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CASHLESS WELFARE CARDS:
CONTROLLING SPENDING PATTERNS TO WHAT END?

by Shelley Bielefeld

INTRODUCTION

Delivering social security payments by means of cashless welfare cards has had a protracted trial in Australia, with various income management schemes in operation, the latest of which is the Forrest Review inspired Cashless Debit Card (CDC) issued by Indue Ltd.[1] These schemes have been controversial since the first compulsory income management program emerged as part of the Northern Territory Intervention, yet the trend of cashless welfare delivery is expanding, considerably increasing the overall cost of social security payments. A key government rationale for various forms of cashless welfare is that something must be done to address the risk that welfare recipients might use their income to support substance abuse and gambling.[2] Numerous welfare recipients subject to income management report that it has created additional difficulties for them in meeting their needs. Despite this, advocates of cashless welfare are keen to declare income management a success,[3] rationalising further expansion and possibly smoothing the path to increased privatisation of social security payments in the process. Unlike earlier income management schemes operating with a government issued BasicsCard, the CDC involves a commercial financial services provider making a hefty profit from delivering this costly program.

The CDC was introduced in the Ceduna region in March 2016 and the East Kimberley in April 2016. As has been the case with other types of income management, the CDC applies disproportionally to Indigenous peoples, who make up 565 of 752 people subject to the card in Ceduna and 984 of 1,199 people on the card in Kununurra and Wyndham.[4] The implementing legislation for the CDC is the *Social Security Legislation Amendment (Debit Card Trial) Act 2015* (Cth) ('the DCT Act'). The objectives of the legislation contained in s 124PC are to reduce the amount of cash 'available to be spent on alcoholic beverages, gambling and illegal drugs', 'determine whether such a reduction decreases violence or harm in trial areas', 'determine whether such arrangements are more effective when community bodies are involved', and 'encourage socially responsible behaviour'.

The CDC quarantines 80 per cent of a person's regular welfare payment.[5] This restricted portion may be reduced if trial participants disclose their private circumstances to a community panel and the panel chooses to exercise its discretion in favour of a reduction.[6] Different appointment processes have been adopted for community panel members in each trial site and they have different panel guidelines.[7] For instance, in Kununurra and Wyndham the Department of Social Services engaged in an expression of interest process to recruit panel members.[8] Community panels have not been set up 'in a timely manner',[9] thus applications for reductions in restricted portions were delayed. Feedback from some participants also indicates that community panel outcomes are seen as arbitrary, and that its processes are difficult to navigate.[10]

The government emphasises that the CDC has been co-designed with Indigenous leaders in the trial areas via a consultation process, however the nature of what was agreed and the extent to which there was co-design of the CDC has been contested.[11] Some Indigenous elders and community members indicate that the broadly applied mandatory CDC was not the targeted scheme they had supported in consultations, and assert that they do not want the card in their community because it fosters shame and causes suffering.[12] For instance, Mimi Smart, an elder of the Yalata community, argues that the trial should be cancelled.[13] She states:

> when it was first talked about … I thought it was going to be for … people that hang out in Ceduna drinking and causing trouble, and not … people living in Ceduna who don't drink and get into trouble. I didn't think it would be for … people who do look after their kids. I thought the cashless card would be targeted.[14]

Problems have also been raised by some stakeholders and community members who maintain that the government had already decided to go ahead with the CDC at the time the consultation occurred.[15] Yet regardless of inadequacies with consultation,[16] the CDC will inform government policy about placing more stringent conditions on access to government

income support.[17] It is therefore important that problems with the scheme be given due attention.

Government commissioned evaluations and reports reveal significant problems with various forms of income management, yet the government remains committed to this type of welfare reform regardless of evidence that it has increased difficulties for many people subject to it.[18] The most recent report is the Wave 1 Interim Evaluation Report of the CDC, described by government ministers responsible for the CDC as 'positive'.[19] Yet a thorough reading of this report gives cause for concern.

ANALYSIS OF THE WAVE 1 INTERIM EVALUATION REPORT

Orima Research was commissioned to conduct the evaluation of the CDC in Ceduna, Kununurra and Wyndham. Orima interviewed CDC trial participants, family members of CDC participants and other stakeholders. Of the 552 interviewed CDC participants 97 per cent identified as Aboriginal or Torres Strait Islander peoples.[20] The report concluded that the trial suffices for a 'proof-of-concept', and claimed the CDC 'has been effective in reducing alcohol consumption, illegal drug use and gambling'.[21] A close reading of the report reveals that this statement represents a small part of a more complex picture. Reduction in substance use and gambling occurred for 22 per cent of surveyed participants, but the data indicates that for the vast majority of CDC participants—77 per cent—the trial is making no difference in terms of alcohol, gambling and illegal drug use.[22] That means that over three quarters of those subject to the CDC derived no benefit from it in relation to the government's most heavily emphasised rationale for the card. Of the CDC participants '43 per cent reported no change and 34 per cent reported that they did not drink alcohol, gamble or take illegal drugs before or after the Trial'.[23]

Research indicates that the CDC has led to a range of consequences ostensibly unintended by policymakers. The report reveals that there are significant problems for numerous participants forced to use the card, with 49 per cent of participants reporting they were worse off under the CDC compared to 22 per cent who said it led to improvements.[24] Reasons given as to why the CDC made peoples' lives worse include being prevented from paying 'bills', being unable to purchase desired 'personal items', and lacking access to sufficient cash.[25]

Some CDC participants indicate that certain 'private landlords' only accept cash payments or rent paid via 'forms … not easily able to be met by' card holders, 'resulting in difficulties meeting tenancy requirements'.[26] Eighteen per cent of CDC participants voiced concerns about problems purchasing goods and services that were meant to be permitted expenditure via the card.[27] Problems with the CDC have arisen in the context of participants needing to 'transfer money to children … away at boarding schools'; purchase second hand goods; make small purchases in 'cash-based settings (e.g. fairs, swimming pools, canteens)'; 'make purchases from merchants … where EFT facilities were unavailable', and purchase petrol.[28] This has led to 'frustration' for CDC holders 'who can feel "discriminated" against by their inability to access these'.[29]

Some Indigenous elders and community members indicate that the broadly applied mandatory CDC was not the targeted scheme they had supported in consultations, and assert that they do not want the card in their community because it fosters shame and causes suffering.

Although the government envisioned that the CDC would only prohibit purchase of alcohol and gambling products, the CDC has been 'declined at stores both within and outside the Trial sites, and … some cases *do* seem to involve merchants telling cardholders that they cannot use the particular card'.[30] In the face of these challenges, the Orima report recommends education to help welfare recipients be 'more confident' using their cards and 'more assertive with merchants' who say they cannot accept the card for transactions.[31] This suggestion inappropriately frames problems with the card as a confidence and assertiveness deficit on the part of CDC holders. It also ignores important contextual factors. Indigenous people acting assertively in Australia have sometimes been arrested or punished for being assertive rather than compliant.[32] In situations of power imbalance, being assertive can come at a cost.

Some CDC holders appear to be experiencing anxiety about their finances due to automatic payments being deducted from their accounts resulting in 'late payment fees', 'interest charges' and what 'appear to be unauthorised withdrawals'.[33] This has led to some people 'spending much or all of their money as soon as it comes in just to make sure it is not taken away'.[34]

The need for CDC participants to have access to technology to check their card balances is also problematic. Some CDC users are outside areas with phone service, do not have mobile phones, or if they do have mobile phones often lack 'phone credit'.[35] Feedback by CDC holders indicates that the Indue App needed to check

account balances is not always operational.[36] Close to half the CDC participants indicate they had problems using the card.[37] In addition, numerous power outages have left people reliant on the card with less cash available to purchase essential goods and services during blackouts.[38] The CDC has also presented problems for card holders with 'limited internet access', limited 'digital literacy', and 'limited English levels'.[39]

Although caring for children effectively has long been part of the government rationale for compulsory income management, in the East Kimberley 34 per cent of trial participants ran out of money to pay for things needed for their children's education expenses, and 38 per cent ran out of money for other essential non-food items for children.[40] CDC participants and their families report that demands to share resources, often referred to as 'humbugging', has increased since the CDC was introduced.[41] In the East Kimberley 58 per cent of participants reported needing to borrow money from family and friends, and 42 per cent of Ceduna participants likewise needed to borrow money to survive.[42] Furthermore, homelessness or sleeping rough was reported amongst 9 per cent of participants in the East Kimberley and 6 per cent of Ceduna participants.[43] These figures suggest that survival needs are not being adequately met for numerous participants subject to the CDC.

Costs borne by welfare recipients subject to the scheme are high indeed, but costs are also steep in financial terms.

Some family members of CDC holders indicate that the card fosters social exclusion by preventing trial participants from 'being able to send money to kids/family/friends or buy them presents' and limits the ability of children to 'go on excursions'.[44] Others report that keeping track of money is made more difficult by the card.[45] Health research indicates that social exclusion and lack of autonomy can lead to poor health outcomes for Indigenous peoples.[46] This feedback on the CDC is therefore concerning.

The report identified numerous 'negative social impacts' for CDC participants, including 'that community members who thought they spent their money appropriately felt as though they were being "penalised" and / or "discriminated against"'.[47] This suggests that some see the CDC as a punishment rather than a supportive program.

Some card holders resist the scheme in their own way by adopting behaviours to circumvent CDC restrictions. Reported circumvention mechanisms include purchasing permitted goods with the CDC for others 'and being reimbursed with cash (sometimes for less than the full value)', 'making spurious transfers for "rent" or to BPAY biller accounts … and then withdrawing cash from the end receiving account', 'Merchants overcharging for a product or services and then refunding the difference in cash', 'Gambling using non-cash wagers' and using 'CDCs as payment for a lost bet', and accessing alcohol by the black market. [48] Some stakeholders reported that other circumvention behaviours included theft, increased harassment of others in the community known to have cash, and prostitution.[49] This highlights that interventions designed to prevent some risks can contribute to other types of risks emerging. The CDC has created other vulnerabilities that are not acknowledged by CDC policymakers.

Despite significant shortcomings of the scheme, Alan Tudge claims the CDC 'has led to stark improvements in these communities'.[50] This indicates that the government is not paying attention to the views of those subject to the card where these conflict with the government's ideological preference for CDC expansion. This is inappropriate. Those subject to the card have unique insights about how it affects their lives and their views should be taken seriously.

PRIVATISATION POSSIBILITIES

CDC participants currently experience privatised delivery of 80 percent of their social security payment. The government has signalled the possibility of further expansion, stating the CDC 'trial … will make a vital contribution towards informing potential future arrangements for income management'.[51] The government is currently seeking to expand the CDC to two new locations, meaning that more welfare recipients will soon be targeted by this scheme.[52]

The government's dedication to continuing income management regimes despite the problems revealed by income management reports and evaluations raises questions. Is income management via the CDC simply smoothing the path towards privatisation of social security payments — and if so at what cost? As this article makes clear, costs borne by welfare recipients subject to the scheme are high indeed, but costs are also steep in financial terms.

Indue Ltd was awarded a contract of $7,939,809 for the trial of the card, and a further contract of $2,870,675.50 for the CDC IT build.[53] These sums are part of a reported $18.9 million allocated to the CDC, with a cost of approximately $10,000 per participant.[54] Indue was contracted to cover the CDC for 'no more than 10,000' welfare recipients from '1 February 2016' to '30 June 2018'.[55] Orima's report indicates that Indue had responsibility for administering $10.5 million of welfare payments 'quarantined via … CDC accounts on

or before 30 September 2016' for around 1850 card users.[56] Thus the amount paid to Indue represents a significant increase in the overall cost of welfare. There is an opportunity cost in this arrangement, as other productive possibilities to empower people struggling with poverty are overlooked.

When assessed against the objectives for which income management was introduced compulsory cashless welfare cards look suspiciously like a boondoggle that society can ill afford. The Oxford English Dictionary defines a boondoggle as 'an unnecessary, wasteful, or fraudulent project'.[57] Despite nearly a decade of policy failure the income management bureaucracy only increases its speed, creating powerful vested interests for a new strain of poverty profiteers and those who build their careers out of these misery making systems.

It is crucial to ask who benefits most from the CDC regime. Cashless welfare cards will increase the wealth of entities like Indue and the overall cost of social security provision in Australia, but without providing advantages for numerous people subject to these measures and delivering detrimental outcomes to many. In an economic climate where there are routinely calls for increased efficiency — and where programs are often said to be evaluated in terms of their ratio of cost to benefit — income management is an anomaly.

CONCLUSION

Evaluation reports have potential to generate important knowledge about how laws and policies operate, however they may also be selectively interpreted to garner support for preferred government policy pathways in order 'to "prove" program success'.[58] Unfortunately this has occurred with numerous income management evaluations to date,[59] and the government's media release declaring the CDC interim evaluation report 'positive' continues this trajectory.

The dominant political rhetoric on income management has presented cash payments to welfare recipients as a high-risk activity due to their presumed preference for poor purchases. Such stigmatising supposition makes for poor policy and income management legislation[60] is an area ripe for reform — not for intensification via an 80 per cent CDC restriction — but abandoning altogether the coercion coupled with surveillance upon which this system is based.

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