in deciding budget allocations.*

  It has been suggested that in Australia this claim may be supported by Commonwealth Grants Commission (CGC) data, on the assumption that States choosing to earmark revenues for particular purposes would be inclined to spend more on such purposes. Smith's (1998a) preliminary analysis of CGC data concluded that in 1995-96, of the three states earmarking lottery revenues to health services, only one spent above average on health services.

  Closer analysis over the years 1991-92 to 1995-96 would seem to support this for hospitals. On the other hand, the one State which hypothecates gambling revenue to mental hospitals, Victoria, consistently spent above standard on mental health from 1991-92 to 1995-96. Further, of the three States that earmark casino taxes for welfare, Victoria again consistently spent above standard on family and child welfare, and on aged and

disabled welfare from 1991-92 to 1995-96. NSW had above standard expenditure on aged and disabled welfare for four of the five years (Commonwealth Grants Commission 1997).

Criticisms of hypothecation highlight a dilemma for governments both in allocating the funds in a way, which the community sees as appropriate and ensuring adequate accountability to government and the public.

Allocating hypothecated funds through the Budget increases transparency and accountability. At the same time it leaves government open to perceptions of substitution, shuffling or placing service providers in a vulnerable position because of the potential volatility of gambling revenue, although as discussed above these are not necessarily caused by hypothecation.

To avoid these difficulties, government can opt for treating hypothecated funds as an additional source of grants for the more general benefit of community, as opted for by most Australian States. This has resulted in very large numbers of relatively small grants, each for objectives set by a community organisation, which may or may not relate to a government funded program. This creates a greater accountability challenge, particularly in assessing outcomes, both for each grant, and the overall outcomes from hypothecated funds.

If the broad objective of the grants is 'community benefit', then innovative evaluation approaches need to be developed which take a broader perspective than that of the effect of individual grants. Evaluations should also assess the extent to which hypothecated funds as a whole contribute to building stronger communities through encouraging self-help and fostering social capital.

Hypothecation of funding should be regarded as a complementary process to 'normal' government funding processes, rather than a replacement. While some community needs should continue to be addressed through ongoing funding (eg, hospitals), the pattern of mostly one-off grants established by the States has the capacity to foster self-help particularly in the States which require communities to make their contribution to costs (financial, in-kind goods, labour). At times, communities need 'a bit extra' to cope with set-up costs or large maintenance items, but can manage day-to-day costs.

States' hypothecation of gambling revenues to health and gambling related purposes

An estimated $1.179 billion of hypothecated revenues was allocated to health and problem gambling related programs and projects by the States according to their most recent annual figures (see Table 1 below).

Table 1: State and Territory Gambling Taxes Hypothecated to Health and Gambling Related Activities

Hypothecated funds distributed through:	**Actual Expenditure $,000**	**Year**
New South Wales		
Casino Community Benefit Fund	5,809	1997-98
Sub-total	**5,809**	
Victoria		
Hospitals and Charities Fund	946,360	1997-98
Mental Hospitals Fund	62,115	
Community Support Fund	1,358	
Sub-total	**1,009,833**	
Queensland		
Golden Casket to Children's health	1,500	1996-97
Casino Benefit Funds	509	1997-98
Gaming Machine Community Benefit Fund	1,552	1997-98
Charities and Rehabilitation Fund	*	
Sub-total	**3,561**	
South Australia		
Hospitals Fund.	83,625	1997-98
Gamblers Rehabilitation Fund.	1,500	1997-98
Community Development Fund	6,000	1997-98
Sub-total	**91,125**	
Western Australia		
Hospitals	60,500	1997
Lotteries Discretionary Fund	8,309	1997
Sub-total	**68,809**	
Tasmania		
Community Support Levy	203	1996-97
ACT		
None	-	
Northern Territory		
None	-	
Total	**1,179,137**	

* As this becomes part of the Families, Youth and Community Care budget, grants to individual health and gambling-related projects can not be estimated.

In view of the availability of grants data and the differing grant periods used by States, it has not been possible to present the information consistently. Further, the scope of what constitutes 'health' varies from State to State, so only programs and activities consistent with the responsibilities of the Commonwealth Department of Health and Aged Care have been included.

Communities in each State clearly benefit from the funds hypothecated from gambling revenues. However, we have not attempted to make any assessment of whether this

community benefit effectively offsets the costs of problem gambling, or helps to build more resilient individuals and communities less vulnerable to gambling problems.

Research and statistics

Although a body of data and research on gambling is beginning to be built up, it seems to be happening in a haphazard manner resulting in patchy coverage and lack of comparability. Factors contributing to this situation include:

- gambling is seen as a State responsibility even though its impacts are not confined by State boundaries and the emergence of electronic gaming renders State boundaries increasingly irrelevant;

- research into problem gambling is funded from gambling revenues: while longer-term research agendas are being developed in some States, there are perceptions that research agendas, and decisions on who receives funding, could benefit from more independent input, and that future research could benefit from multi-disciplinary approaches that would bring new researchers and new perspectives to the task; and

- the patchiness of research corresponds with the patchiness of the data and statistics available: research is hampered by the lack of data and the snapshot nature of much research does not contribute to building up a body of data.

The Department suggests that areas for further research could include:

- preventive approaches;
- assessing the effectiveness of current interventions;
- problem gambling as a health issue;
- help seeking behaviours;
- under-age gambling;
- Internet gambling; and
- cause of gambling problems.

More broadly, there is a need for improved methodologies for measuring the social and economic impacts of gambling, which more accurately identify the range of negative and positive impacts, and assess these consistently across all States.

Conclusion

Although this submission provides information not readily available elsewhere, it also points to the paucity of information on the impacts of gambling on health. This is surprising given that the existing measurement instruments were developed in the health context and focus largely on mental health. Although there is continuing debate as to the cause of problem gambling, in the Australian context it would seem more useful to regard it as a social issue rather than a human pathology. At the same time, it is suggested that any move to further identify problem gambling as primarily a medical problem be treated with caution.

While there is a need for better data and further research, the major effort for the near future would be best directed to developing comprehensive and nation-wide harm preventive approaches supported by all States and all sectors of the industry, and to more robust and independent evaluation of current programs to address problem gambling.

1. INTRODUCTION

The Commonwealth Department of Health and Aged Care welcomes the opportunity to provide a submission to the Productivity Commission's Inquiry into Australia's Gambling Industries.

The Department particularly supports the Government's decision that the scope of the Inquiry should be wide-ranging and that the Productivity Commission (hereafter 'the Commission') should primarily focus on information gathering and analysis, rather than making formal recommendations.

As acknowledged by the terms of reference, little is known about the broader impacts of the rapid growth of gambling. While the body of information and research on gambling in Australia is growing, there is little nation-wide analysis of the issue. The Inquiry will begin to fill this gap and provide a basis for more informed public debate and policy making on gambling.

This submission largely addresses the following terms of reference:

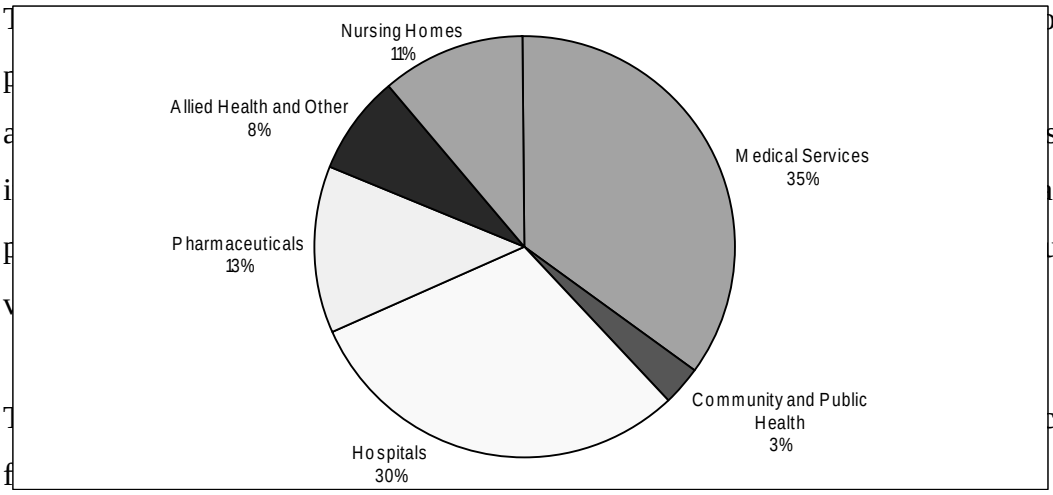
- 3(d) the social impacts of the gambling industries, the incidence of gambling abuse, the cost of welfare support services of government and non-government organisations necessary to address it, the redistributional effects of gambling and the effects of gambling on community development and the provision of other services;
- 3 (g) the impact of gambling on Commonwealth, State and Territory Budgets; and
- 3 (h) the adequacy of ABS statistics involving gambling.

In doing so it concentrates on only a few of the issues raised by the Commission's *Issues Paper*: the roles of government, gambling from a health perspective and the consequent costs to the Commonwealth, the need for a governments to adopt a stronger preventive focus similar to that for other addictive behaviours, and areas for further research.

2. BACKGROUND

Health care in Australia is financed by a mix of public and private funding arrangements: public funding—around 67%; private health sector—around 33% (around 15% from private health insurance funds; and around 18% self funded; includes health expenditure by workers compensation and compulsory motor vehicle third party insurance funds). Outlays on health for 1995–96 by the Commonwealth, States and private health expenditure by major programs can be seen in Figures 1, 2 and 3.[1] Commonwealth outlays for 1998-99 are expected to be over $23.2 billion of which $165.6 million is directed to improving Aboriginal and Torres Strait Islander health.

Figure 1 Commonwealth outlays on health by major programs A$18.6b (1995-96)



- subsidies for medical services under Medicare;
- pharmaceutical benefits;
- direct grants to non-government organisations for the provision of health care;
- grants to the States, including substantial Health Care Funding Grants to support public
- hospitals, and other specific purpose payments; and
- Public Health Outcome Funding Agreements to States and Territories to undertake particular public health activities.

[1] The 1995-96 figures are the most recent comparative figures available.

Figure 2 State outlays on health by program A$7.9b (1995-96)

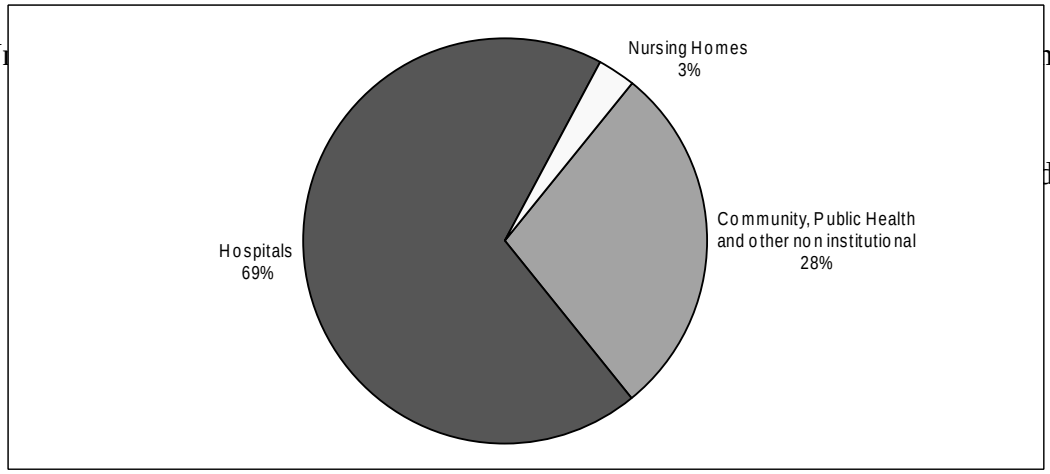


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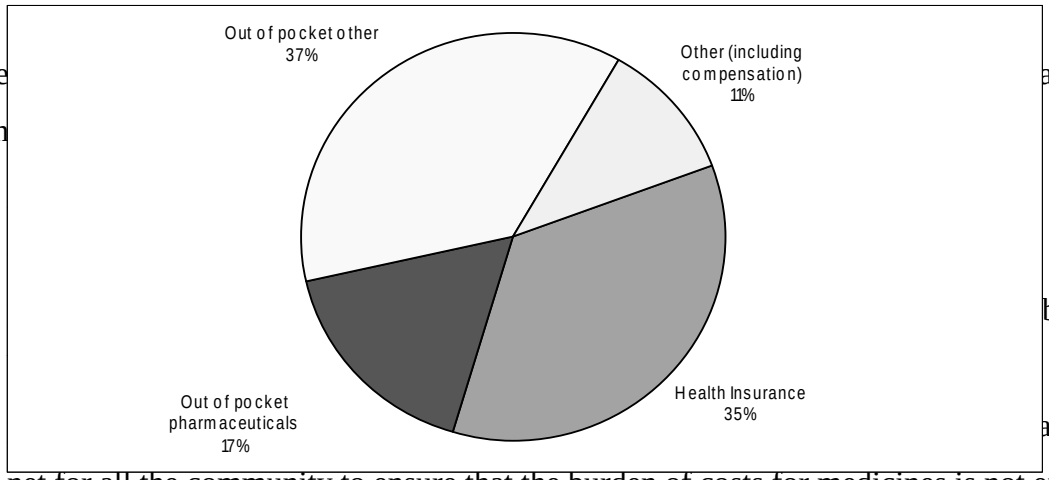
Figure 3 Private health expenditure A$12.5b (1995-96)



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- a safety net for all the community to ensure that the burden of costs for medicines is not excessive.

Gambling is usually regarded as a responsibility of the States and Territories and the Commonwealth Department of Health and Aged Care has no direct role in relation to Australia's gambling industries.

Yet the State, economic and social impacts of gambling intersect with all three sectors of the health system, State, Commonwealth and private.

2. DEFINITION OF GAMBLING

The Productivity Commission has suggested that, basically, 'Gambling involves staking money on uncertain events driven by chance'. It suggests further that:

> *More pragmatically, gambling industries can be defined as involving those activities which people perceive as gambling or governments treat as gambling for regulatory and taxation purposes. The prime forms include gaming (such as gaming machines and table games in casinos), betting and wagering on racing or sporting events, and lotteries, including similar forms of gambling such as keno and bingo.'* (*Issues Paper p.9).*

Defining 'gambling' simply in terms of a transaction (staking money) does little to assist our understanding of the experience of gambling, and how, and by whom, that experience is created and managed.

The Commission's definitions primarily focus on the contemporary, legal gambling industries and highlight three aspects: the act of the gambler (wagering); the traditional question of the morality of the gambler's action (perceptions of what constitutes gambling); and some of the roles of government (regulation and taxation). These aspects are more colourfully described by Smith (1998a in questioning whether gambling is 'a sin, or service, or fiscal salvation?'

The Commission's definition narrows the focus to the forms of gambling taxed by governments: on and off-course totalisator betting; bookmakers; draw lotteries; Lotto and derivatives (Pools; Powerball; Ozlotto); Add-on Lotto games (Super 66 etc); Scratch lotteries; gaming machines (spinning reel, cards, racing and other games played on machines); casino games; and sports betting.

There are many other forms of gambling, some legal and others not; and some more culturally derived. These include raffles, Art Unions, beer tickets, calcuttas, card games, office sweeps, SP bookmaking, etc. These are usually not taxed.

Illegal gambling is seen as providing services (such as money laundering and credit facilities) and creating a context conducive to activities, that legal gambling services do not. Illegal gambling establishments are thought to welcome the compulsive gambler, be less vigilant about excluding minors, and to provide a meeting place for criminal action and prostitutes. (Bult 1992).

Different cultural groups in Australia may have different attitudes towards gambling, particularly the morality of gambling and hence attitudes to problem gambling and help seeking (VDHS 1998b; AIGR 1997)[2]. For example, anthropologists have reported the traditional importance of gambling in various Aboriginal communities. This gambling has taken many forms including wagering over carcasses, clothing or other items (Goodale 1987). Aboriginal gambling for money is a more recent phenomenon since the introduction of the wage system and welfare payments in the 1960s (Hunter and Spargo 1988; Hunter 1993; Steane, McMillen and Togni 1998). Hunter and Spargo (1988) described four card games, probably of Asian origin, that were common and wide-spread among the Kimberley Aboriginal population in the late 1980s. A similar analysis of card games among the Tiwi people is provided by Goodale (1987).

Hunter provides descriptions of the types of gambling activities and assesses the physical, psychological and health impacts of gambling on the communities. Hunter claims that:

> Gambling in many Kimberley communities is a major focus of socialisation and discourse. Many other activities have become organised around it, such as drinking, and the patterns of redistribution of credit and obligation within the community. It is a social activity, and as such has powerful integrative functions for certain subgroups. (Hunter and Spargo 1988; Hunter 1993).

Among the Tiwi people, Goodale (1987) observed that the time and 'luck' involved in gambling was regarded in much the same way as the luck and hard work of hunting:

[2] Research undertaken by Mark Dickerson, Jan McMillen, Erica Hallebone, Rachel Volberg and Richard Woolley.

> *…when a Tiwi man or woman says that gambling, like hunting, is hard work, we may interpret this as meaning both are significant productive activities contributing to the subsistence economy of the household and community and personal inter-community prestige networks (Goodale 1987).*

Thus, Goodale asserts, gambling provides a means of providing for family necessities as hunting did in the past while reinforcing social relationships.

The Department suggests that the Commission consider adopting a definition of gambling which reflects Australian experiences of gambling and assists further understanding of these experiences.

A new definition could capture all of the different elements of the government's interest in gambling: all forms of gambling (those taxed by governments, illegal gambling, and the more culturally derived forms of gambling); industry issues; the harm to individuals and communities; and the interactions between these three elements.

3. GAMBLING AND HEALTH

Problem gambling impacts on the health and well-being of a significant number of gamblers and their families, and results in costs to the health system. In some cases it may be linked with mental health problems. Although there is continuing debate as to the cause of problem gambling, in the Australian context it would seem more useful to regard it as a social issue rather than a human pathology.

4.1 PATHOLOGICAL GAMBLING? OR PROBLEM GAMBLING?

'Pathological gambling' became a diagnostic entity in 1980 through its inclusion in the Diagnostic and Statistical Manual of Mental Disorders*(3rd edn, 1980; referred to as DSMIII) where it was described as*[3]*:*

> … a progressive disorder in which an individual has a psychologically uncontrollable preoccupation and urge to gamble. This results in excessive gambling, the outcome of which compromises, disrupts or destroys the gambler's personal life, family relationships or vocational pursuits. The problems in turn lead to intensification of the gambling behaviour. The cardinal features are emotional dependence on gambling, loss of control and interference with normal functioning.

This description is included in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders *(4th edn, 1995, referred to as DSM-IV) and continues to be used by clinicians and researchers (eg, Sullivan et al 1998; Setness 1997).*

Even so, there is increasing criticism of the capacity of DSM-IV and of the South Oaks Gambling Screen (SOGS) instruments to distinguish between 'pathological gambling' and other mental disorders, and to distinguish between 'pathological gambling' and the 'non-disordered gambling' of players who gamble regularly. Both instruments are regarded as over-estimating the number of people with gambling problems (Walker 1995; Baron, Dickerson, and Blaszczynski 1995; AIGR 1997).

Attempts to explain gambling as an addictive behaviour include causal theories of self-control/ self-regulation, excessive appetites, mood and affect, and impulsivity (Baron, Dickerson, and Blaszczynski 1995 surveying recent literature). These authors, however, argue that the central construct to the psychological characteristics underlying these explanations of addictive behaviours is 'impaired control or choice'.

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[3] It should be noted that The Diagnostic and Statistical Manual provides descriptions of diagnostic criteria or behavioural symptoms, not a definition, although the descriptions are frequently referred to as definitions.

There has been a move away from the notion of gambling as a pathology and the terms 'problem gambling' and 'problem gamblers' have become favoured. Some definitions of 'problem gambling' focus on the act of gambling, others focus on the consequences, and some on both.

Some researchers, however, consider that the process of re-definition can create a benign image for a potentially addictive activity while ensuring that responsibility for gambling-related problems is seen to rest with the individual rather than the gambling industry. Bruscella (1997), for example, notes that the Victorian Gaming Industry's Code of Practice prefers 'responsible gaming' to 'problem gambling', with people who are gambling excessively being described as 'customers requiring assistance in responsible gaming'.

The Victorian Casino and Gambling Authority recently commissioned the Australian Institute of Gambling Research (AIGR 1997)[4] to assess the various definitions of problem gambling and to recommend which should be adopted. The study reviews research into gambling as a mental disorder, as an addiction, and as excessive behaviour. It also draws on interviews with representatives of ethnic and Aboriginal communities as well as other community, church and media representatives.

Not surprisingly, the AIGR reported that industry representatives regarded 'the "mental health/addiction" approach … as [being] too rigid and "scientific" to validly define and measure problem gambling'. They considered the definitions of 'pathological' and 'problem' gambling act as a barrier to understanding gambling problems in ethnic communities, and that it may not be valid to have a universal definition. Some industry representatives suggested adopting the term 'responsible gambling', consistent with the Victorian Gaming Industry's Code of Practice.

The AIGR concluded that in both the research literature and the views of stakeholders the above definition of 'pathological gambling' is contested. Further, it 'is couched in language that is not compatible with Australian attitudes and social perspectives'.

[4] Research undertaken by Mark Dickerson, Jan McMillen, Erica Hallebone, Rachel Volberg and Richard Woolley.

In view of this, the AIGR proposed the following definition:

> *'Problem Gambling' refers to the situation in which a person's gambling activity gives rise to harm to the individual player, and/or his or her family, and may extend into the community (AIGR, 1997, p.2).*

While providing some scope notes on the elements that might constitute 'harm', the AIGR states that:

> *'Harm' is essentially a value judgement made by individuals, by families and by the community. What is judged to be harmful for an individual will depend very much on social norms and will vary according to gender and to the lifecycle of the individual. … Where the individuals and families involved live in a society with diverse cultural values and expectations then it will be more difficult, for researchers and service providers, to discern the nature and extent of 'harm'.*

This provides a pragmatic approach, one which has the potential to encourage a preventive and early intervention approach similar to the public health approach adopted in relation to other addictions. At the same time, the notion of 'harm to the individual' leaves open the issue of links with mental health problems.

The AIGR (1997) states that an acceptable and valid definition is needed as the first and essential step in developing research methods. The definition proposed by AIGR would support research within its own terms but would not provide a basis for further research into the innate characteristics or causes of gambling problems or the development of associated research methods. On the other hand, DSM-IV and SOGS either were not designed for these purposes, or are of only limited use for these purposes.

Although a new definition is important in the longer term, it is suggested that further work on defining the problem at this time may not be as productive as seeking to address problem

gambling or prevent it from emerging. Concentrating only on the consequences of problem gambling is too late, with problem behaviours having become entrenched (see Section 4.4).

It could be argued that better definition of gambling related problems is needed for a number of other purposes:

a) predictive screening;
b) estimating potential prevalence for policy and planning purposes;
c) providing gamblers and their families with a tool for understanding and monitoring gambling behaviour;
d) measuring the level of demand for assistance;
e) assessing the type of assistance needed by individual gamblers; and
f) 'keeping the stats'.

The strengths of the definition proposed by the AIGR are that it:

- provides a non-judgmental tool for gamblers or family members to assist them in beginning to 'own' that there is a problem and to seek help. Owning that there is a problem is an important first step;
- allows for cultural differences; and
- would assist with monitoring service usage under d) and e) above.

The AIGR definition provides less help for other purposes. It does not provide a predictive capacity. On the other hand, the use of an instrument to screen individuals against the possibility that they might become problem gamblers would not be appropriate. It supports only limited measures in relation to assessing the type of assistance needed by individual gamblers. Many people with a gambling problem either do not seek help, or seek help for related problems in which case thepsychologist or counsellor is more likely to focus on a cluster of symptoms related to impulse control problems, rather than solely on the 'symptom' of gambling. It could be argued, therefore, that an additional concept (such as 'pathological gambling') and an additional gambling-specific tool (such as DSM-IV or SOGS) are not needed – unless research demonstrates that such a condition is unique and has discrete causes.

4.2 Impact of gambling on health and well-being

In *The Queen of Hearts* study of women gamblers, Brown (1997) notes the lack of documented evidence about health issues and problem gambling. Similarly, Blaszczynski and Farrell (1998) note that while high rates of affective disorders and suicidal ideation have been consistently reported among clinical populations of pathological gamblers, evidence in the Australian context is patchy.

This section will focus fairly narrowly and not include discussion of the growing body of Australian evidence on the broader social impacts of problem gambling (eg, loss of income and housing, deterioration in nutrition) even though these may be regarded as public health issues. It is assumed that these will be covered by other submissions.

Brown found that 57 (56%) of the women in her study reported that gambling adversely affected their health. Symptoms named by the respondents included: depression, stress, anxiety, lethargy, insomnia, poor nutrition, suicidal thoughts, increased caffeine and nicotine consumption, sweats, confusion, panic and ulcers[5]. Apart from the State funded counselling services (G-Line and Break Even) and Gamblers Anonymous, 18 out of the 84 women in the study who had sought help had accessed psychologists/ psychiatrists, doctors, community health professionals and other counsellors. The women indicated that they named gambling problems as the reason for seeking assistance (see also VDHS 1998b).

It is commonly accepted that many other gamblers or members of their families may seek assistance from health workers but without naming gambling as a problem – they present for related health or mental health problems, such as those identified above (see, eg, Sullivan et al 1998).

Blaszczynski and Farrell's study of 44 completed gambling-related suicides based on records obtained form the Victorian State Coroner's Office provides some descriptive evidence of health status before the completed suicide. Fourteen (31.8%) of the cases had previously

[5] A further issue commented upon by women when interviewed, but not included in the list of health issues, is passive smoking. Not all venues have non-smoking areas.

attempted suicide, and in at least seven cases there were two or more attempts. In terms of co-morbidity, depression was the most frequent co-morbid condition among the suicides.

The AMA has acknowledged the increasing demand on General Practitioners for advice and support by developing a course on Information and Support Services for Gambling-Related Problems (AMA 1998). Practitioners attending the course are being asked to keep statistics so that a better picture of the level of demand for assistance with gambling related problems can be established. As yet the course has only been held in Sydney, but the AMA is working with the Rural Health Education Foundation to enable regional and rural General Practitioners to access the course.

There is very little direct evidence on the impact of gambling on the health of Indigenous people. The few studies of gambling in Aboriginal communities have focussed on a particular community or region so it can not be assumed that they are representative of Aboriginal communities more broadly.

In their study of gambling in Kimberley Aboriginal communities, Hunter and Spargo (1988) conclude that:

> In those … communities where gambling is common, it is impossible to avoid the direct or indirect repercussions. The fallout from gambling involves the entire community. … its consequences affect physical, psychological and social domains.

Gambling adversely affects nutrition. It is a direct competitor for sustenance resources. Losers diminish their purchasing capacity for the remainder of the pay period, and winners may divert their winnings to luxury items of alcohol. The nutrition of children may be neglected while games are in progress (see also Goodale 1987) and general household hygiene may be compromised when gambling debts result in unpaid electricity and water bills. Hunter observed that while 'drinking is not typical during games, and drunks are discouraged' alcohol usually flows after gambling ceases.

These observations of Kimberley communities are supported by more recent work with Aboriginal communities in South Australia. The South Australian Licensing Court recently endorsed the decision of the State's Gaming Machine Commissioner to deny the Nundroo Hotel Motor Inn a gaming machine licence. The Court's decision took into account the socio-economic impact gaming machines would have on 'extremely dependent people' in the Yalata and Maralinga and Tjarutja Aboriginal communities, and the likelihood that they would increase the already high level of poverty and alcohol abuse suffered by them (Abraham 1998). While gambling is restricted to card games, at least the money circulates within the community. Where electronic gaming machines are introduced, gaming shifts from a social to an individual activity and the money lost goes to the owners of the gaming licence – and probably out of the community.

4.3 Costs of gambling to the health system

No attempt has been made to estimate the health costs flowing from gambling related problems. Costs are commonly regarded as falling on State and Territory social programs and costs to Commonwealth, State and Territory and private health funding are generally overlooked.

Any attempt to estimate the health-related costs of gambling in Australia runs into difficulties. There is no way of tracking costs to Commonwealth, State and Territory and private health funding. There is no Medicare item for 'problem gambling'. Hence, the claims of General Practitioners and private psychiatrists against Medicare give no indication when patients are seeking help for health problems related to gambling or when hospital services are accessed by attempted, or completed suicides relating to problem gambling.

In the United States, Goodman (1996) observed that with the increasing demand for problem gambling counselling more health insurance companies were beginning to provide coverage. Even so, for many gamblers their costs are covered only if they are coded as being treated for depression. He notes that the American Psychiatric Association, Gamblers Anonymous, and the National Council on Problem Gambling have been actively lobbying for gambling to be defined as a 'disease'. This pressure would seem to be driven more by the desire to increase the willingness of insurance companies to pay for the treatment of problem gambling, than by evidence that problem gambling is a medical condition.

The Department considers that the introduction of a Medicare mechanism primarily for quantifying demand for assistance with problem gambling is not appropriate. Problem gambling has not been conclusively identified as a medical problem. Nor is fixing problem gambling primarily a Commonwealth responsibility as would be implied by providing Medicare funding. As Hunter and Spargo (1988) have warned in the context of Kimberley Aboriginal communities, while gambling has significant health consequences '… its intensity and form is, at root, a result of social and economic forces which act in a particular cultural setting … we

must be cautious of the medicalization of complex social problems' (Hunter and Spargo 1988).

Health costs to Commonwealth, State and private health funding vary from State to State depending on the approach to problem gambling counselling in each State. Costs are largely to the Medicare Benefits Scheme with some also accruing to the Pharmaceutical Benefits Scheme and hospital funding.

In most States support is primarily provided through State-funded counselling services (G-Line and Break Even) and Gamblers Anonymous. There are no public in-patient services for problem gamblers and few private inpatient services although, historically, there have been more inpatient services in NSW. Current evidence on the relative merits of inpatient services and counselling services in the community does not support any significant change to this pattern.

The list of providers collated by the AMA for NSW (AMA 1998) indicates the ways in which costs flow to the Commonwealth and private health insurers:

- three providers list in-patient services and a further four provide residential programs. Fees range from $75 per week to $3,150 per week;
- nine listed services are provided in public hospitals, private hospitals or other clinical settings. Session rates range from $50 to $100 per hour;
- one provider bulk bills;
- two providers state that private health insurance is recommended;
- two providers mention that they are nominees for social security benefits and hence there is no charge to clients or the fee is set at 75% of benefit payment; and
- two services state that they are Department of Veterans' Affairs providers.

This information is at best indicative and while the costs to Commonwealth funding for health and aged care may be relatively small, some allowance needs to be made in any overall estimates of costs. The information also points to the need for health workers to be better informed about gambling so that they can be more responsive to help seeking by gamblers.

4.4 Preventive approaches

Preventive approaches are currently used in relation to a wide range of health and well-being issues including drug and alcohol abuse, injury prevention, youth suicide, child abuse, and domestic violence. More active preventive approaches need to be taken to preventing harm being caused by problem gambling. Such approaches would recognise that for most people gambling is a normal recreational activity that does not result in problem behaviours. They would include preventing anticipated harm and reducing actual harm and recognise that for some individuals abstinence may be the best approach.

The principles of 'player fairness' and 'a right to know' were raised by the Victorian Office of the Auditor General (VAGO 1998; see also ACOSS 1997) 'as vital to maintaining public confidence in the industry' in the context of gaming machines. The Auditor General recommended that the Gaming Authority should 'drive the development and dissemination within the industry of a *Players Charter* which articulates the whole range of information deemed as essential to players in order that their position in terms of fairness is totally assured'. This principle could be seen as applying more widely and underpinning preventive strategies.

The more recently established (or expanded) sectors of the industry are beginning to develop consumer protection approaches such as the Victorian Gaming Code of Practice. It is clear, however, more needs to be done before these do effectively prevent harm – and before the general community perceives regulators and all sectors of the industry as actively seeking to prevent harm. The fast emerging area of Internet gambling provides an additional challenge as precisely who should share the responsibility for preventing harm is less clear cut.

The NSW Casino Control Authority, in its submission to the Independent Pricing and Regulatory Tribunal's Inquiry into Gaming (1998), points to the many provisions in the *Casino Control Act (1992)* aimed at consumer protection, and to its own strategies to support consumer protection at Star City. The Act and regulations provide for:

- staff training in responsible service of alcohol, and identification of persons who may be affected by problem gambling;
- providing to patrons, and displaying within the casino, the rules of games;
- the preclusion of credit betting and restrictions on cheques and deposit accounts;
- voluntary exclusion provisions;
- complaints mechanisms;
- the exclusion of minors;
- a requirement to prevent intoxication, indecent, violent or quarrelsome conduct;
- restrictions on advertising and enabling the making of 'regulations regarding the placement of notices with respect to the availability of counselling services'; and
- providing the Authority with powers to exclude persons who leave children unattended and at risk at the casino complex.

The Authority states that, in addition, it works with Star City on a range of consumer protection strategies including:

- promotional material which provides information on problem gambling counselling services;
- the provision of personal counselling assistance in crisis situations;
- regular contact with representatives of the ethnic community and the local community to address issues and impacts; and
- the location of automatic teller machines at a significant distance from gambling areas.

Even so, elsewhere in its submission the Authority recommends that the responsibility for addressing problem gambling rests with other agencies:

> *A substantial amount of research and analysis has been completed in the problem gambling area. It is now appropriate for action to be taken through existing professional health, education and social welfare agencies to deliver the practical outcomes required.*

Similar initiatives are being taken by the Victorian Gaming Industry through the development of its voluntary Code of Practice, 'Responsible Gaming'. Bruscella (1997), however, argues that the notion of 'responsible gaming' shifts the focus of responsibility from the industry to the gambler.

It could be argued that the industry can not be expected to take responsibility for addressing the problems caused by gambling – that these are better handled by professional agencies – and that the industry should be only expected to pay for the costs of the negative externalities it causes through an even higher level of taxation.

Certainly it is desirable that the industry continue to help offset the costs of problem gambling through taxation. However, relying solely on this approach is inadequate as has been demonstrated in relation to alcohol and smoking. It is simply 'paying for someone else to mop up the damage after the event' and does little to help *prevent* gambling problems arising. This Department considers that, if problems are to be prevented, it is necessary for the industry take a more active role 'up front' and not wait until problems have happened.

Experience to date indicates that preventive approaches to problem gambling need to be wide-ranging. It is suggested that preventive strategies for problem gambling might cover:

- *The responsibilities of individual gamblers including measures that might improve understanding of gambling risks, to make it more likely that gambling is and informed choice, eg, measures relating to promotion and marketing in the media and in gaming venues:* Not 'everyone is a winner' as is implied by much gambling advertising. This approach to advertising needs to be tested as to whether it constitutes false advertising, and further consideration needs to be given to the inclusion of 'enjoy in moderation' type messages in all advertising as now occurs with alcohol advertising. Where there are industry standards, such as Victorian Gaming Machine Industry Advertising Code of Practice, more transparent monitoring of adherence is suggested.

- *Community education and information that encourages gamblers to consider the risks to their families as well as themselves from excessive gambling* While some States are beginning to invest substantial funding in community education, there is a need for more consistent effort by all States and for research into what are the most effective strategies. Some researchers and commentators argue that greater responsibility should be given to schools to conduct gambling awareness classes. It is suggested that while teaching the calculation of odds in maths classes seems to be useful, the cost-effectiveness of separate classes with specific curricula is questioned. Young people involved in a NSW study of gambling on the Internet took seriously and were likely to be influenced by mass media and current affairs coverage of other youth getting into trouble through gambling (ACOSS 1997).

  Media campaigns emphasising personal responsibility have proven successful in other problem areas (eg, 'If you drink and drive, you're a bloody fool'). Consistent, nation-wide campaigns to address problem gambling could be developed through co-operation among the States.

- *Clarifying government roles*: At the broadest level, clarifying possible conflicts between the various roles governments play in relation to gambling could help create a better context for the success of other preventive strategies.

- *Regulation:* While regulation aimed at consumer protection is a first step, the active involvement of all industry sectors in responsible self-regulation, and the monitoring and assessment of the effectiveness of regulation are also needed, including the effectiveness of industry self-regulation.

- *Planning and location of venues:* There is community concern at increasingly easy access to electronic gaming machines as they extend into suburban shopping centres. Some researchers are concerned that co-location with essential services tends to further legitimise gambling as a form of harmless entertainment (eg, Davies 1996). The development of planning guidelines covering the placement of outlets in shopping centres,

and for strategies to minimise negative impacts where approval is given for new outlets is to be encouraged.

- *Re-constructing the context of gambling*: Problem gamblers in the *Queen of Hearts* study first found gambling venues 'comfortable,' 'soothing', 'seductive' – a place of inducements and fantasy: '… it's the automatic doors … when they close it's another world … [a] fantasy world. You're instantly transported out of reality'. In retrospect, the same features were identified as contributing to their gambling problems. Further consideration needs to be given to the impacts the carefully constructed contexts of the

gambling have on vulnerable gamblers, for example, the practices of cutting gamblers off from the reality checks provided by clocks, and ensuring that gamblers can not see outside the venue (eg, Brown 1997; Bruscella 1997).

- *Training and rewarding gaming staff for taking a practical preventive role:* In arguing for the adoption of the terminology of 'responsible' (rather than 'problem') gambling (AIGR 1997), industry representatives provided acute observations of the observable behaviour of gamblers as an indicator of potential problems: for example, body language indicating stress; verbal signs of irritability or aggression; gamblers who regularly play alone; regular gamblers who play for long, unbroken periods; changes in the player's 'normal' betting strategy or erratic, irrational wagers. Staff should be trained to make these observations and to take appropriate action.

5. GOVERNMENTS AND GAMBLING

State and Territory governments have multiple responsibilities in relation to gambling including:

- legislation and regulation
- licensing of operators
- promotion of gambling
- revenue raising
- allocation of gambling revenue, including hypothecation to specific purposes
- developing policies and programs to address the negative impacts of gambling, and
- commissioning research into the impacts of gambling.

This section will first comment briefly on the multiple roles of governments, and then discuss revenue raising and issues relating to the hypothecation of gambling revenues. The next section will provide a case study of hypothecation of revenues by the States to health purposes.

5.1 Governments and gambling: their multiple roles

The multiple functions listed above may be vested in one or more departments and may be linked to State Treasuries. Awareness of the potential for conflict is demonstrated by the mission statements of the relevant departments. For example the NSW Department of Gaming and Racing's mission and supporting documentation, as made available to the public via the Internet, provides a carefully articulated awareness of the difficulties States face in balancing conflicting objectives. The Department was established in March 1995 to regulate the key industries involved in gaming, racing, liquor and charities. Its mission is 'the proper conduct and development, in the public interest, of the gaming, racing, liquor, and charities in New South Wales'.

To achieve its mission, the Department has established six corporate purposes:

1. *Industry viability*: a regulatory and policy framework that balances opportunities for continuing development of the industries against the public interest.

2. *Consumer services*: a regulatory and policy framework that allows consumers access to fair and equitable gaming and wagering services and appropriate liquor services.

3. *Industry compliance*: a regulatory and policy framework that provides for responsible, responsive and accountable industries, with appropriate enforceable sanctions for non-compliance.

4. *Public interest*: a regulatory and policy framework, and review process, that takes into account all social and community impacts of legislative and policy measures; and reconciles the tension between development of industries and the public interest.

5. *Optimum revenue*: a regulatory and policy framework that provides a continuing and sound revenue base to the Government from the revenues.

6. *Agency competence.*

Of particular concern to the public is the role of government in promoting a potentially addictive behaviour – a role which is in sharp contrast to the part State governments play in discouraging and preventing other addictive behaviours.

5.1 Revenue Raising and hypothecation

Although gambling taxes provide only around 2% of national revenues, in the last five years states have become increasingly reliant on gambling revenues. In 1996-97 they collected $3.4 billion, or 11%, of their taxes from gambling.

State and Territory gambling taxation revenues for 1996-97 are summarised in Table 1. Traditionally the racing industry was the major source of revenues, which were then supplemented by lottery revenues. These in turn proved susceptible to competition from casinos, but even more recently from gaming machines which are proving to be the gamble of choice for Australians.

Table 1

GAMBLING EXPENDITURE AND TAXATION 1996-97

State/Territory	Population 18 & Over (Million)	Expenditure ($Million)	Expenditure Per Head* ($)	As a % of HDI**	Taxation ($Million)	Taxes Paid Per Head ($)
Australia	13.831	10,037,400	725.72	3.03%	3,423,331	247.51
New South Wales	4.700	3,957,908	842.11	3.36%	1,236,205	263.02
Victoria	3.469	2,756,736	794.68	3.21%	1,157,439	333.65
Queensland	2.510	1,561,417	622.08	2.89%	444,969	177.28
S. Australia	1.123	638,280	568.37	2.53%	249,612	222.27
W. Australia	1.325	699,588	527.99	2.29%	205,098	154.79
Tasmania	0.348	151,523	435.41	2.04%	58,949	169.39
ACT	0.229	171,600	749.34	2.29%	46,250	201.97
N. Territory	0.129	100,349	777.90	3.27%	24,809	192.32

Source: Tasmanian Gambling Commission, *Australian Gambling Statistics*

* This has been calculated using the population table on page 8 of *Australian Gambling Statistics* which provides more up-to-date figures than were used to calculate other tables in this publication.

** Household Disposable Income

Smith's comprehensive analysis,*Gambling Taxation in Australia*, funded by the Australian Tax Research Foundation provides an extensive analysis of 1994-95 gambling taxes and the purposes for which they are earmarked (Smith 1998a Appendix 1). She notes that, apart from gambling tax revenues that go into consolidated revenue, some go into trust funds, some are returned to the racing or sports industry (rebates to racing clubs, bookmakers, sporting clubs; distribution to sports clubs more generally).

Most States and Territories state that health is one of the areas that benefits from hypothecation. Hypothecation may be either by direct transfer to hospitals funds, or through various community benefit funds. Table 2 identifies the sources and levels of gambling revenue potentially hypothecated to health-related programs and initiatives.

TABLE 2

GAMBLING TAXES HYPOTHECATED TO HEALTH RELATED PROGRAMS

SOURCE	NSW	VIC	QLD	WA	SA	TAS	ACT	NT
Racing	Nil	100% of revenue (28.2% of player loss) to Hospitals and Charities Fund		**Nil**	About 45% of revenue to Hospitals Fund (actual % decided each year)	**Nil**	**Nil**	**Nil**
Lotteries Unless otherwise indicated , programs may also receive funding transferred to consolidated revenue	Nil	*Conducted by Tattersalls, a private sector organisation:* 35% on turnover up to $200m, 35.5% on $200m to $600m, 36% on over $600m. Revenue transferred by standing appropriation from consolidated fund to Hospitals and Charities Fund and Mental Hospitals Fund.	*Golden Casket* $1.5 m annually to Children's Health	*State lottery, Lotto, Oz Lotto and Instants* Under the lotteries Act 1990: 16% of sales income to hospitals; some of the 5% to charities may also go to health related programs	*Lotto and Oz Lotto* Net operating surplus (equal to around 33% of sales) transferred to Hospitals Fund *Instant Scratchies* Net operating surplus (equal to around 31.5% of sales) transferred to hospitals fund	Nil	Nil	Nil

SOURCE	NSW	VIC	QLD	WA	SA	TAS	ACT	NT
Casinos	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Core State taxes	CBL 2%	CBL 1% of gross monthly gaming revenue to the Hospital and Charities Fund	CBF 1% of gross revenue	Nil	N/a	N/a	N/a	N/a
Other State charges								
Other	Nil	Nil	Nil	Nil	Nil	Nil	N/a	N/a
Taxes								
Sports related	Nil	12.5% of turnover to Hospitals and Charities Fund	See below*	N/a	Average 15% transferred to Hospitals Fund	Nil	N/a	N/a
Keno								

SOURCE	NSW	VIC	QLD	WA	SA	TAS	ACT	NT

Poker Machin es *Clubs*	Clubs with annual revenue >$1m: may apply 1.25% to community projects: welfare & social services inc. family support, child protection, supported accommodation & counselling; development inc. community health & education. Clubs have *complete discretion* as to allocation of funds.	33.3% of Clubs revenue to Hospitals and Charities Fund	Tax on clubs, 10% of revenue (up to $10,000) rising by increments to 45% (for $1.4m+). Tax on hotels, a flat 45%. Gaming Machine CBF receives 4% of Keno tax and 8.5% of machine tax. Charities and Rehab Fund receives 6% of Keno tax and an annual allocation by Treasury	No gaming machines	Poker machines in clubs and hotels: $1.5m annually to Gamblers Rehabilitation Fund $19.5 (or similar amount set annually) to CDF of which some $9.m spent on health	CSL being phased in from 1997: 2% of gross profit (50% to health)	Nil	CBL on Draw Card Machines: planned but on hold
            Hotels	Nil	33.3% of Hotels revenue to Hospitals and Charities Fund 8.33% of the total daily net cash balances to the CSF	N/a	No gaming machines		4% CSL (50% to health)	Nil	CBL: planned but on hold

CBL: Community Benefit Levy **CSF:** Community Support Fund **CBF:** Community Benefit Fund **CDF:** Community Development Fund

Sources: Julie Smith, *Gambling Taxation in Australia*, Australian Tax Research Foundation, 1998a. Research Study No. 32, Appendix 1.

Updated by John Williams Consulting Pty Ltd, 1998.

In questioning whether government reliance on gambling taxes is a 'good bet', Smith (1998a) draws on mainly overseas literature to consider issues relating to the earmarking of gambling taxes. Smith suggests that earmarking:

a) may be used to make the public sector appear smaller;
b) is open to criticism of lack of transparency by providing 'profit sharing arrangements' with certain industries and associations;
c) increases regressivity by being spent disproportionately on activities enjoyed by higher income households;
d) may act as a 'tax price' for public goods, making governments more efficient and accountable for the type of services they provide;
e) may avoid budget scrutiny and not be evaluated against other priorities for government in the way that on-budget expenditures are;
f) does not necessarily produce greater certainty about future revenue sources;
g) creates a false perception as to the level of contribution they make to specified programs and activities;
h) 'merely reshuffles government spending and revenues rather than increase resources for the funded social programs'; and may even reduce overall funding as earmarked resources may be taken into account in deciding budget allocations.

Earmarking, *per se*, does not necessarily result in the negative impacts enumerated by Smith. Rather, it is the way in which hypothecated funds are managed that is critical. Certainly it is clear from the report of the Victorian Auditor General's Office on the establishment stages of the Casino Community Support Fund that transparent management practices are essential (VAGO 1996).

In relation to health-related activities and programs, f), and h) are the issues of most concern to the public, to consumers of services and to service providers.

Earmarking does not necessarily produce greater certainty about future revenue sources which may cause problems for agencies funded substantially from earmarked revenues

Smith (1998a) argues that:

a) there is some evidence Australian gambling revenues are highly sensitive to fluctuations in the economy with year-to-year volatility of gambling expenditures exceeding that of GDP, although 'the rate of growth in gambling activity is fairly closely correlated with economic growth (r^2=0.33)';
b) in the longer term gambling revenues are unstable due to the short gambling 'product life'; and
c) earmarked revenues, at least in the US, 'remain vulnerable to raids from cash-strapped legislatures'.

She cautions that new public spending programs funded from gambling revenues may lock governments into increasing revenue dependency on sustaining gambling activity – equivalent to gamblers chasing losses (see also Goodman 1996).

As noted above, over time the sources of gambling tax revenue have shifted and expanded from the racing to lotteries which in turn proved susceptible to competition from casinos and gaming machines. Fitzgerald (1988) notes that the next source of volatility likely to erode the gambling tax base is the risk from on-line gambling (see also Farrell and Ford 1998).

The assertion that earmarked funds 'remain vulnerable to raids from cash-strapped legislatures', implies that, in comparison, programs funded from consolidated revenue are protected from savings measures and changing government expenditure priorities, which is not necessarily so. It also assumes that hypothecated revenues are used for 'program' funding (i.e., for programs designed to achieve objectives set by government, usually receiving recurrent funding).

The pattern of health-related grants differs from State to State.[1] Hypothecated revenue from lotteries in Victoria (35% to 36% of turnover), WA (16% of sales), and SA (net operating surplus, equal to around 33% of sales), is transferred to Hospital Funds and not distributed as direct grants. Although lotteries revenue in SA is declining (14% lower than in 1991-92) in the other States it has increased since 1991-92.

In *Western Australia* the majority of the direct grants for 1997 were one-off capital grants (renovations, furnishings, equipment and computers etc) to community organisations including $3.4 million to services for the aged. There were also eight equipment grants to support medical research totalling $2.6 million (one including some staff costs).

In *Queensland* grants from the Community Benefits Funds for the Jupiters Casino, the Cairns Reef Hotel Casino and the Breakwater Island Casino also comprise one-off capital and equipment grants. Similarly, the Gaming Machine Community Benefit Fund supports small capital, equipment and information grants with a ceiling of $15,000 per grant.

In *New South Wales* for 1997-98 the pattern is somewhat different. The majority of the grants were to support service delivery (including $3.7 million for problem gambling counselling and $0.795 million for preventive programs related to gambling), and research into gambling ($0.257 million); with far fewer capital grants (often for vehicles associated with service delivery). Of close to 50 health-related grants, 20 were for funding over 2 to 3 years, but the funding received was a relatively small portion of the total Fund.

In *Victoria*, too, substantial funding is directed to service delivery. The*Casino Control Act 1991 (Vic)* provides for 8.33% of money paid into electronic gaming machines in hotels to be paid into the Consolidated Fund and transferred to the Community Support Fund by way of standing appropriation. Under the Act, the Minister for Gaming may apply the funds as follows:

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[1] The pattern of State and Territory grants is discussed in more detail in Section 6, below. The co-operation of State agencies in providing information either direct to this Department or to Mr John Williams on behalf of the Department is acknowledged and appreciated.

- *firstly,* an unspecified portion determined by the Minister to the Research and Development Fund for the purposes of research relating to the social impact of gambling;

- *secondly,* 70% of remainder (unspecified split) paid to:
- Minister administering the Sport and Recreation Act 1972 for the benefit of sport and recreation clubs or programs; and
    - the Minister administering the *Community Services Act 1970* for the provision of
        - financial counselling services;
        - support and assistance for families in crisis;
        - programs for the prevention of compulsive gambling;
        - programs for the treatment and rehabilitation of persons who are compulsive gamblers; and
        - in consultation with the Ministers administering the *Youth Affairs Act 1986*, government initiatives on youth homelessness.

- *thirdly,* the balance for payment to the Ministers administering the *Ministry for the Arts Act 1972* and the *Tourism Victoria Act 1982* (VAGO 1996).

This structure and the substantial allocations to particular areas of direct service delivery would seem to indicate a more 'program' approach, for example, for 'Programs that include Initiatives to Address Problem Gambling'. Even so, this depends on only a portion of the overall hypothecated revenue ($39.4 million or 11% out of $352.5 million in 1998). Victoria also uses some funds to pilot new initiatives with a view to moving successful initiatives onto recurrent funding from consolidated revenue. This approach was taken with the Prevention of Youth Homeless Program which has now been transferred to ongoing funding.

Overall, for the four States considered above, the degree to which agencies are dependent on hypothecated funds has been minimised. In addition, in none of these States are hypothecated funds used for entitlement programs.

An associated issue has been raised by the Commission in the *Issues Paper*, namely 'Are hypothecation mechanisms an improvement on normal government processes?'

Hypothecation of funding should be regarded as a complementary process to 'normal' government funding processes, rather than a replacement.

While some community needs should continue to be addressed through ongoing funding (eg, hospitals), the pattern of mostly one-off grants established by the States has the capacity to foster self-help particularly in the States which require communities to make their contribution to costs (financial, in-kind goods, labour). At times, communities need 'a bit extra' to cope with set-up costs or large maintenance items, but can manage day-to-day costs.

Earmarking 'merely reshuffles government spending and revenues rather than increase[s] resources for the funded social programs' and may even reduce overall funding as earmarked resources may be taken into account in deciding budget allocations.

This conclusion appears to be based largely on US experience. Smith (1998a) notes that in Australia it may be supported by Commonwealth Grants Commission data. On the assumption that States choosing to earmark revenues for particular purposes would be 'inclined to spend more on such purposes', she has undertaken a preliminary analysis of CGC data. She notes that in 1995-96, 'Of the three states earmarking lottery revenues to health services, only one spent above average on health services'.

Closer analysis over the years 1991-92 to 1995-96 would seem to support this for hospitals. In 1991-92, all three States had higher than standard per capita expenditure and two continued above standard expenditure for 1992-93 and 1993-94. But for 1994-95, expenditure for all three States was below standard.

On the other hand, the one State which hypothecates gambling revenue to mental hospitals, Victoria, consistently spent above standard on mental health from 1991-92 to 1995-96. Further, of the three states that earmark casino taxes for welfare, Victoria again consistently spent above standard on family and child welfare, and on aged and disabled welfare from 1991-92 to 1995-96, and NSW had above standard expenditure on aged and disabled welfare for four of the five years (Commonwealth Grants Commission 1997).

In view of this, and the patterns of funding described in the previous section, it seems that earmarking does not necessarily reshuffle or reduce funds for social programs.

To make a more conclusive assessment it would be necessary to track the funding for an area of social need over a number of years, taking into account funding from consolidated revenues and from hypothecated funds, changes in levels of need, all relevant policy decisions, and all changes to organisational arrangements and program boundaries.

The concerns raised by Smith highlight a dilemma for governments both in allocating the funds in a way which the community sees as appropriate and ensuring adequate accountability to government and the public.

Allocating hypothecated funds through the Budget process for the support of social programs with specified objectives and defined outputs and outcomes will increase transparency and accountability. At the same time it leaves government open to perceptions of substitution, shuffling or placing service providers in a vulnerable position because of the potential volatility of gambling revenue, although as discussed above these are not necessarily caused by hypothecation.

To avoid these difficulties, government can opt for treating hypothecated funds as an additional source of grants for the more general benefit of community, as opted for by most Australian States. This has resulted in very large numbers of grants, usually for relatively small amounts, each with its own objectives set by a community organisation, which may or may not relate to a government funded program. Often the grants are for minor capital works or the purchase of equipment.

This situation creates a greater challenge in demonstrating accountability, particularly accountability for outcomes, both for each grant and for assessing outcomes, overall, from hypothecated funds.

There are a number of accountability strands.

- Within government:
  - assurance that the legislated levels of gambling revenues are transferred to designated purpose Funds; and
  - assurance as to the transparency of decision making and that all revenues in designated Funds are allocated, and in a balanced way, to achieve the objectives of the Funds.

- In relation to grant recipients, whether community organisations or other government departments:
  - assurance that the recipients of hypothecated funds have used them for the purpose for which they were granted; and
  - assurance that the funds have contributed to achieving outcomes.

While assurance on these issues is essential, the challenges will be for governments to develop risk management approaches and innovative evaluation approaches.

The Victorian Auditor General's Office (VAGO 1996) has argued that greater attention needs to be paid to the adequacy of performance measurement and evaluation frameworks and the achievement of outputs and outcomes, including at the level of each project funded.

It is suggested that this approach is more suited to some forms of grants than others. Grants to formal government programs – especially those relating to offsetting the impacts of gambling, should be subject to stringent program evaluation and accountability. Similarly project funding to support research into gambling and projects to address the effects of gambling should be rigorously evaluated, not just at the project level but in terms of the extent to which governments, the industry and relevant service deliverers are making use of research outcomes (see further below, 7. Research and Statistics).

'Program evaluation' and 'outputs/outcomes' approaches are less appropriate where there large numbers of relatively small capital grants, each with its own objectives set by a community organisation. Risk management approaches should play a major part. Responsibility for this should rest with the government department in the application and

assessment phases, rather than solely on the grant recipient after the receipt of the grant. To require a community organisation to develop outputs and outcomes measurements, and an evaluation framework, for a grant to enable replacement of stoves in home units for elderly widows, for example, seems inappropriate.

If the broad objective of the grants is 'community benefit', then innovative evaluation approaches need to be developed which take a broader perspective than that of the effect of individual grants. Evaluations should also assess the extent to which hypothecated funds as a whole contribute to building stronger communities through encouraging self-help and fostering social capital.

6. STATES HYPOTHECATION OF GAMBLING REVENUES TO HEALTH RELATED PURPOSES

Table 3 (below) summarises indicative amounts hypothecated to health and health related activities. It has not been possible to present this consistently for either a calendar or financial year, given the timing of States' grants programs. The figures are indicative estimates based on information supplied by Treasuries, Community Benefit Funds and other government departments or gambling organisations.

The scope of what constitutes 'health' varies from State to State depending on program structures and other factors. We have taken a fairly narrow approach and attempted to identify programs and activities consonant with the responsibilities of the Commonwealth Department of Health and Aged Care. Hence, hypothecated funding to disability programs, for example, has mostly been excluded. Given the Commonwealth's preventive public health focus, many other grants might have been included. For example, the Queensland Gaming Machine Community Benefit Fund for 1997-98 provided a large number of small grants, totalling over $700,000, for the erection of sun shelters at schools, community and sporting venues.

6.1 New South Wales

All tax revenues go to Consolidated Funds except the *Casino Community Benefits Fund* (CCBF). The CCBF consists of 2% of casino revenue, which is allocated to approved projects, not necessarily connected with gambling or health. The CCBF indicates that, from 1995 to date, it has allocated $9.7 million to problem gambling, $6.7m to counselling and treatment, $2.2m to education and awareness and $0.8m to research.

Table 3

State and Territory Gambling Taxes Hypothecated to Health and Gambling Related Activities

Source of hypothecated funds	Actual Expenditure $,000	Year
New South Wales		
2% of casino revenue paid into Casino Community Benefit Fund and allocated at the discretion of Trustees. Just over half went to the health and gambling projects.		
Problem gambling counselling	3,729	1997-98
Research into gambling	257	1997-98
Gambling programs	795	1997-98
Health	913	1997-98
Aged Care	115	1997-98
Sub-total	**5,809**	
Victoria		
HOSPITALS AND CHARITIES FUND		
• 1% of casino revenue	8,043	1997-98
• All Club Keno tax, based on 12.5% of Keno revenue to $100 million, is usually paid into the two principal Funds. In this year the Treasurer paid only into the H&CF.	2,590	1997-98
• Gaming machine tax – one third of revenue of clubs and hotels.	553,785	1997-98
• Lotteries – allocated between H&CF and Mental Hospitals Fund as decided by the Treasurer.	261,382	1997-98
• All the Government's share of TAB revenue, which is 28.2% of player loss.	120,560	1997-98
MENTAL HOSPITALS FUND		
• Lotteries revenue as allocation by the Treasurer.	62,115	1997-98
Community Support Fund		
• Gaming machines as in hotels pay an extra 8.34% of revenue into the CSF, part of which was allocated to gambling and health related activities.	1,358	1997-98
Sub-total	**1,009,833**	
Queensland		
• Golden Casket to Children's health – in practice a fixed annual sum.	1,500	1996-97
• Casino Benefit Funds – 1% of casino revenues of which some was allocated to health and gambling projects.	509	1997-98
• Gaming Machine Community Benefit Fund – raised from 4% of Keno tax and an allocation of 8.5% of gaming machine tax. In 1997-98 the Fund got 8.7% of the combined taxes, of which health and gambling projects got part.	1,552	1997-98
• Charities and Rehabilitation Fund – 6% of Keno tax and an allocation through the budgetary process.	*	
Sub-total	**3,561**	
South Australia		
• All Lotteries and Keno revenues go to the Hospitals Fund.	73,500	1997-98
• Approximately 45% of TAB revenue goes to the Hospitals Fund.	10,125	1997-98
• Fixed annual gaming machine tax levy to Gamblers Rehabilitation Fund.	1,500	1997-98
• Allocation to Community Development Fund from gaming machine tax. In 1997-98 this was $19.5 million.	6,000	1997-98
Sub-total	**91,125**	
Western Australia		
• Hospitals – 16% of lotteries turnover.	60,500	1997
• Lotteries Discretionary Fund	8,309	1997
Sub-total	**68,809**	
Tasmania		
• Community Support Levy paid for by a 2% levy on club income and 4% on hotels. 50% is spent on gambling and health.	203	1996-97
ACT		
None	-	
Northern Territory		
None. Plans for a Community Allowance Fund have been put on hold.	-	
Total	**1,179,137**	

Source: Summarised from information provided to John Williams Consulting Pty Ltd by relevant State Departments

* As this becomes part of the Families, Youth and Community Care budget, grants to individual health and gambling-related projects can not be estimated.

Its 1997-98 allocation to 205 projects was $11 million, with an estimated $5.810 million going to projects to address problem gambling or to health related projects as follows:

Problem Gambling Counselling	$3.729m
Research into Gambling	$0.257m
Preventive Programs	$0.795m
Health	$0.913m
Aged Care	$0.115m

Within these totals, programs specifically directed at ethnic groups amounted to $0.608 million.

Although not strictly hypothecated revenue (rather taxes forgone), clubs in New South Wales have always claimed to plough money back into the community, including to some health projects. The larger ones are now being encouraged by government to allocate a share of revenue to support worthy projects. Under a *Community Development and Support Act* clubs which have more than $1 million gaming machine revenue have the option to devote 1.25% of this revenue to community projects. This is offset in taxation they would otherwise have had to pay.

Of this 1.25%, a Category 1 tranche of 0.42% must go to community groups looking after low income and disadvantaged groups. Category 2 (0.83%) can go to traditional club areas such as sport and schools. Health related projects, such as sponsorship of hospital wards and provision of facilities for aged care hostels, come under Category 1, though not automatically. The money cannot be directed to the community at large; it still must be directed to the underprivileged.

The Registered Clubs Association recently conducted a survey of clubs' spending on members and on thousands of community projects. However, given the volume and aggregation of information it has not been possible to easily identify health and aged care projects.

6.2 Victoria

Gambling taxes in Victoria are largely applied to health purposes. In 1996-97 $921.1 million was applied to two funds; $866.6 million to the Hospitals and Charities Fund and $54.5 million to the Mental Hospitals Fund. The total rose to $1,008.5 million in 1997-98.

The funds derive from casino, Keno, gaming machines, lotteries and racing[2]:

- 1% of casino revenue goes to the Community Benefit Levy. This was $8.043 million in 1997-98. It is allocated 100% to the Hospitals and Charities Fund through the Consolidated Fund, which is the normal routing of funds.

- 100% of Club Keno tax revenues go to the Hospital and Charities Fund, as do all TAB tax revenues, though Bookmakers tax remains in the Consolidated Fund. The 1997-98 values were: Keno $2.59m and TAB $120.56m respectively. Keno tax revenue is made up of 12.5% of Keno turnover to $100 million. TAB tax is based on 28.2% of player loss.

- The lotteries position is more complicated. Tattersalls runs the lotteries in Tasmania, ACT and Northern Territory. There are taxation deductions in respect of sales in these areas. By legislation, all Tattersalls taxation must go to the Hospitals and Charities and the Mental Hospital Funds, so more than the purely Victorian taxation goes into to the Fund. The other States' taxations (less commissions) are remitted to them, with those amounts being reimbursed to the Funds from the Consolidated Fund. In 1997-98 the Hospital and Charities Fund received $261.4 million and the Mental Hospital Fund $62.1 million from this source.

- Club gaming machines pay one-third of their revenue in tax, which goes to the Hospitals and Charities Fund. This is true also of hotels, which are taxed an extra 8.34% for the Community Support Fund. Health and gambling related programs and projects received

[2] There are minor permit fees to be introduced on Lucky Envelopes and Bingo. These were estimated to amount to $200,000 a year. This covers costs of administration only.

$1.358 million.

According to the Community Support Fund Unit, up to 30 September 1998 a cumulative $17.5 million has been allocated to Families in Crisis projects (victims of child abuse, respite care for families with severely disabled children, other crisis assistance). $39.4 million went on problem gambling programs (research, counselling, community education, financial counselling, etc.). $72.4 million went into drug initiatives (research, education, training, etc.). Other areas of disbursement were Youth ($26.4m), Arts ($62.8m), Tourism ($27.3m), Sport and Recreation ($97.8m) and Other ($19.9m).

6.3 Queensland

Most gambling taxes go to consolidated revenue. There are seven exceptions:

- *Lotteries* The Golden Casket jackpot gives a minimum of $1.5 million towards Children's Health: in practice this amount is not exceeded.

- Three *Casino Community Benefit Funds*, one each for Cairns and Townsville casinos and a joint Jupiters/Brisbane Fund which receive a levy of 1% on casino revenues, which would have been $4,320,000 in 1996-97, up 130% on 1991-92. The Townsville Fund allocated $216,000 in March and July 1998, of which $8,700 was for equipment for health related activities. The Jupiters/Brisbane Fund allocated $3,735,000 on August 1997 and February 1998. Of this, about $470,000 was in the provision of equipment for health groups and Lifeline. Of $1 million donated so far the Cairns Fund donated $30,400 to health projects.

- The *Gaming Machine Community Benefit Fund* is paid for from two sources. The first is a grant of 4% of the Keno tax. The second is 8.5% of gaming machine tax. The sources of funds for the *Charities and Rehabilitation Fund* are 6% of Keno taxation and a discretionary sum allocated by Treasury through the normal budget process.

  In 1997-98, operating under a different tax and allocation system, the amounts dedicated

to these funds totalled the equivalent of 8.7% of gaming machine/Keno taxes paid to the *Gaming Machine Community Benefit Fund* ($17.3 million, of which estimated grants to health and aged care programs amounted to $1.552m), *Charities and Rehabilitation* got

13.3% ($26.4m, see below for its distribution), while Sport and Recreation got 22% ($43.7m). The *Gaming Machine Community Benefit Fund* has, up to this year, been limited to grants of $15,000 or less. Furthermore it cannot combine with other agencies to jointly award larger sums.

- *Charities and Rehabilitation Fund* monies are bundled together with funds derived by Families, Youth and Community Care from Consolidated Funds. We are informed that it is impossible to separate out particular programs and ascribe Charities and Rehabilitation Fund as the source of the monies for those programs, though undoubtedly some of the total Fund finds its way into health and aged care areas.

- Sport and Recreation Fund.

6.4 South Australia

All but a fraction of 1% of the Lotteries revenue (including Keno) goes into the South Australian Hospitals Fund. This amounted to $73.5 million in 1997-98. TAB revenues of $22.5 million were divided between the Hospitals Fund and the racing industry, with the Hospitals Fund getting about 45%. The lottery revenue is 14% lower than in 1991-92, while the racing revenue is at the same level, being smaller in real terms.

$1.5 million a year from gaming machine revenue is paid into a Gamblers Rehabilitation Fund. There is also a Community Development Fund of $19.5 million, of which $9 million goes specifically to Health. Last year $3 million of this was spent on Disability Services and $6 million on measures to reduce hospital waiting lists. These funds were not in existence in 1991-92.

6.5 Western Australia

TAB and casino taxes go to Consolidated Funds. The Casino levy of 1% of revenue goes to the Burswood Park Fund, which looks after the Park and provides grants only for sports and recreational facilities. 16% of the Lotteries turnover (40% of revenue) is allocated to hospitals. This was $60.5 million in 1997, approximately 30% higher than in 1991-92.

There is also a Discretionary Spending component of 5% of gambling revenue which is controlled by Western Australia Lotteries. The total fund amounted to $33.7 million in 1997, of which only one grant of $45,000 was made for the support for people with gambling problems. There were many other grants which are health-related. Allocations identified as relating broadly to health occurred in the following classifications in 1997:

Community Development General	$0.083m
Emergency Services General	$0.746m
Aboriginal Services	$0.022m
Aged Services	$3.256m
General Community Services	$1.391m
Samaritan Fund	$0.111m
Medical Research	$2.655m
Total	$8.264m

6.6 Tasmania

In Tasmania clubs pay 2% and hotels pay 4% of their gaming machine revenues into a Community Support Levy. Of this, half is devoted to 'research into gambling, services for the prevention of compulsive gambling, treatment or rehabilitation of compulsive gamblers, community education concerning gambling and other health services'. In 1996-97 the revenue of the Levy amounted to $203,000, but gaming machines have only just been introduced outside the casinos, so this was expected to rise with the spread of gaming machines.

6.7 Australian Capital Territory

Here gambling taxes go to Consolidated Funds. Clubs with monthly revenues over $25,000 pay an extra 1% (23.5% instead of 22.5%) on their gaming machine earnings. This goes to the Australian Institute of Sport. Hence, no funds are hypothecated to health-related

purposes.

6.8 Northern Territory

It was planned to set up a Community Allowance Fund with gaming machine taxation, however, planning for this was suspended in January 1996 pending a review of gaming. All gambling taxation goes into consolidated revenue.

Communities in each State clearly benefit from the funds hypothecated from gambling revenues. However, it is has not been possible in this study to make any assessment of whether this community benefit effectively offsets the costs of problem gambling, or helps to build more resilient individuals and communities less prone to gambling problems.

7. RESEARCH AND STATISTICS

Although a body of data and research on gambling is beginning to be built up, it seems to be happening in a haphazard manner resulting in patchy coverage and lack of comparability.

Gambling is seen as a State responsibility. There is no nation-wide perspective on any aspect of gambling even though its impacts are not confined by State boundaries and the emergence of electronic gaming renders State boundaries increasingly irrelevant.

Research into problem gambling is mostly funded from gambling revenues. While in Victoria and NSW efforts to establish research programs are progressing after somewhat shaky beginnings, in other States gambling-related research seems not to be a priority. In WA, although $2.655 million was allocated to research from the Lotteries Discretionary Fund in 1997, this provided equipment for medical research.

While in one way it is appropriate that gambling revenue should pay for research into the impacts of gambling, there are perceptions that the current research agenda, and decisions on who receives funding, could benefit from more independent input. In Victoria, for example, the Auditor General considered that there were grounds to support the transfer of research funding ‘to an area of government independent of the regulatory and other statutory functions of the [Casino and Gambling] Authority (VAGO 1996).

With the establishment of the Problem Gambling Research Program in Victoria in 1997, a longer-term research agenda is being developed, marking a shift away from deciding on an annual basis what research projects will be funded. The program aims to examine the effects of gambling on individuals and their families, clients' responses to support systems and the effect of these services on people who use them (VDHS 1998b).

Even so, all research is commissioned with the topics being decided by Government Departments. Researchers consider that this is limiting the usefulness and cohesiveness of research: commissioned projects and trends in data may raise more questions but there is no opportunity to follow these through.

Overall, the patchiness of research corresponds with the patchiness of the data and statistics available. Research is hampered by the lack of data and the snap-shot nature of much research does not contribute to building up a body of data.

Gambling data collected by the Australian Bureau of Statistics (ABS) falls into two categories: industry data; and data on individual habits relating to gambling primarily collected through the Household Expenditure Survey. Both sources are limited in the extent to which they can inform our understanding of gambling problems and the development of policy advice.

- *Industry data* As part of the ABS Service Industries Surveys, information is collected on income, expenses and employment of organisations involved in gambling industries in Australia. The most recent published report covers 1994-95 and does not reflect the considerable changes and expansion that have taken place in more recent years. Results from the 1997-98 survey are expected to be released in mid 1999 (ABS 1996, 1997, 1998).

- *Individual Habits: Household Expenditure Survey (HES)* Current outputs from the HES relate to the 1993-94 financial year. Results from the 1998-99 HES should be available early in 2000. By the nature of the survey, data is limited to average household expenditure on a range of gambling activities (Lottery, Lotto type games, TAB/on course

betting, Poker machines, Casino games), although the data may be examined flexibly by a range of socio-economic characteristics.

The Minimum Data Set commissioned by the Victorian Department of Human Services provides the most substantial data set but it is limited to information on self reported 'problem gamblers' seeking help from the 18 Break Even counselling services operating from 30 sites around Victoria.

It is suggested that future research might benefit from collaborative, multi-disciplinary approaches. This would bring new researchers and new perspectives to the task while building on the expertise of the current pool of researchers.

The Department considers that the following areas for further research could include:

- *strategies for preventing harm from problem gambling:* the development and evaluation of more cohesive and consistent preventive approaches across jurisdications;
- *assessing current interventions:* more stringent evaluation of current interventions to establish a better understanding of 'what works, for who, and in what circumstances';
- *problem gambling as a health issue:* a better understanding of problem gambling as a health issue, including the links between problem gambling and health, including mental health and suicide;
- *help seeking behaviours:* a better understanding of help seeking behaviours (eg gender and/or cultural group differences) and the implications for designing education programs and interventions; are help seeking behaviour by problem gamblers different from, for example, people seeking help for AIDS, or for other forms of dependence such as substance abuse;
- *under-age gambling*: the extent and impact of under-age gambling, its correlation with other risk behaviours and links to youth suicide;
- *Internet gambling:* will Internet gambling shift gambling problems more firmly into the family context with more significant impacts on the well-being of families? and
- *cause of gambling problems:* continuing research into the causes of problem gambling and links with other addictive behaviours and with risk taking.

More broadly, there is a need for improved methodologies for measuring the social and economic impacts of gambling, which more accurately identify the range of negative and positive impacts, and assess these consistently across all States.

8. CONCLUSION

While this submission provides a wealth of information not readily available elsewhere, it also points to the paucity of information on problem gambling as it impacts on health. This is surprising given that the existing measurement instruments were developed in the health context and focus largely on mental health. Although there is continuing debate as to the cause of problem gambling, in the Australian context it would seem more useful to regard it as a social issue rather than a human pathology. At the same time, it is suggested that any move to further identify problem gambling as primarily a medical problem be treated with caution.

While there is a need for better data and further research, the major effort for the near future should be directed to developing comprehensive and nation-wide preventive approaches supported by all States and all sectors of the industry, and to more robust and independent evaluation of current programs to address problem gambling.

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