Public Health Association of Australia
submission on Social Services Legislation Amendment (Cashless Debit Card) Bill 2017

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Introduction

The Public Health Association of Australia

The Public Health Association of Australia (PHAA) is recognised as the principal non-government organisation for public health in Australia working to promote the health and well-being of all Australians. It is the pre-eminent voice for the public’s health in Australia. The PHAA works to ensure that the public’s health is improved through sustained and determined efforts of the Board, the National Office, the State and Territory Branches, the Special Interest Groups and members.

The efforts of the PHAA are enhanced by our vision for a healthy Australia and by engaging with like-minded stakeholders in order to build coalitions of interest that influence public opinion, the media, political parties and governments.

Health is a human right, a vital resource for everyday life, and key factor in sustainability. Health equity and inequity do not exist in isolation from the conditions that underpin people’s health. The health status of all people is impacted by the social, cultural, political, environmental and economic determinants of health. Specific focus on these determinants is necessary to reduce the unfair and unjust effects of conditions of living that cause poor health and disease. These determinants underpin the strategic direction of the Association.

All members of the Association are committed to better health outcomes based on these principles.

Vision for a healthy population

A healthy region, a healthy nation, healthy people: living in an equitable society underpinned by a well-functioning ecosystem and a healthy environment, improving and promoting health for all.

Mission for the Public Health Association of Australia

As the leading national peak body for public health representation and advocacy, to drive better health outcomes through increased knowledge, better access and equity, evidence informed policy and effective population-based practice in public health.
Preamble

PHAA welcomes the opportunity to provide input to the inquiry into the Social Services Legislation Amendment (Cashless Debit Card) Bill 2017. The reduction of social and health inequities should be an over-arching goal of national policy and recognised as a key measure of our progress as a society. The Australian Government, in collaboration with the States/Territories, should outline a comprehensive national cross-government framework on promoting a healthy ecosystem and reducing social and health inequities. All public health activities and related government policy should be directed towards reducing social and health inequity nationally and, where possible, internationally.

Social Determinants of Health

The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between countries. This is particularly pertinent when considering issues such as the social welfare policy.

The determinants of health inequities are largely outside the health system and relate to the inequitable distribution of social, economic and cultural resources and opportunities. Health inequities are the result of the interaction of a range of factors including: macro politico-economic structures and policy; living and working conditions; cultural, social and community influences; and individual lifestyle factors.

PHAA Response to the Bill

Purpose of the Bill

“This Bill removes section 124PF of the Social Security (Administration) Act 1999, which specifies that the cashless debit card trial will occur in up to three discrete locations, including no more than 10,000 people, and will end on 30 June 2018. Removing this section will support the extension of arrangements in current sites, and enable the expansion of the cashless debit card to further sites.”

Features of the trial

“The Cashless Debit Card Trial (CDCT) aims to reduce the levels of harm underpinned by alcohol consumption, illicit drug use and gambling by limiting Trial participants’ access to cash and by preventing the purchase of alcohol or gambling products”¹ p3.

The trial was mandatory for all working age recipients of income support payments, with 50-80% of government support payments directed to a restricted bank account accessed through the debit card. The trial was conducted in Ceduna, South Australia, and the East Kimberley region of Western Australia from 2016-2017, with over 2,000 participants. There was a significant majority of participants identifying as Aboriginal and Torres Strait Islanders – 75% in Ceduna and 80% in East Kimberley. Aboriginal and Torres Strait Islander make up just over one-quarter of residents in the trials sites, so they were significantly over-represented among trial participants.

A key feature of the trial was that it was conducted in two small and geographically remote communities. The results of this trial may therefore not be generalisable to larger, less remote communities.
**Evaluation of the trial**

**Evaluation method**

The evaluation involved 2 waves of data collection, 6 and 15 months after the trial commenced, including both qualitative and quantitative data. Community leaders, stakeholders and merchants, as well as participants were surveyed for the evaluation.

There were 552 participants in wave 1 data and 479 in wave 2 data, but only 134 had data collected in both waves. Therefore, there are only 134 participants from whom longitudinal data (comparing results from waves 1 and 2) is valid. However, the results in the evaluation report from waves 1 and 2 are presented as though they can be directly compared, and indeed these comparisons are made in the descriptions of the results. Where the results of waves 1 and 2 were different, it must be remembered that these were different people, not the same people reporting an improvement over time. For this reason, this submission focuses on the results from wave 2, which overall are more positive of the trial, and demonstrates that even these results do not mean there were benefits for the majority.

Alcohol restrictions were in place before the CDCT began, with restrictions applying from 2011 in the East Kimberley, strengthened in December 2015, and from 2012 in Ceduna, strengthened in September 2015. In the East Kimberley region, this means there was only 4 months between the strengthening of the alcohol restrictions and the implementation of the CDCT, and in Ceduna, 6 months. The evaluation assumed that questions regarding pre-trial alcohol consumption were answered with the level of consumption post-alcohol restrictions. This does not take into account possible confusion among participants about the difference between the two programs.

Another potential problem with this is that participants were being asked at 6-12 months post implementation about behaviours prior to the CDCT. Recall error - noted in the evaluation report as being likely to be present - would therefore potentially affect all responses to questions about behaviours prior to the program implementation, calling into question the reported decreases in alcohol and gambling consumption. Interviews were conducted with other participant groups (community leaders, merchants etc) prior to implementation of the CDCT. Ideally, potential participants would have been identified and surveyed at this point also to increase the accuracy of reported behaviours.

**Findings**

**Overall**

The views of participants seemed to be less positive than those of the other groups. For example, in Wave 2, 24% of participants felt their children’s lives were worse, compared with 17% who thought they were better. Improvements noted were able being able to provide basic needs better, while not being able to give their children cash and not being able to buy them things with cash were seen as reasons why they were worse off. Similarly, at Wave 2, 32% of participants felt the trial had made their lives worse, compared with 23% who thought their lives were better.

With a social program such as the CDC, there is a significant difference between having the program be not beneficial for a large minority of participants, and having the program be actually harmful for that large minority. If those for whom benefits are not felt say it is having little to no impact on their lives then a program might reasonably be considered to be worth implementing because there is a benefit to some. However, when there are also harms being caused, these must be balanced against the successes in a very different way.
Alcohol consumption, gambling, illegal drug use and violence

Self-reported changes in alcohol consumption, gambling or illegal drug use showed mixed results, with 48% reporting decreases in at least one of these behaviours and 49% reporting no change. Positive results for the trial are demonstrated for some, but not a majority of participants. Indeed, the only factor on which a majority reported a benefit, was 54% of participants reporting a decrease in the how often they spent more than $50 a day on gambling.

Alcohol consumption was reported to have not changed for 52% of participants, decreased for 41% and increased for 4%. This means that the majority of participants did not report decreasing the frequency of consuming alcohol.

Importantly, the frequency of binge drinking (6 or more drinks on one occasion) showed slightly worse outcomes. No change was reported by 51%, a decrease by 37%, but 8% reported an increase in frequency of binge drinking. These findings are backed up by the perceptions of non-participants with 7% reporting that they had noticed an increase in drinking since the trial started. One-in-twelve participants reporting an increase in binge drinking is a strongly negative outcome that should not be ignored.

The CDCT was conducted as part of a package that included additional drug and alcohol support services, and financial and family support services, which were used by about one-fifth of participants. This perhaps speaks to the importance of culturally capable services building up the Aboriginal and Torres Strait Islander health workforce in both Aboriginal Community Controlled Health Organisations and mainstream health services. If the CDC were rolled out across the country, it would need to be accompanied by a similar increase in services throughout the country. It is not clear whether or not this has been budgeted for in this Bill.

There were no clear results on violence from the evaluation. Of participants, 36% reported noticing no change in violence in the community since the CDCT, 24% noticed an increase, and 20% noticed a decrease. Of non-participants, 37% noticed a decrease, 31% no change and 12% an increase.

Unintended negative outcomes and consequences

Problems reported in the Wave 1 interim evaluation with being able to use cash at places that are predominately cash-based such as fairs, swimming pools and canteens, were addressed through for example, the introduction of EFTPOS facilities at cash-based fairs. While this may be feasible during a trial in only 2 sites, were the CDC rolled out across the country, the logistics of addressing issues such as these would be exponentially more complicated and most time and cost intensive. Also, even after these issues were “addressed”, one-third (33%) of participants at Wave 2 noted continuing problems of this type.

The results of the evaluation report also indicate some other possible unintended negative consequences of the CDCT. For example, 6% of non-participants reported being robbed in the past month in Wave 1, compared with 11% in Wave 2. Similarly, the proportion of non-participants reporting being threatened or attacked with a gun, knife or other weapon in the past month increased from less than 1% to 6% from Wave 1 to 2. It is not clear from the report whether these increases are significant or what the pre-CDCT results may have been. However, the results do warrant further investigation to determine whether robberies against non-participants increased after the commencement of the CDCT.

Financial benefits were felt by less than half of participants. In Wave 2, 45% reported being able to save more money than previously, and 50% reported not being able to. Over one-quarter (27%) of participants reported noticing increases in ‘Humbugging’ or harassment for money, with just 17% noticing a decrease.

One of the proposed benefits of the trial would be better and more involved parenting. However, while 40% of participants said they were better able to care for their children, 48% said they were not.
The program logic for the CDCT recognised the possibility of a black market developing as people find ways to circumvent the program and access cash. The evaluation report questioned community leaders, stakeholders and merchants about this possibility, but did not ask participants. Those who were asked identified multiple forms of circumvention occurring - including grog running, transferring between account, card sharing, a drug dealer providing EFTPOS facilities, prostitution and merchants allowing cash-backs - but noted that these were based on hearsay reports. Multiple media and online reports support the notion that black market activities of this kind are occurring. How widespread these practices are is currently unknown. Further research into this is required to fully understand the implications of the cashless debit card.

**Review of the evaluation**

A review of the evaluation by the Centre for Aboriginal Economic Policy Research at the Australian National University found that “the authors qualify a number of their apparently positive findings with various caveats, but, at the same time, the evaluation itself has serious flaws, so even those findings are contestable” p1. Recall evaluation in pre-level drinking; alcohol results are mixed with the largest proportion in each group reporting no change; a reduction in gambling was found in only one site and it was very small, with data covering a much broader geographical area, and could have been related to factors other than the CDCT; very small number of respondents to the illegal drug taking questions so the data are likely to be unreliable; police data about assaults in East Kimberley rising was not reported.

**Previous income management programs**

Income management programs have been tried in the past in Australia, evaluated and abandoned as being unsuccessful. In the Northern Territory, income management was introduced in 2007 as part of the Federal Government’s Northern Territory Emergency Response. The revised version of this, introduced in 2010, included a number of streams with different conditions applying. Compulsory Income Management applied to those who had been in receipt of certain income payments for longer than a specified period of time, and people in this category were able to apply for an exemption. Under voluntary income management, people were able to volunteer to participate. There were also other streams of compulsory income management including for people assessed by Centrelink as being vulnerable.

The evaluation of this program, conducted by the Social Policy Research Centre at the University of New South Wales in collaboration with the Australian National University and the Australian Institute of Family Studies included longitudinal data from participants, qualitative interviews with a number of stakeholders, administrative data from the program, review of social worker case files, and transaction data from the shops accepting the income management card.

Similar to the CDCT, the vast majority (90%) of participants in the NT system were Aboriginal and Torres Strait Islander, and 80% were in the compulsory streams of the program. The program was found to be largely successful in ensuring the managed income was not spent on prohibited items. However, problems with the operation of the card were noted, financial capabilities of the participants were not built, and there were differing views on the program by participants. Those on the voluntary income management were much more likely to want to stay on it than those on the compulsory streams. Four-in-five under voluntary management wanted to remain, compared with 45% of Aboriginal and Torres Strait Islanders and 31% of non-Indigenous participants on compulsory streams. One-third of participants thought the program had made no difference to them, two-fifths thought it had made things better and one-quarter thought it had made things worse for them, finding it to be unfair, embarrassing and discriminatory.
Overall, “the evaluation could not find any substantive evidence of the program having significant changes relative to its key policy objectives, including changing people’s behaviours”7 p xxi. Participants in the voluntary stream reported a reduction in alcohol problems in their family but not in their community. Many people who reported wanting to stay on the program said they were used to it and it made things easier. The card meant that effectively they had to put less effort and attention into managing their own money. The evaluation found that the program actually increased dependence on welfare for many participants, rather than building capacity and independence. The evaluation report recommended that income management may be successful for certain individuals as part of an individually tailored program, but that at broader community levels, there is less engagement with individuals and tailoring of the program to suit individual needs. “Building capacity is a challenging process that requires time and resources, and it cannot be developed by simply imposing restraints”7 p xxii.

A 2012 Parliamentary Library report on income management looked at schemes in the Northern Territory, Queensland and Western Australia and found a lack of quality evaluations of the programs. It concluded that it was unclear whether the results were overall in support of or against income management, but that where positive changes were found they were ‘uneven and fragile’8.

The costs of previous programs of this type have not been fully evaluated or reported publicly. The evaluation of the Northern Territory program noted that the Department of Social Services had requested that a cost-benefit analysis not be conducted “because of problems trying to disentangle the specific expenditures on income management from other Departmental and DHS expenditures, and problems of identifying quantifiable outcomes to which a value can be attached”7 p 3. The Auditor General estimated the program to cost up to $7,900 per person per annum9. Evidence of the cost of the CDCT are similarly difficult to find, and were not included as part of the final evaluation report. Media reports based on a freedom of Information request suggest that it may be costing as much as $10,000 per person per annum – 70% of the cost of the welfare payments themselves10. With no demonstration of quantifiable benefits or benefits to quality of life, this cost is not defensible, and would be more appropriately spent on the provision of services to these communities to address the social harms this program is aimed at.

Implementing programs in Aboriginal and Torres Strait Islander communities

The social problems that the CDCT is trying to address are complex and related to many factors including drug and alcohol abuse, violence, safety, unemployment, poor and overcrowded housing, and poverty. Solutions are needed, but need the cooperation and engagement of the communities and therefore cannot simply be imposed upon people6.

With the over-representation of Aboriginal and Torres Strait Islander peoples in the CDCT, the evaluation found that some community leaders and stakeholders noted that the trial did not adequately take into account local customs, culture and traditions1.

PHAA recommends that all policies build on evidence-based approaches and are developed in collaboration with Aboriginal and Torres Strait Islander communities in a way that strengthens and supports culture, health and capacity. Projects should be multi-strategy and community-led to address local issues, in recognition of the heterogeneity of the Aboriginal and Torres Strait Islander communities in Australia. Aboriginal and Torres Strait Islander communities are found throughout Australia, from major cities to very remote areas, and each has different needs and resources. There is a need to facilitate the provision of a multifaceted range of services within communities, and aim for equitable levels of service delivery across the nation.

An holistic approach is required, including socioeconomic, cultural, emotional and trauma, grief and loss, and valuing Indigenous knowledge and cultural beliefs and practices.
A strengths based approach is important, recognising, building on and validating good practice led by Aboriginal and Torres Strait Islander people. This requires longer term funding and sustainability to achieve long term goals, and therefore funding should not be short term and should facilitate a partnership approach to implementation.

Conclusion

PHAA supports the inquiry into the cashless debit card trial. We are keen to ensure a thorough review of the evidence in line with this submission. We are particularly keen that the following points are highlighted:

- The evaluation report did not show positive outcomes for the majority of participants – participants were more likely to say that the program had made the lives of them and their children worse rather than better
- Previous programs of this type have been tried in Australia and found to be ineffective
- Addressing the social problems in Aboriginal and Torres Strait Islander communities is complex and requires evidence-based and strengths based approaches developed in collaboration with local communities

The PHAA appreciates the opportunity to make this submission and the opportunity to contribute to the review of the cashless debit card trial.

Please do not hesitate to contact us should you require additional information or have any queries in relation to this submission.

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29 September 2017
References