UnitingCare Australia

Submission to the Community Affairs Legislation Committee Inquiry into the ***Social Security (Administration) Amendment (Continuation of Cashless Welfare) Bill 2020***

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About UnitingCare Australia

UnitingCare Australia is the national body for the Uniting Church's community services network and is an agency of the Assembly of the Uniting Church in Australia.

We give voice to the Uniting Church's commitment to social justice through advocacy and by strengthening community service provision.

We are the largest network of social service providers in Australia, supporting 1.4 million people every year across urban, rural and remote communities.

We focus on articulating and meeting the needs of people at all stages of life and those that are most vulnerable.

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Introduction

UnitingCare Australia welcomes the opportunity to provide feedback on the *Social Security (Administration) Amendment (Income Management to Cashless Debit Card Transition) Bill 2019* (the Bill).

The cashless debit card (CDC) compulsorily quarantines a portion of a person's social security benefits, placing up to 80 per cent of their income support onto a card that cannot be used to withdraw cash or purchase alcohol or gambling products. This Bill seeks to transition approximately 25,000 income management participants across the Northern Territory and Cape York to the CDC. It also makes the CDC permanent in the existing four trial sites. In addition to expanding and extending the CDC, the Bill removes the requirement for an independent evaluation of the program and gives the Minister the discretionary power to increase the proportion of funds quarantined on the card.[1,2]

As an organisation that supports social justice and the inherent right to self-determination of our First Peoples, we strongly recommend that this Bill be rejected. There is a clear and compelling need for more effective policies that tackle entrenched poverty, long-term unemployment and the social problems that stem from profound social and economic disadvantage. We also recognise that alcohol and drug abuse cause significant health and social harms across Australia. This Bill, however, does not provide an effective response to these pressing social problems. We believe the CDC is a counterproductive measure that is not supported by evidence and risks compounding some of the very factors that contribute to ongoing disadvantage and disempowerment among those who rely on income support.

Critically, this Bill disproportionately targets our First Peoples and undermines their right to self-determination. It is fundamentally at odds with the principles of co-design, collaboration and community control which ostensibly underpin the new Closing the Gap Agreement. We support a voluntary opt-in approach to income quarantining, developed in consultation with communities and backed up with wrap-around supports. This Bill, however, perpetuates a mandatory, one-size-fits-all approach. The compulsory nature of the card, together with the restrictions and disruptions it causes in people's lives, erodes choice, control and agency. And, despite the recent rhetoric of 'partnership' and 'co-design', those who will be most affected by the proposed expansion of the trial – particularly those living in remote areas of the Northern Territory – have been denied an effective voice and say into a policy that will fundamentally affect their lives. Beyond some tokenistic consultations, those who will be subject to the CDC have had limited opportunity for meaningful participation, choice and partnership in the development, delivery and evaluation of this policy.

This submission is informed by input from the Uniting First Peoples' Network, which comprises Aboriginal and Torres Strait Islander leaders from the Uniting Aboriginal and Islander Christian Congress (UAICC) and from the Uniting Church and its service agencies. Drawing on this feedback and our analysis of the existing evidence base, we identify several objections to the expansion of the CDC trial. In addition to undermining the goals of self-determination and co-design, we reject the underlying assumption that poverty, unemployment and entrenched disadvantage stem from irresponsible behaviours, idleness, and poor lifestyle choices. This deficit model of social disadvantage blames individuals for

their poverty and unemployment, deflecting attention away from the wider structural causes of unemployment and poverty, such as a lack of available work.

Second, we challenge claims that the expansion of the CDC is supported by evidence.[2] Despite more than a decade of various forms of income management in different parts of Australia, there is little evidence that compulsory income quarantining has any widespread or sustained benefits – either at the individual, family or community level.[*] There is also a lack of reliable evidence demonstrating the efficacy of the CDC in existing trial sites, with an independent audit of the evaluation identifying numerous flaws and concluding an expansion of the trial could not be justified given the lack of credible evidence.

While there is little evidence of effectiveness, there is evidence that compulsory income quarantining has led to a range of adverse consequences, including an increase in social exclusion, stigma, difficulty providing for family needs, and the erosion of individual autonomy. Ongoing practical and logistical problems have beset the roll-out of the card, and its reliance on internet and communications infrastructure is likely to prove problematic in the remote areas to which it is to be expanded. If passed, this Bill risks creating problems that the Government has failed to address and acknowledge in the trials that have been undertaken to date.

The CDC is also incompatible with domestic and international human rights laws, including the right to social security, the right to privacy and the right to self-determination. It has proven extremely costly to administer and its expansion will only divert resources away from other, more productive approaches to tackling inequality and entrenched poverty.

Ultimately, we believe that the CDC is a paternalistic and punitive measure, driven by ideology rather than evidence. While reducing the harmful effects of drug and alcohol addiction is a legitimate policy objective, the social security system is neither an appropriate nor effective policy lever for achieving such outcomes. Using social security as a punitive tool to control and disempower people detracts from the underlying purpose of the social safety net, and it does not address the underlying factors leading to drug and alcohol abuse or long-term unemployment. For First Peoples who have been subject to more than a decade of paternalistic interventions in the Northern Territory, the expansion of the CDC merely perpetuates a costly and top-down policy approach that has failed to deliver meaningful benefits to those affected.

It is imperative, therefore, that the Bill currently under consideration by the Senate is rejected. While the Government has an opportunity to reset relations with our First Peoples, the imposition of the CDC is the very antithesis of self-determination and is at odds with the stated aspirations of partnership and co-design. It is time for a different approach. For our First Peoples, this means recognition by Government that they must be in the driver's seat in making decisions about their lives. And in a context of recession and growing poverty and inequality across Australia, we urge the Government to reinstate poverty alleviation as the central goal of income support policy, rather than extend a punitive income quarantining agenda on the basis of questionable evidence.

[*] The Federal Government has implemented a range of different forms of compulsory income quarantining across Australia. The CDC is one form. Income quarantining involving the BasicsCard is another form. For clarity, when referring to these distinct forms of income quarantining this submission adopts the terms the Cashless Debit Card (CDC) and Income Management respectively. Collectively, these will be referred to in this submission as income quarantining. Both forms are underpinned by the same key principles – the quarantining of social security payments and restrictions on how and where quarantined funds can be spent.

Overarching concerns with income quarantining

Undermines self-determination and the Closing the Gap refresh

Recent Government rhetoric has underscored the importance of working in partnership with First Peoples in developing policies and moving beyond "command and control, top-down approaches".[3] While UnitingCare Australia welcomes the Government's stated commitment to partnership and self-determination, it is imperative words are translated into action. We believe compulsory income quarantining is the antithesis of self-determination, both at a collective and individual level. It also contradicts the Government's commitment to the Closing the Gap Refresh. The expansion and continuation of a top-down program that divests people of the power to make choices to govern their own financial affairs is severely out of step with principles of both self-determination and partnership.

Government programs that are forced onto communities, such as the Cashless Debit Card, are disempowering and deny people the opportunity to develop appropriate local responses to social challenges. For those subject to the card, the implicit assumption is that they cannot be trusted to budget responsibly and are therefore not entitled to the same financial autonomy and choice afforded to others. This deficit-oriented approach has detrimental social and emotional effects, with a strong body of evidence demonstrating the relationship between disempowerment and lack of control with poor health and wellbeing.[4,5,6,7] As highlighted in a recent empirical study conducted with income management participants across Australia, many of those subject to compulsory income management reported feelings of stigma and shame, with the card eroding their sense of autonomy and signalling to others "that they were a 'problem to be fixed', that they were individuals lacking responsibility, infantilised subjects unable to manage their lives".[8]

While this study shows that many of those subject to income management oppose its imposition, we recognise there are differing views within communities. However, while some community members support some form of income quarantining, a clear and consistent view conveyed from our own networks in the Northern Territory has been opposition to any form of *compulsory* income management. Accordingly, while we support a voluntary opt-in scheme that provides people choice and control, we do not support a mandated, blanket approach that pre-emptively designates a person as socially or financially irresponsible simply because they receive income support.

Although the Government have repeatedly asserted the cashless debit card is widely supported in the existing trial sites, their own commissioned research suggests otherwise and indicates a more complex range of stakeholder perspectives. On 6 May 2020, the Government released two commissioned reports from a baseline study of the CDC trial in Hinkler, Queensland. The qualitative report draws on 74 stakeholder interviews and 66 interviews with people who were on or about to be put on the card, with many interviewees reporting "that they were opposed to the trial of the CDC".[9] Those opposed to the CDC considered that the card would be socially divisive, would fail to address the underlying causes of substance abuse for people with addiction issues, and would do nothing to generate desperately needed jobs in the region. This report also documents significant

cardholder concerns about increased shame and stigma brought about because of the CDC program.

Such concerns also underscore the lack of meaningful consultation and co-design. The Explanatory Memorandum claims the government has consulted extensively with communities in the Northern Territory, in addition to co-designing the CDC trials in existing sites.[10] Such claims, however, are not substantiated and have been contested by local community members. Information sessions or briefings conducted by Departmental staff do not constitute consultation, and the impact statement included in the Explanatory Memorandum does not elaborate on who was consulted with. For example, it indicates that in mid-2019, the Department of Social Services undertook consultation with communities that expressed an interest in learning more about the card and how it may support their communities. Between August 2018 and April 2019, the Department conducted meetings and feedback sessions across the Barkly region with key stakeholders, but these are not identified. Further consultations have reportedly occurred in the Barkly region and also in Cape York, but no further details are provided. The feedback from our own networks and from key community stakeholders in the Northern Territory is that the consultations undertaken to date have been limited and inadequate, and largely focused on the logistics of how and when changes will be implemented.[11,12] This is at odds with a genuine partnership and co-design approach, which would involve engaging communities at the outset in identifying problems and developing solutions – not simply offering the opportunity for feedback once a policy or program has been announced.

In existing trial sites, some community members and groups have indicated they have not been consulted about the design, scope or application of the card, and they have criticised the consultation process as opaque, high selective and unreliable as an indicator of community sentiment. For example, the Gidarjil Development Corporation, which is one of the largest Indigenous organisations in Bundaberg, indicated it had not been consulted about the roll-out of the CDC in the Bundaberg and Harvey Bay region. During previous inquiries into the expansion of the CDC trial, various representatives from the region told the Committee that the consultation process had been difficult to access and unrepresentative of the community.[13] Some claimed divergent community views were marginalised and those directly affected were not adequately included. Others who attended meetings with the Department questioned the adequacy of the consultations, noting that they were primarily information sessions about the proposed trial and allowed little scope for community members to raise concerns.[14]

This approach is inconsistent with standard understandings of co-design or co-creation, which generally involve a bottom-up process whereby policymakers partner as equals and engage in a process of open dialogue with communities or service users.[15] Critically, the results of a co-design process should be subject to negotiation with participating groups, and cannot be predetermined. Yet the approach that has been adopted appears to perpetuate the top-down mindset that has been adopted in the Northern Territory for over a decade. As John Paterson from the Aboriginal Medical Services Alliance Northern Territory has stated:[16]

> The unwarranted haste of imposing the cashless welfare card on our communities recalls for us the disastrous and ill-advised imposition of the Intervention on our communities without consultation and without our consent. The injustice and trauma of the Intervention still burns with us. Once again, we are stigmatised and targeted as not being capable or worthy of managing our own affairs. The cashless

> welfare card will directly impact on more than 23,000 Territorians currently on income management as a result of the intervention. Aboriginal income support recipients in the Northern Territory have now been subject to more than a decade of costly, paternalistic interventions, including income management and Work for the Dole. Over this period, poverty and unemployment have worsened. It is evident that income management has failed, yet the government is intent on continuing to try to coerce us into change by further extending the policy. It simply will not work.

This suggests that the policy process has not been one of actual co-design – as claimed by the Government. An opportunity to be a conversational participant in policy discussions does not equate to co-design – especially when important matters regarding policy objectives, design and implementation have already been determined.

If the Government is to meet its commitment to resetting relations with First Peoples, it must move away from top-down and one-size-fits-all programs such as compulsory income quarantining. This point was acknowledged in the Prime Minister's 2020 Closing the Gap address to Parliament, where he criticised the top-down way in which the Closing the Gap policy had been implemented by previous governments and indicated a change in approach by his Government:

> Over decades, our top down, government knows best approach has not delivered the improvements we all yearn for… We perpetuated an ingrained way of thinking, passed down over two centuries and more, and it was the belief that we knew better than our Indigenous peoples. We don't.
>
> We must restore the right to take responsibility. The right to make decisions… It must be accompanied by a willingness to push decisions down to the people who are closest to them. Where the problems are, and where the consequences of decisions are experienced. That is what we must do…
>
> Our new approach to Closing the Gap provides some of the answers to this question. An approach that is built on partnership. On giving back responsibility. An approach of listening. Of empowering.

The current push to expand and entrench the CDC, which disproportionately affects First Peoples, reflects everything the Prime Minister criticised about the previous Closing the Gap policy. We welcome the partnership approach that has recently been adopted in relation to Closing the Gap, however this needs to be applied consistently across all policies that have a significant impact on Aboriginal and Torres Strait Islander lives. As the Prime Minister correctly stated, top-down policies that are not driven by First Peoples will ultimately fail.

Lack of supporting evidence

In a bid to justify the expansion and extension of the CDC trials, the Government has championed the alleged success of the CDC trials, insisting that a sound evidence base has been established. As the Minister for Families and Social Services has declared:[17]

> The evidence on the ground shows that the cashless debit card is making a real difference, improving people's lives and improving communities… We have also seen decreases in drug and alcohol issues; decreases in crime, violence, and antisocial behaviour; improvements in child health and wellbeing; improvement in financial management; and the ongoing and even strengthening of community support for the card on the ground.

Such claims, however, do not withstand scrutiny: both the official evaluation of the CDC, and the wider body of evidence on income management, do not demonstrate that the CDC is effective in meeting its stated objectives.

Flaws in the evaluation of the trial

The Government has heavily relied on the ORIMA Final Evaluation Report on the CDC trial in Ceduna and the East Kimberley, which was released in September 2017.[18] A closer analysis of this Report reveals conflicting findings and inconclusive results, along with significant methodological flaws that call into question the report's findings. Methodological problems include the lack of baseline data; fundamental weaknesses in the survey design (rendering the outcomes highly liable to recall inaccuracies and social desirability bias); statistically insignificant sample sizes; a lack of comparison with administrative data and wider population statistics; flawed data weighting methods; and a failure to incorporate principles and standard practice in relation to conducting research among Aboriginal and Torres Strait Islander communities.[19,20,21] Further issues stem from interpretive flaws and invalid claims regarding causation, including a failure to adequately take into account confounding variables and the effects of concurrent policies and programs, such as alcohol restrictions and additional funding for local support services. These multiple issues call into question the reliability, validity and generalisability of the evaluation findings.

These concerns were underscored by the 2018 audit from the Australian National Audit Office (ANAO), which concluded monitoring and evaluation of the CDC "was inadequate" and "as a consequence, it is difficult to conclude whether there had been a reduction in social harm and whether the card was a lower cost quarantining approach".[22] The report documented a host of problems with the design, implementation and reporting of the evaluation, including the lack of robustness in data collection; the failure to use baseline data and available administrative data; the failure to build evaluation into the program design; the absence of any cost-benefit analysis; poor risk management; inadequate review of key performance indicators; poor procurement practices; and inconsistencies between the stated findings and the actual data collected through the evaluation. In addition, the ANAO question the generalisability of the evaluation findings, noting the trial "was not designed to test the scalability of the CDC" and that "[m]any findings from the trial were specific to the cohort (predominantly Indigenous) and remote location".[22] In short, the ANAO's scathing assessment indicates that the expansion of the CDC trial to the Northern Territory and Cape York, and its entrenchment in existing trial sites, is not justified by the official evaluation.

In addition to misrepresenting the ORIMA evaluation, the Explanatory Memorandum refers to the baseline data collected from the Goldfields CDC trial site, incorrectly stating that the baseline report "identified economic issues in the region prior to the introduction of the Cashless Debit Card, including issues relating to alcohol and drug use, and associated crime, violence and impacts on child health and wellbeing".[10] This so-called 'Baseline Study of the Goldfields' is a qualitative study that commenced at least three months *after* the CDC was introduced in the Goldfields region.[23] As such, it is not able to provide a proper before and after comparison. It draws exclusively on responses from a small and selective sample of stakeholders and does not include any quantitative data, such as alcohol sales, use of rehabilitation or other addiction-related services, or crime episodes. The report notes the rollout of the CDC trial coincided with a substantial increase in police numbers in the Goldfields region ("Operation Fortitude"), but it does not attempt to disentangle the effects of the CDC from the boost in policing or from other concurrent policies and programs. Based on this study, it is not credible to say there have been improvements when the evidence simply is not there.

Despite these conflicting and inconclusive findings, and indeed evidence of adverse outcomes, the Government has misrepresented the baseline study and evaluation findings, portraying highly selective and contested results as proof of success. This partial and partisan representation of the data is deeply concerning. It reflects a tendency of proponents of compulsory income management to take "a 'cherry picking' approach to the results of evaluations, one which stresses any positives and supportive findings, and either ignores and rationalises away any qualifications, or indeed negative findings".[24]

The findings from other evaluations of income quarantining

There is little reliable evidence that compulsory income quarantining has widespread or sustained benefits – either at the individual, family or community level. This is despite more than a decade of various forms of income quarantining operating in different parts of Australia.

Numerous evaluations have been undertaken which show little, if any, evidence of positive change associated with compulsory income management. The most comprehensive evaluation of New Income Management in the Northern Territory "could not find any substantive evidence of the program having significant changes relative to its key policy objectives, including changing people's behaviours".[25] This evaluation was conducted over a number of years, allowing medium and longer-term impacts to be assessed. It was based on a robust methodology which included a detailed longitudinal survey of participants, comparison with a control population unaffected by the measure, extensive analysis of administrative and other quantitative data, and field work with individuals and communities across the Northern Territory. The evaluation found no evidence of changes in spending patterns; no evidence of improved financial wellbeing; no evidence of improvement in community wellbeing, including for children; and evidence of the kind of learned helplessness that flows from making people dependent on the decisions of others. The review found that, "rather than building capacity and independence, for many the program has acted to make people more dependent on welfare". While compulsory forms of income management were found to be ineffectual, the evaluation did find some positive outcomes, albeit limited, for voluntary income management.

Similarly, a 2016 review of income management programs, undertaken by the University of NSW, concluded:

> No evaluation has found that compulsory forms of income management [IM] have resulted in medium or long-term behavioural change at the individual or community level. There is some evidence that voluntary forms of IM have some impact on financial harassment and possibly on financial management although they can also result in higher levels of dependency on the welfare system for those who become habituated to IM. In addition, there is evidence of unintended negative consequences of IM, particularly compulsory forms of IM.[26]

Another review of the multiple evaluations of income quarantining, undertaken by the Centre for Aboriginal Economic Policy Research in 2016, found no conclusive evidence of benefit. It indicated the most effective schemes were voluntary and targeted to people with high needs as part of a holistic set of services. Further, it found that "a recurrent thread across many of the evaluations" was that compulsory income management can "diminish financial management skills and increase dependency on the welfare system".[24]

While a core rationale for the introduction of compulsory income quarantining was to improve child welfare, recent analyses reveal a range of child health and wellbeing

outcomes have worsened under income management among Aboriginal children in the Northern Territory.[27] A detailed analysis of population-level administrative data from the Northern Territory concluded that "income management did not improve one measure of child health outcomes, and, by extension, that income management does not appear to have produced the desired change in household consumption patterns".[28] Of concern, infant mortality has increased[29]; birth weights have declined by between 100 and 150 grams[28]; school attendance rates have declined[30]; the rate of death caused by injury among Indigenous children has increased[29]; and child abuse and neglect substantiations have increased.[29]

Thus, the existing evidence base shows that compulsory income quarantining:

- does not result in widespread or sustained benefits – either to the individual subjected to it, or to their community;
- is poorly targeted;
- is not cost-effective;
- can result in strong negative subjective experiences;
- can damage financial management skills; and,
- can discourage vulnerable people from seeking assistance.[31]

The weight of evidence does not, in short, support the continuation and expansion of compulsory income quarantining.

The evidence on tackling drug and alcohol addiction

One of the central justifications the Government has provided for implementing the CDC is the need to tackle drug and alcohol addiction. There is no doubt that alcohol and drug abuse contribute to significant social, health and economic harms across communities. However, while there is a clear need for comprehensive government policy to reduce drug and alcohol-related harms, there is no conclusive evidence that imposing income quarantining is an effective response.

First, contrary to the assertions made in the Explanatory Memorandum, there is no evidence of a causal relationship between the receipt of cash payments and drug and alcohol addiction.[32] While some people on income support may have issues with drug and alcohol use, the majority do not use illicit drugs and do not have alcohol addictions. Household expenditure data from the Australian Bureau of Statistics shows that people whose main source of income is social security typically spend less on alcohol compared to the average Australian household.[33] Similarly, the ORIMA evaluation of the CDC trial indicated that most income support recipients in the trial locations did not have issues with alcohol, drugs or gambling.

The research evidence from both Australia and overseas provides little evidence that restricting cash payments overcomes drug and alcohol addiction.[34] The 2014 evaluation of New Income Management in the Northern Territory concluded, "the evidence is that income management has had no impact on alcohol consumption or alcohol-related harm".[25] Empirical studies from the United States have also suggested welfare benefits in the form of cash payments do not encourage substance abuse, and that there are social costs and externalities for depriving alcoholics and addicts of social security benefits.[35,36]

For those with serious drug and alcohol addictions, cutting off access to cash may result in 'circumvention' behaviours, with addicts seeking out other means to access alcohol and drugs, often with detrimental consequences for those around them. A number of Australian studies and inquiries have shown that, when income management has been used to restrict access to alcohol in Aboriginal communities, people with alcohol addiction have engaged in a range of activities to circumvent restrictions on their patterns of spending.[25,37] These activities include humbugging (asking relatives for cash or other items quarantined by the card), card sharing, theft, taxi cashbacks, and swapping purchased items for cash. A number of those surveyed for the evaluation of the CDC trial reported an increase in such activities, and interviewees from the recent baseline study from Hinkler suggested there were various 'work-arounds' which those with drug and alcohol dependency could resort to in return for cash.[9] A further concern with denying access to cash for people with entrenched drug and alcohol addiction is the potentially enhanced risk of family violence and criminal activities.[37,38]

Ultimately, income management does not address the underlying causes of drug and alcohol addiction, and there are more effective evidence-based approaches that should be pursued. Achieving meaningful and sustained reductions in alcohol and drug-related harms requires attention to the systemic factors and social determinants that contribute to substance abuse, such as limited education and employment opportunities, limited community infrastructure, and under-resourced health and mental health services. This approach is emphasised in Australia's *National Drug Strategy 2017-2025,* which refers to research showing "health and wellbeing are not simply a matter of lifestyle choices" and "solid evidence" for the negative effects of "lack of control over one's life circumstances".[39] Thus, if the Government is genuinely committed to meeting the objectives of its own National Strategy to reduce alcohol and drug-related harms, it is imperative it draws upon the existing evidence of what works and abandons compulsory income quarantining.

Evidence of harm

The research on compulsory income quarantining indicates it can create a number of unintended consequences for some people. A key concern is the potential to create or exacerbate social problems, including the very problems the CDC is meant to remedy.[8] As discussed above, there is some evidence that compulsory income quarantining can exacerbate unequal power relations, compound problems with family violence, and contribute to risk-taking and socially detrimental behaviours for those with entrenched drug or alcohol addictions. The 2014 evaluation of the New Income Management in the Northern Territory found that, rather than promoting financially responsible behaviours, income management tends to erode financial management skills and indepedence.[25]

One key concern is the additional financial burden that the CDC places on individuals and families. For example, in the Final ORIMA Evaluation Report, many of the surveyed participants reported running out of money to buy food or pay for items for their children:

- 49% reported that they had "**run out of money to buy food**", and by Wave 2 the figure had increased to **52%**;
- 32% said they did "**not have money to pay some other type of bill when it was due**", and by Wave 2 the figure had increased to **35%**;
- 32% reported they had "**run out of money to pay for things that… children needed for school**, like books", and by Wave 2 the figure had increased to **45%**;

- 31% reported that they had "**run out of money to pay for essential (non-food) items for… children**", and by Wave 2 the figure had increased to **44%**;
- 50% reported that they had needed to "**borrow money from family or friends" to survive**, and by Wave 2 the figure had increased to **55%.**[18]

While these negative outcomes cannot be attributed to the card alone, such high levels of financial stress are concerning and conflict with the Government's narrative of overwhelming policy success.

There is also clear evidence that forcing people to have the bulk of their meagre income attached to card, with only a small portion accessible as cash, constrains choices and makes life more difficult for people already experiencing financial disadvantage.[8] Compulsory income quarantining excludes people from the cash economy and risks further entrenching poverty by cutting people off from more cost-effective means of purchasing items, such as second-hand goods market, garage sales and other more economical cash purchases.[40] Some merchants are cash only, require a minimum spend for EFTPOS purchases, or charge a surcharge for payments made by card – thereby preventing people from making certain purchases, or requiring them to spend more than what they otherwise would have expended. The CDC also makes a range of other cash transactions difficult, such as cash payments for rent (for example, splitting housing costs in share-housing arrangements), the payment of small expenses associated with children's education (such as payment for excursions, purchases at the school canteen), and various services or products requiring cash (parking metres, shopping trolleys, laundromats).

As indicated above, compulsory income quarantining has also had a disproportionate impact on women, with particularly concerning implications for women and children fleeing domestic violence. The Australian Law Reform Commission Inquiry into Family Violence emphasised that income quarantining should be avoided in the context of family violence as it can lead to more problems.[38]

Practical and logistical problems

The Explanatory Memorandum describes current arrangements for providing customer service to CDC trial participants as user-friendly and workable. This description is at odds with feedback from participants in existing trial sites, who have reported a range of practical and logistical problems using the CDC which have contributed to financial hardship, stress and feelings of humiliation and shame. We acknowledge that, compared to the BasicsCard, the CDC provides some additional functionality, however we remain concerned about the likelihood of significant practical issues for cardholders.

Practical challenges arise from cardholders' inability to cover small cash transactions, merchant surcharges and requirements that prevent the use of the card for certain purchases, and the inability to purchase goods or services in the cash economy or from merchants lacking EFPTOS facilities. Additional practical and logistical issues include a high rate of failed transactions and transaction errors[41]; power outages; difficulties ascertaining card balances (including for those without phones or sufficient phone credit, internet access, or access to a mobile phone or internet server coverage); disruption of established payment arrangements; and delays replacing lost cards. Some CDC holders have reported difficulties navigating the technology required to access the restricted portion of their social security

payment, leading to a host of problems, including problems paying rent and paying for other essentials such as medical devices.

Within the UnitingCare Australia network, some of our agencies in South Australia have documented the adverse effects of the CDC technology:[42]

> While there are a number of concerns about the lack of responsiveness on the part of Centrelink and the long waiting times, the automation of welfare services has removed the face to face interaction between case workers and income support recipients. A reduction in human contact can result in an increased likelihood of miscommunication and confusion – not everyone is literate or numerate, and technology can be confusing, overwhelming and alienating… The introduction of mobile phone apps for checking one's CDC account balance, hailed by DSS as 'digital inclusion', has left many people on the Card feeling inept and overwhelmed because they either do not own smart phones, are not familiar with such technology, do not have the literacy or numeracy skills, and/or do not have sufficient funds to pay for the cost of mobile data and downloads. The so-called technologies of 'digital inclusion' are in fact serving to exclude and alienate a number of people on the Card who have previously been comfortable with managing their own cash in hand.

The extension of the CDC to the Northern Territory poses particular concerns. Consistent and reliable communications infrastructure is a particular issue in remote areas in the Northern Territory. Moreover, Centrelink resources have been pared back in remote NT communities and regional councils are increasingly refusing to assist community members with banking and Centrelink matters. This work will likely fall to local NGOs and Aboriginal organisations who are not resourced to assist, meaning that people in remote communities may struggle to access help with CDC issues.

The cash economy in these areas is also significant, and many small Indigenous enterprises do not utilise electronic payment methods. This poses the risk that there will be adverse effects on local Aboriginal businesses and enterprises, including the Traditional Credit Union, along with the effects on local economies built on notions of reciprocity. As Liam Flanagan from the Arnhem Land Progress Aboriginal Corporation has noted, the extension of the CDC will undermine the viability and growth of many smaller businesses and community enterprises in remote communities:

> These incubators are supporting Yolngu entrepreneurs to transition from welfare to small-business ownership, at the same time as bringing new products and services to market within their communities. At this stage, all these businesses are cash based, with the majority currently lacking the sophistication or the economic viability to move to an ecommerce platform to accept the Indue card. This new barrier could impact severely on the viability of these businesses, particularly if the board of director's fear comes to fruition and the amount of money quarantined is increased at a later date.[43]

Undermines the core purpose of social security

The Government maintains that compulsory income quarantining is an effective means of overcoming problems such as long-term unemployment, gambling addiction, and drug and alcohol abuse. UnitingCare Australia firmly believes, however, that addressing complex social and health issues through the social security system is inappropriate and fundamentally flawed. This approach implies that correcting poor spending decisions is the solution to difficult problems whose genesis lies elsewhere. It is not only ineffectual, but also contrary to the underlying needs-based and poverty alleviation focus of income support.

Social security is a first and foremost a redistributive mechanism that provides a safety net for those who are otherwise without. The need to reaffirm and strengthen this underlying goal of social security is crucial in a context of growing inequality and unacceptable levels of poverty in Australia.[44] It is also vital that the social security system is designed and administered in a way that is respectful and supports the inherent dignity of people. An important aspect of human dignity is self-determination and the ability to exercise decisions about one's own life, free from social stigma and unjustified government interference.[45]

Compulsory income management represents a fundamental shift away from this understanding of social security, moving the focus from redistribution and poverty alleviation to social control. Using social security to impose conditions and restrictions on some people, and not on others, violates the autonomy and dignity of income support recipients, and implicitly questions their capacity for rational choice. It also reinforces hierarchies of 'deservingness' among those on low incomes. In remote areas, we are also concerned that the application of punitive approaches, such as compulsory income management, are contributing to a growing number of people disengaging from the social security system altogether.

The specific design of the CDC scheme, whereby access to cash is limited to income support recipients in designated regions, effectively redefines people's financial autonomy and their right to social security on the basis that they live in a region where poverty and disadvantage is concentrated. Such an approach is not only at odds with the principle of a needs-based and non-discriminatory social security system, but also feeds into stigmatising and divisive rhetoric that denigrates people who receive social security, particularly First Peoples living in remote areas. The notion that people cannot be trusted and require surveillance and control perpetuates a divide between the "deserving" and "undeserving" poor – a divide which UnitingCare Australia strongly repudiates.

Erosion of human rights, privacy and consumer protections

Human rights implications

A person should not lose their basic rights simply because they receive income support. However, if enacted, this Bill will undermine the human rights of individuals subjected to the CDC, including the right to social security[46], privacy[46], equality and non-discrimination (particularly racial discrimination)[47], and self-determination.[46]

Under international law, limitations on human rights are only permissible when States can demonstrate such limitations are a reasonable, necessary and proportionate way of pursuing a legitimate objective.[46] In this regard:

a) any limitation on human rights must fulfil a legitimate and pressing purpose;
b) any limitation on human rights must be targeted, proportionate and interfere with rights to the minimal extent possible; and,
c) limitations on rights must be demonstrably justified and evidence-based.

We believe the Government has failed to provide credible, cogent and compelling evidence that the limitations on human rights imposed by the CDC are reasonable, necessary and proportionate.

The Parliamentary Joint Committee on Human Rights (PJCHR) has previously found compulsory income management does not satisfy the criteria justifying limitations on human rights, stating that:

> the income management regime involves a significant intrusion into the freedom and autonomy of individuals to organise their private and family lives by making their own decisions about the way in which they use their social security payments. The committee considers that the imposition of conditions restricting the use that may be made of such payments enforced through the BasicsCard system represents both a restriction on the right to social security and the right not to have one's privacy and family life interfered with unlawfully or arbitrarily.[48]

The Committee further states: "the burden lies on the government to justify that such limitations are justifiable, namely that they are a rational and proportionate means of pursuing legitimate objectives".[48]

The current Bill does not resolve the fundamental human rights concerns previously identified by the PJCHR. In order to justify the infringement of human rights, the Statement of Compatibility refers to "positive findings" from the interim Evaluation Report, asserting that "any limitation… is reasonable and proportionate".[1] However, to be permissible, any limitation of a human right requires a "very high degree of probability" and supporting evidence which meets a "stringent standard of justification". The evidence should be "cogent and persuasive and make clear the consequences of imposing or not imposing the limit." The PJCHR have previously concluded that the CDC trial fails to meet these stringent standards, noting the Evaluation contains mixed and inconclusive findings and fails to establish a rational connection between the CDC and the trial's stated objectives.[49]

The PJCHR raises further concerns about the compulsory nature of the card, noting this approach cannot be justified as proportionate:

> In its 2016 Review, the committee stated that, while income management 'may be of some benefit to those who voluntarily enter the program, it has limited effectiveness for the vast majority of people who are compelled to be part of it'. The application of the cashless debit card scheme on a voluntary basis, or with a clearly defined process for individuals to seek exemption from the trial, would appear to be a less rights restrictive way to achieve the trial's objectives. This was not discussed in the statement of compatibility.[49]

The Statement of Compatibility also downplays the intrusiveness and coercive nature of the CDC, maintaining that there is no significant infringement of privacy, choice or autonomy for those who are subjected to the card. UnitingCare Australia does not agree with these claims. Restricting how a person can access and spend their social security benefits clearly interferes with their right to personal autonomy and, therefore, their right to a private life. We also contest the assertion that the right to self-determination is not engaged by the CDC. As noted above, there has been a lack of adequate consultation and co-design, and this in turn infringes on the right to self-determination. As the United Nations Economic and Social Council emphasises, the "right of individuals and groups to participate in decision-making processes that may affect their exercise of the right to social security should be an integral part of any policy, programme or strategy concerning social security."[50]

Further, we believe the Bill is discriminatory given the disproportionate effect on First Peoples. We note that the UN Committee on the Elimination of Racial Discrimination has expressed concerns about the discrimination faced by First Peoples under compulsory income management and has recommended that Australia "maintain opt-in forms". Under the UN Declaration on the Rights of Indigenous Peoples, countries such as Australia are obligated to "consult and cooperate in good faith" with Indigenous peoples "in order to

obtain their free, prior and informed consent before adopting and implementing legislative and administrative measures that may affect them."[51] Such obligations are not consistent with the expansion and continuation of compulsory income management for First Peoples.

Consumer protections

It is beyond the scope of this submission to fully examine the consumer protection implications of the Bill, however we note a range of concerns have been previously canvassed by organisations such as the Consumer Action Law Centre and the National Social Security Rights Network. The requirement to hold a prescribed bank account, for instance, directly interferes with the right to private contract, and potentially exposes card holders to increased costs and inconvenience. The cardholder has no say about which account 80 per cent of their benefits are directed to, and the imposition of the CDC may also impede access to affordable banking measures have been established to support people with very low incomes.

The CDC is applied to a particularly financially vulnerable cohort, and it is imperative that they benefit from the consumer protections and accountability mechanisms that other people expect. However, we note with concern that ASIC has exempted Indue from certain financial services laws and consumer protection regulations. Indue also does not subscribe to the Centrelink Code of Operation, nor to any industry code of conduct – codes which include a range of important commitments and independent compliance and monitoring requirements. The absence of such consumer protections and accountability mechanisms is deeply concerning and, as David Tennant has remarked, risks creating a "banking underclass" that are denied the basic rights and protections that other citizens take for granted.[52]

Issues with privacy and data sovereignty

The Bill provides for broad information sharing powers, granting the Secretary the power to obtain information or documents that they consider may be relevant to the operation of the CDC trial. This means that the Secretary can effectively compel a person to provide a range of information or documents, including information about their personal circumstances as well as information about how the CDC is being used by trial participants.

These intrusive powers have been justified on the basis that they are necessary for the Secretary to be able to obtain information relevant to "whether a person should not participate in the CDC trial on the basis of their mental, physical or emotion [sic] wellbeing or where they can demonstrate reasonable or responsible management of their affairs (including their financial affairs)."[2] Such a wide-ranging justification is unwarranted and excessive. Neither the Bill nor the Explanatory Memorandum clarify what type of information can be shared. Concerns about these wide-ranging information sharing powers have been raised by the Senate Standing Committee for the Scrutiny of Bills:

> …the committee is concerned that allowing the sharing of information about trial participants, and extending the secretary's power to require information and documents, may trespass unduly on individuals' privacy. In this respect, the committee notes that neither the explanatory memorandum nor the statement of compatibility provide detail as to the type of information that may be shared under proposed sections 124POB, 124POC and 124POD, or the type of information or documents that may be required under paragraph 192(db).

In addition to this, the Committee notes that:

> …the explanatory materials do not identify any relevant safeguards in relation to the collection of information under paragraph 192(db). In relation to proposed sections 124POB, 124POC and 124POD, the statement of compatibility states that there are 'effective community safeguards' in place. However, it does not provide any further detail (for example, expressly identifying the safeguards or explaining how they will operate in practice). The statement of compatibility states that 'there are still safeguards in place to protect individual privacy', and that some information collected, used and disclosed for the purposes of the CDC will be protected under the Privacy Act 1988. However, it is unclear whether, and if so, how, these safeguards would apply to the disclosure of information under proposed sections 124POB, 124POC and 124POD, or to the collection of information under paragraph 192(db).

While this power for information sharing currently exists within the *Social Security (Administration) Act 1999* in relation to Income Management, its application under the CDC poses additional concerns given the sophisticated technology and the extensive data captured by the Indue Card. As envisioned by Andrew Forrest, a system such as the CDC has the potential to monitor in detail the purchases made by income support recipients and could eventually allow "existing data mining technology" to be used "to monitor use of the card to detect any unusual sales or purchases, with… on-the-spot penalties on retailers and individuals for fraudulent use of the card".[53]

The extension and expansion of the CDC prompts wider concerns around the application of digital technologies to the provision of social security, and the implications for more intensive surveillance and control over the lives of those on the lowest incomes. Philp Alston, the former UN Special Rapporteur on extreme poverty and human rights, has noted that "systems of social protection and assistance are increasingly driven by digital data and technologies that are used to automate, predict, identify, surveil, detect, target and punish".[54] The Special Rapporteur expressed concern that the use of electronic cards to administer social security is facilitating more efficient monitoring and surveillance of people experiencing poverty by governments and private companies, without adequate safeguards being put in place to protect people from discrimination or arbitrary invasions of privacy:[54]

> First, in the context of social security benefits and assistance, there is a real risk that beneficiaries are effectively forced to give up their right to privacy and data protection to receive their right to social security as well as other social rights. A second concern is the blurring of the lines between public and private surveillance. Welfare state authorities increasingly rely, either actively or passively, on private corporations for the surveillance and targeting of beneficiaries. Private entities have different motives for their involvement in benefit and social assistance systems and this may lead to conflicts between the public interests these systems ought to serve and the private interests of corporations and their owners. A third concern is the potential for deliberate targeting and harassment of the poor through new technologies in the welfare state… [N]ew abilities to collect information and store it digitally for an undefined period of time create a future in which a wealth of information can be held against someone indefinitely.

Cost-ineffectiveness and privatisation

The CDC is an extremely costly program to administer, diverting funds away from evidence-based programs and under-resourced support services. Accountability for public funds requires a clear articulation of the costs and benefits of the CDC trials prior to any further expansion. However, contrary to a recommendation from the ANAO, there has been no cost-benefit analysis of the scheme or comparison with the cost-effectiveness of other policy responses, such as increased support services. A recent Freedom of Information request indicated the total cost for the implementation of the CDC program to the end of the 2019-

2020 financial year was $79.754m.[55] This represents an unacceptable opportunity cost, depriving other more effective program and services of funds. We believe the funds expended on continuing and expanding the CDC would have far greater impact if they were directed toward measures grounded in evidence of what works, and developed and led by communities.

A further concern is the large portion of funds directed toward the private companies contracted to roll-out the CDC. In the initial phase of the CDC trials, Indue was awarded a contract of $7.9 million, with an additional $2.9 million to develop the CDC information technology infrastructure. It is unclear what additional funds Indue has received as the CDC trial has been extended and expanded since 2017. However, it is clear a significant amount of public funds is being diverted to private entities to administer income quarantining – despite the lack of demonstrable benefits for the people subjected to the CDC.[56]

The expenditure directed toward private providers, such as Indue, is misplaced and inappropriate in a climate where genuine job creation is urgently needed, and alternative program funding is required to address the social issues the government claims to be targeting with the CDC. We simply cannot afford to dedicate precious funding to failed but expensive policy options like the CDC when resources are so desperately needed for the programs and approaches that create job opportunities, support struggling families, and reduce the harms created by alcohol or substance abuse.

Concerns with specific provisions in the Bill

Widens the net of compulsory income quarantining in the Northern Territory

In relation to the Northern Territory, the Government has claimed the proposed legislation will merely involve a 'transition' of those currently on income management (the Basics Card) to the CDC. We remain concerned, however, that this Bill will eventually capture more people than would otherwise be subject to income management under current settings. Under existing arrangements, the majority of people on income management in the Northern Territory are on either the "long-term recipient" or "disengaged youth" measure. For these people, the payment type and the *length of time* receiving the payment are triggers for income management. However, under the proposed section 124PGE(1) of the Bill, the long-term welfare recipient and disengaged youth Income Management categories are collapsed. Rather than a person's length of time on social security being the key trigger for income management, it will simply be a question of which category of social security payment they are receiving. This effectively means every person living in the Northern Territory and receiving Youth Allowance, Newstart Allowance, Parenting Payment or Special Payment (who are not studying full time) could eventually be subject to the CDC.

Removal of independent evaluation requirements

The Government should be able to demonstrate its policies are effective, meet their objectives and outcomes, represent value for money and, most importantly, benefit those affected. Accordingly, any decision to commit further funds to income management must be informed by robust and independent evaluation, with community input into the design and delivery of any evaluation.

Despite this, the Bill removes the statutory requirement for an independent expert evaluation within six months of the completion of a trial review, replacing this with "a desktop evaluation to lessen the ethical implications associated with avoidable repeat contact with vulnerable individuals".[2]

This shift away from a full evaluation to a desktop review is unjustified and deeply concerning. It is critically important any new initiative that will impact on people experiencing disadvantage is robustly evaluated, particularly where there is a possibility that people may experience further disadvantage as a direct result of the initiative. A desktop evaluation removes the rigour, independence and contextualisation of data that is required to understand the effects of any given policy intervention. It also excludes the voice of the people most affected, which is fundamental to understanding the implications of a program.

Critically, the move to a "desktop review" precludes a more participatory, co-designed model of evaluation and contradicts the Government's stated intention to develop a stronger Indigenous Evaluation Strategy.[3] Evaluation as a practice does not have a good track record of recognising Indigenous self-determination in Australia. In June 2019, the Australian National Audit Office reported that the evaluation framework for the Australian Government's Indigenous Advancement Strategy (IAS) had no reliable method for measuring long-term outcomes, a full five years after the IAS was established. This

prompted the Minister for Indigenous Australians to ask the Productivity Commission to "develop a whole-of-government evaluation strategy for policies and programs affecting Indigenous Australians, to be used by all Australian Government agencies".[57]

In relation to income support and employment interventions, an abiding weakness of government evaluations is the application of government formulated and imposed criteria, without respect for First Peoples' self-determination and sovereignty. As highlighted in our previous submissions on the CDC, official evaluations of the CDC have failed to meet the relevant ethical guidelines for research and evaluation, including specific standards for research relating to First Peoples.[58] Aboriginal and Torres Strait Islander peoples and organisations often contribute to evaluations, but they typically do so as program participants and stakeholders, with little control over what evaluation questions are asked or how their answers will be used by government.

The approach adopted in this Bill appears to perpetuate this approach. Evaluations that are consistent with the goal of self-determination should use genuinely participatory and culturally appropriate methods, ensuring Aboriginal and Torres Strait Islander people take the lead in defining what 'successful' policies and programs look like. We believe this genuine co-design approach should be incorporated in any policy or program evaluation affecting First Peoples, including income quarantining.

Places excessive power in the Minister's hands

Currently, most people on Income Management in the Northern Territory have 50 per cent of their payment restricted (70 per cent under the child protection measure). These percentages are retained as the starting point in the Bill.

The Bill, however, gives the Minister an unacceptably broad power to increase the quarantined amount up to 80 per cent with very limited parliamentary oversight. We note that, compared to the 2019 Bill to extend and expand the CDC, the current Bill has modified the provisions relating to the discretionary powers of the Minister, which had previously enabled the Minister to increase the quarantined amount to 100 per cent. While the current Bill permits a lower percentage cap for quarantined funds, we remain concerned that insufficient legislative safeguards are in place, with potentially far-reaching implications for how those subject to the CDC manage their private lives and personal finances. Such concerns were expressed by the Senate Standing Committee for the Scrutiny of Bills in relation to the 2019 Bill, where it was noted:

> …the committee remains concerned that proposed subsections 124PJ(2A) and (2B) would confer on the minister a broad power to determine, in relation to classes of trial participants, the portion of restrictable payments that are restricted, with little or no guidance on the face of the bill as to how this power is to be exercised… The committee is also concerned that ministerial determinations would be made by notifiable instrument. In this respect, the committee notes that notifiable instruments are not subject to the tabling, disallowance, and sunsetting requirements that apply to legislative instruments under the Legislation Act 2003. Parliamentary scrutiny of the determinations would therefore be limited.

We share the Committee's concerns, and believe decisions that have far-reaching implications for people's lives should, at a minimum, be subject to robust Parliamentary scrutiny and debate, accompanied by a statement of compatibility with human rights.

Limited avenues to exit trial

While people subjected to the CDC trial may be able to apply to exist the scheme, the process has proven extremely onerous and difficult to navigate. In assessing applications, the factors the Department have taken into consideration have been broad and ambiguous,[59] For example, a person seeking to exit the trial must demonstrate to the Department "reasonable and responsible management of their affairs (including financial affairs)".[60] To date, assessments of whether an applicant reaches this threshold have involved an extremely wide range of personal matters, with those applying to exit the CDC trial potentially subject to intense and invasive scrutiny.

The Bill provides the Minister with new powers to determine the decision-making principles for exit criteria through a legislative instrument. The Secretary will be bound to consider these criteria before determining whether a person can reasonably manage their affairs and therefore exit the CDC program. While decision-making principles are an improvement to the process, their content remains unspecified.

Under the current legislation, the Secretary can exempt a person from the CDC program if they are satisfied that being on the program poses a serious risk to a CSC participant's mental, physical or emotional wellbeing. This decision cannot be revoked. The Bill enables any government agent or agency to request the Secretary to review and to revoke an exemption previously made based on a person's wellbeing. However, there are no specified criteria and decision-making principles for decisions concerning exemptions, and the Secretary's discretion is effectively unfettered.

The departmental statistics on exit and exemption applications underscore the problems with current arrangements. As at 25 September 2020, of the 12,114 people on the CDC program, only 2.3 per cent applied for a wellbeing exemption and 1.6 per cent were approved; 11 percent applied to exit the program and only 2.6 percent were approved.[61] The Department's response to a question on notice indicates that the average processing time for exit applications is five months, with 40 staff from the department and Services Australia staff involved in assessing applications.[62]

Conclusion

There is a clear and compelling need for more effective policies that tackle entrenched poverty and the social problems that stem from profound social and economic disadvantage. This Bill, however, does not provide an effective policy response to poverty or disadvantage, and we urge the Committee to recommend it be abandoned. We support the use of a voluntary, opt-in approach developed in partnership with communities and supported by wrap-around services. However, as this submission has shown, the blanket and mandated application of the CDC is a blunt measure driven by ideology rather than evidence, and it risks compounding some of the very factors that contribute to ongoing disadvantage and disempowerment among those on low incomes.

UnitingCare Australia recognises there are deep-seated social and economic problems in many communities across Australia, especially the lack of job opportunities, inequitable health outcomes, and the effects of alcohol and drug abuse. It is because we take these problems seriously that we want to properly understand their causes. Simplistic views – that the main underlying problem is 'welfare dependency' – are likely to lead to simplistic solutions that are costly, ineffective, and bring shame on those affected. And simplistic solutions that are imposed and developed without community input and support will ultimately fail.

We believe the considerable resources expended on the CDC and other forms of compulsory income quarantining would be better spent on improving the adequacy of income support payments and funding appropriate and effective services for struggling individuals and families. Increasing the punitive and paternalistic aspects of social security is a misplaced policy lever for improving social outcomes. Such an approach detracts from the underlying purpose of the social security system. With inequality growing and poverty levels remaining unacceptably high, we urgently need to reinstate poverty alleviation as the central goal of income support policy, rather than extending a punitive income support agenda on the basis of questionable evidence.

We urge the Committee to reject this ideologically driven approach that hurts rather than helps. Instead of punitive and paternalistic interventions, there is a pressing need for flexible, supportive and non-judgemental social security policies that build social resilience and cohesion and provide real income security. And if the Government is genuinely committed to tackling complex social and health issues, such as alcohol and drug addiction, we encourage it to adopt a holistic approach that respects the dignity of people, is grounded in evidence, and implemented in genuine partnership with communities.

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