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Ethical Blindness, EGMs and Public Policy: A Tentative Essay Comparing the EGM and Tobacco Industries

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Abstract Arguing a case by way of analogy can be perilous. Each problem has its own particulars that analogy and examples from other domains often obscure. Therefore it is with some trepidation that this paper discusses similarities and differences between the poker-machine (EGM) and the tobacco industries. The author has no special knowledge of the tobacco industry beyond that of the reasonably informed citizen. Rather it is out of concern about ethics and product safety for EGMs that the paper addresses the following question: what, if any, are the substantive ethical differences between the EGM industry and the tobacco industry?

Keywords EGM · Tobacco · Ethics · Public policy

Answering a significant question will help to illuminate why public policy on EGMs—in Australia certainly, but elsewhere also—is ethically blind. By 'blind' I mean that policy does not take an ethical perspective. This is not to say that it does not have one, just that it does not consider ethics explicitly. The question I will consider below is: what, if any, are the substantive ethical differences between the EGM industry and the tobacco industry? Differences surely exist, but the ones I will emphasize are not so obvious. It will take a little time to explain them, so it is easier to start by pointing out rather obvious similarities.

My own ethical perspective will be evident to the reader as the argument unfolds. However, let me say now that it is a form of moral realism that necessarily joins ethical and other facts in the world. I have articulated my approach elsewhere (Doughney 2005; 2004; 2002) and will not say more here, save to acknowledge a debt to Julius Kovesi, whose work remains insufficiently recognized (see e.g. Kovesi 1967). The approach that I endeavor to articulate also contains a practical emphasis on eliminating avoidable harms or suffering (wrongs, evils, injustices). Thus those who might have perspectives on ethics as otherwise different as those of Raimond Gaita and Peter Singer (see e.g. Gaita 1999; Singer 1993) might still agree with my conclusions.

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The most obvious similarity between the EGM industry and the tobacco industry is that both market harmful or unsafe products. Hence both industries face regulations that other businesses do not. For example, it is illegal to sell tobacco products to minors. It is illegal for minors to enter gaming rooms of venues. Implicit in such regulations is the notion of consenting adults: adults, we assume, are capable to exercise informed consent. The state, however, intervenes to protect minors from the harms that smoking and EGMs cause.

Another important similarity is that the tobacco and EGM industries offer powerfully control-impairing products. Regular use works to extinguish control by users, and it is this that sets in motion the chain of events and decisions that cause harm. Loss of control over time spent at the machines and, therefore, over income lost also extinguishes any reasonable notion of informed consent.

Regardless of whatever 'pleasures' smoking and EGMs may provide, it is true that both products also cause death. Tobacco products cause sequences of biological changes that cause, among other illnesses, fatal cancers and cardiovascular disease. This occurs especially among heavier smokers and those with existing susceptibilities, co-morbidities or exposures (e.g. asthma, family history, asbestos). Similarly EGM use, especially heavy use, can combine with other factors (e.g. co-morbidities such as depression) to cause a sequence events and decisions that culminate in suicide.

In the State of Victoria in Australia between June 2001 and June 2005, the National Coroners' Information System estimated that a minimum of 70 suicides had gambling problems as their principal cause. The report, which used Victorian Coroners' findings as evidence, warned that the 'figures provided may be an under-representation of relevant deaths' because another, interrelated, cause was cited by the Coroner. According to a manager of a regional Gamblers' Help service, Julie Nelson:

> It's very easy to minimize the effect—I know of suicides which were gambling-related, but in the coronial inquest they said it was because of family failure or business failure... We have a lot of people who say they have thought about it, certainly contemplated suicide... but most of those people have been able to find enough reasons to go on. (Cited in Butler 2005)

The National Coroners' Information Service report said that 68 of the 70 recorded gambling-related suicides were by EGM users or their partners. The report was the first of its kind.

Six years earlier the Australian Medical Association (AMA) had issued a position statement on gambling problems. Remarkably, the AMA advised its members to integrate into their practice measures to identify and treat problem gambling. The 1999 statement said, inter alia, that:

1. Medical practitioners should be aware of the adverse impacts of problem gambling on the physical and mental health of individuals and their families. Patients with problem gambling may present with symptoms which appear unrelated to gambling. Other patients may present with health-related concerns arising from a family member's gambling problem.
2. Medical practitioners should include gambling as part of their systematic lifestyle risk assessment when taking a medical history.
3. Where a gambling problem is suspected, a psycho-social assessment should be undertaken.
4. Where relevant, a shared-care approach to the case management of people with gambling problems and their families may be developed. The general practitioner can be assisted

by community agencies such as gambling intervention and counseling services, community mental health, relationship counseling, alcohol and drug, financial advisory services and legal services.

5. Information kits which include screening and assessment questionnaires should be available to all medical practitioners, especially general practitioners, to help identify, manage and refer patients affected by problem gambling.
6. Undergraduate and postgraduate medical education courses should include the recognition of problem gambling as a health issue. Medical practitioners are encouraged to participate in continuing education related to the detection and management of the adverse health effects of problem gambling.

A later study by the AMA, in 2002, said that in one in 50 patients attended a medical practice explicitly because of problems with gambling. EGMs were the overwhelming cause. Of course, the AMA's reaction is hardly surprising or odd. Medical practitioners surely will develop codes to address the public health aspects of all manner of new social phenomena. What should strike us as surprising and odd about doctors including 'gambling as part of their systematic lifestyle risk assessment when taking a medical history' (AMA 1999) is that they do so because governments[1] in Australia, New Zealand and elsewhere actually created the EGM problem.

That is one important difference from the tobacco industry. Governments created the EGM industry in response to the rise of the neo-liberal policy agenda that required their budgets—especially their social budgets—to be cut in order to 'fund' tax cuts for businesses and individuals. Governments licensed the industry and either created or transformed the enterprises that would supply the EGM 'product.' In doing so, and in continuing to rely on EGM revenues, governments intentionally, and by their own volition, became causal agents in the resulting harm. That harm can be grave. According to the AMA position statement:

> The AMA acknowledges that the social, physical and mental health of people with problem gambling and of their families are often at risk as a result of reduced household income and associated social disruption. They may experience stress-related physical and psychological ill health. Other adverse effects include family breakdown, domestic violence, criminal activity, disruption to or loss of employment and social isolation. Additionally, problem gambling may compromise their capacity to afford necessities such as adequate nutrition, heating, shelter, transport, medications and health services.
>
> Severe problem gamblers are at risk of self-harming behavior including attempted suicide. (AMA 1999)

Clearly none of the harms of EGMs or tobacco are inconsequential. It is an odd word, 'inconsequential.' Its positive form, 'consequential,' means, literally, that these harms have consequences. In this context it means that 'they matter.' Indeed, harms matter. Whatever they are, or whatever causes them, harms matter. It matters that someone loses their job, suffers mentally, experiences a heart attack, has a long illness, suicides or dies of cancer. Imagine the improbable: that suicide is just a consequence of a random act of willfulness. It matters nonetheless. The suicide—a death, any death—matters none the less because no life—any life—matters none the more. All life is equally valuable.

[1] I will not distinguish below between Federal and State levels. Though each functions differently, via the taxation system, both are complicit (see e.g. Doughney 2002, Chapter 1; 2006)

Yet, I would argue, not all harms are the same. An accidental death is not the same as a murder, and nor is a death from natural causes. The loss is the same, but a murder adds the harm of willful injustice to the random injustice of natural caprice and to the physical/psychological harm of mere death. 'Mere death' is also an odd phrase, but I think we all know intuitively what it means in this context. We grieve equally the loss of a natural death, the accidental death and the murder. Yet we despair at the random injustice of accidental death, and we rage at the terrible injustice of a murder.

Although I have made similar remarks before (Doughney 2002), citing the views of philosophers such as Simone Weil and Raymond Gaita, I was reminded of their force by an opinion article by Nicholas Kristof reprinted by the Melbourne *Age* (Kristof 2006) from the *New York Times*. The piece was an appeal for action by the international community to stop the genocide in Darfur. The author's contention was that the deaths in Darfur commanded special moral attention because, even though more human beings in total may die in wars or from epidemics, there was something especially horrific about genocide. These deaths were the intentional work of a government, acting itself and through agents, to wreak a terrible vengeance on a people.

We mark the distinction between causes of death not because there is a quantitative difference in *death* per se. Death is equally tragic, ceteris paribus,[2] because life is equally valuable. The difference is in the cause. Some causes are more or less inevitable, and some are more or less avoidable. We might guard against the risk of accidents, but a murder is entirely dependent on volition and therefore is entirely avoidable. Something about the fact that someone inflicts avoidable harm willfully makes that harm (and not its consequences) more egregious and more unjust.

I have used the examples of death and murder for two reasons. First, examples at the limit—extreme examples—help to highlight ethical-moral dilemmas. Secondly, the examples of death and murder actually relate directly and unequivocally to the similarities and differences between EGM and tobacco industry products. Both industries/products *cause* harm. Both cause avoidable harm. Both cause death, which is to say that the ultimate physical consequence of harm results from their use. Moreover no industry *must* produce cigarettes or EGMs. It is a question of volition or choice. Producers produce these products for a reason. They choose to do so, and governments provide the legal framework in which individuals, both humans and corporate, can make that choice. Governments therefore choose, too. The least they do in both the EGM and tobacco cases is to license dangerous products that cause death. They do so knowingly.

Of course, governments also create the legal framework for other products that can cause grave harms: motor vehicles, or kitchen knives, or power tools, or petrochemicals and so on.[3] What is the difference? I think there are two important differences. The first concerns the manufacturer/supplier's intentions. Manufacturers and suppliers of the above products intend their products to have safe uses (driving to work, slicing bread, drilling holes and manufacturing plastics etc.). They issue product safety guidelines that suggest safe ways to use the product and to minimize the risk of accident. In the case of cars, for example, governments impose additional rules (speed limits, seatbelts, airbags etc.) to restrict the scope for accident or harms caused by accidents. Manufacturers of cutlery do not intend

[2] Other things remaining the same. A peaceful death in old age after a well-lived, fulfilling life is different from the painful death of a child from cancer.

[3] Obviously we may consider alcohol and illicit drugs as well. However, to do so would extend the scope of this paper unreasonably. Hence I will resist the temptation.

that carving knives be used to kill. Carmakers do not intend that their products veer into oncoming traffic.

Nonetheless governments regulate the use of the motor vehicles rigorously. The most obvious restriction is that adults must be licensed to use the product. The license holds our addresses and can be cross-referenced to our vehicles by their registration plates. We readily assent to such restrictions because we know that cars, used wrongly, can cause awful harms and death. Yet governments have failed to regulate the EGMs as rigorously. As outspoken industry critic Sue Pinkerton is fond of reminding us, Ford and GM-Holden would be pilloried if 15% of their vehicles went to road with known harm-causing design faults. Such harm-causing features we call 'faults' in vehicles, but in EGMs they are just design features. Language is important in policy discourse, as are efforts to decode it and express it in common terms.

In contrast to motor-vehicle industry regulation EGM regulation has both created the industry and given it the space in which its control-impairing and harm-causing features (faults by any other name) can flourish. The same is evidently true for tobacco. Whatever dents regulation and other forms for government intervention (warnings, regional caps, etc.) have caused, they manifestly have not changed the EGM and tobacco delivery regimes qualitatively.

My reason for considering other potentially dangerous products has been to demonstrate why both the EGM and tobacco products are different from them and should be treated differently. The difference is simply this: unlike the other industries mentioned, the EGM and tobacco industries intend users to consume their products in precisely the ways that directly, and without further mediation, initiate the casual chain that results in known harms. Smokers must light the cigarette and breathe in the smoke. Rothmans do not intend that a packet of Winfield be lit in a bucket and observed for its smoke patterns at a distance of five meters. Similarly the EGM industry intends that users sit at the machines, play, and lose. They do not intend that users set a loss limit of $2 and then get up off their seats and walk away. Likewise the tobacco industry does not intend that smokers merely smoke one cigarette per week. Both industries supply control-impairing products that, used as intended, will inevitably cause some users to suffer profoundly. They will suffer because the products, used as intended, will cause them to use the product in harmful quantities. Almost all smokers will smoke potentially lethal amounts. The EGM product,[4] used precisely as intended, will cause users to lose control of time and money in sufficient numbers for the industry to flourish.

Understanding the distinctions just described helps us to understand some of the ethical dimensions of the EGM policy debate. However, we can understand better the ethical problems specific to EGMs if we now explore some of the distinctions between the EGM and tobacco industries. I have already mentioned the first one, but I will mention five other differences:

1. Government created the EGM industry for neo-liberal budgetary reasons
2. Government is a partner in the EGM industry
3. Increased tobacco taxes reduce smoking, partly because use is more evenly distributed across smokers than it is across users of the EGM product
4. Increasing the consumer cost ('taxes') of the product is unlikely to reduce use and losses because of the problem of 'user concentration'

[4] We must take the word 'product' to mean all of the product's various aspects, namely its manufacture, technology, distribution, means of provision, industry structure, licences and modes of consumption.

5. It is easier to identify those whom EGMs will harm than to identify which smokers will contract potentially lethal illnesses

It is essential to understand the fourth difference above, a particular feature of the EGM industry: 'user concentration.' Losses concentrate among a relatively small proportion of users (though the absolute number can be as high in Victoria as one-quarter of a million people). It is misleading therefore to rely on average data. For example, a witness statement given to the Productivity Commission in 1998 by Tabcorp senior executive Tricia Wunsch said that 80% of total losses (i.e. Tabcorp's total revenues) came from 20% of users. This is what she said:

> One thing that I will say, just in terms of where the revenue comes from, is there's a general 80:20 rule, the idea that 80 percent of your revenue comes from 20 percent of your customers, and that's certainly true in our business as well. Obviously somewhere in that 20 percent would fall anyone that might have problems with gambling but I couldn't say how much. (Wunsch 1998)

Equally significant are statements in a leaked report concerning a card-based loyalty membership scheme tested by EGM operator Tattersall's across 13 venues in 2002. The authors regarded members of the trial scheme as a reasonable approximation of poker-machine users in general (Tattersall's 2002, p. 42). The key data derived from the membership program were that 15% of users contribute 57% of losses and 34% of users contribute 82% of losses. The 15% were regulars. They spent an average of 2 h and 33 min at the machines and lost more than $100 each visit (Tattersall's CRP 2002, p. 42). Using data for 'participation rates' or 'prevalence rates'—i.e. the percentage of adults who use EGMs in a given year—we can calculate the average losses per year for the heavy users (i.e. the 15% above). The formula is:

$$\mathrm{Lh} = (60/15) \times \left(\sum \mathrm{L} \Big/ \mathrm{u} \sum \mathrm{P}\right) = 4\left(\sum \mathrm{L} \Big/ \mathrm{u} \sum \mathrm{P}\right)$$

That is, average losses per heavy user (Lh) are equal to four times (which, of course, is also equal to 80/20) the ratio of total user losses (ΣL) to the number of the adult population who use EGMs (i.e. total adult population (ΣP) times (u) the participation rate). Table 1 gives the data for participation rate 33.33%, which corresponds to the most recently estimated rate of 33.5%.

Table 1 EGM Losses Revenues for Heavy Users Victoria and Melbourne Dollars and Percent 'Equivalised' Household Disposable Income

	Total Net Losses Per Adult (18+) 2004–2005 (2005 Population Projection)	Total Net Losses Per Heavy User 2004–2005 (with 33.3% Rate)	Total Net Losses Per Heavy User 2004–2005 (with 33.3% Rate) as Percent of Approx. Equivalised HDI (%)
Metropolitan total	664.77	$8,141	28.4
Victorian total	618.27	$7,419	25.9

Sources: VCGR (2005a, b), ABS (2005)

Table 1 also gives figures for the share of household disposable income (HDI) constituted by heavy losses. The term 'equivalised' HDI means the following:

> ...average (mean) equivalised disposable household income... (i.e., the income that a single person household would require to maintain the same standard of living as the average person living in all private dwellings in Australia) was $549 per week (ABS 2005).

The weekly amount of $549 translates to almost $29,000 per year. Heavy users with average disposable incomes therefore lose an average of one-quarter or more of their disposable income to EGMs (i.e. to the industry). Even if we assume that heavy users of EGMs have the same income distribution among them as do Victorians as a whole, this means that a substantial majority of the population of EGM users will have lower incomes. The reason is simple: more Victorians have lower incomes than have higher incomes. What happens is that the higher incomes, not the numbers of people who have them, pull up the averages. Hence the majority of Victorians, and the majority of EGM users, will have 'equivalised HDIs' that are less than $29,000 per year. Hence the actual percentage of the disposable income of heavy users taken by the industry as revenue will be significantly greater than the 26–28% figure shown in Table 1.

The EGM industry unambiguously depends on losses of this magnitude. Without them revenues would be more than halved. Yet losses of this magnitude inevitably cause harm. If loss of control were merely a matter of people spending excessive time in front of a computer screen, then we might fear for their sociability. However, when that loss of control combines with the ferocious revenue-generating, loss-causing algorithms of the EGM, the financial consequences set in motion the complex causal chain of events and decisions that devastate lives. In this sense the physical/psychological harms, while not strictly a direct or first-order means to achieve the EGM industry's ends, are a means nonetheless. The reason is that large concentrated losses are the main means to the industry's end, and all other harms stem directly from them.

Unlike the tobacco industry, the EGM industry can readily identify (electronically by mandatory user-card systems and ordinary observation) those who lose too much time and, therefore, too much money. The signs by their nature are not hidden. However, given the distribution of cigarette smokers it is harder to know which individuals will succumb to lung cancer, for example. The cellular signs of the disease-in-itself are by their nature hidden. Certainly predictors such as heavy smoking, family history and other co-morbidities are apparent, but exactly who will contract the disease is opaque until he or she does. EGM harm by comparison is easier to detect and to prevent by intervention. That the industry does not genuinely act to avoid avoidable harm to identifiable individuals makes that harm intrinsically worse. We also know that co-morbidities between alcohol, smoking and gambling necessarily increase the risk of harm. Yet the mode of delivery of EGMs in hotels and clubs, 'smoking rooms' notwithstanding, actually facilitates continuous use, loss of control and harm.

The fact that concentrated losses of the above magnitude are necessary for the industry to function as it does is more than sufficient reason for action. Nevertheless, when we couple the physical and psychological harms with the injustice of it all, then the case for action becomes compelling. What is the injustice, again? The injustice stems from the fact that the EGM industry knows that such harms will occur necessarily. The industry knows the real price that many will pay for using its product precisely in the manner intended. Yet the industry makes the choice to market the product nonetheless (as does the tobacco industry with its). In making that choice—a free, unforced choice made in the interests of profit—the

industry acts causally. By its own volition it becomes the cause of others' suffering, regardless of whether or not it acts within the legal parameters set by the government of the day. It becomes an unethical agent. The industry therefore is morally culpable in that, knowing the harms, it chooses to accept them as part of the complex intentions it acts upon in marketing its product (its ends). The tobacco industry does this equally, though the EGM industry additionally fails to intervene when it can readily identify the signs of harm to individuals and thereby act to prevent them.

More serious injustice occurs in the case of EGMs, however, because our governments are partners in causing the harm. In breach of their duty to protect, they created the EGM industry and maintain it still. Why? The answer, too, lies in a venal arithmetic: accumulated revenue. The term 'industry' is, of course, just a placeholder for the proper names of shareholders in total EGM revenue. Government is the major (institutional) shareholder. It has vested its managerial control in executive (operator) shareholders: Tattersall's and Tabcorp. They in turn franchise to the locals: the pubs and clubs.

What then should we do? What should researchers advocate? What should social activists call for? I must confess that, the longer I research this subject, the simpler my answers become. Right now I think that the best response is this: market a product made qualitatively safer or none at all. This is the precautionary principle, which should have prevailed from the outset. The lesser evil between none at all and the present product regime is none at all. Perhaps that will help to put product-safety measures such as user-card technologies and serious reductions in machine numbers on the policy agenda.

Wither research? Research continues to be important, of course, but for shaping an ethical public policy we already know quite enough about the EGM industry.

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