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To The Senate Committee Members,

**RE: Social Security (Administration) Amendment (Continuation of Cashless Welfare) Bill 2020**

We are writing in regard to the inquiry for the abovementioned amendment. We are researchers at Monash University, University of South Australia and Menzies School of Public Health who have been doing work with stakeholders in the trial site in South Australia to quantitatively assess the outcomes of the Cashless Debit Card Program.

The results of our quantitative assessment have been published in a peer reviewed research article: <https://doi.org/10.1080/0312407X.2020.1817961>

We attach to our letter a summary of the research and its conclusions.

Sincerely,

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### Submission:

#### Social Security (Administration) Amendment (Continuation of Cashless Welfare) Bill 2020

The stated objective of the Cashless Debit Card (CDC) has been to “support people, families and communities in places where high levels of welfare dependence co-exist with high levels of social harm.” The mechanism of the Card is to restrict consumer spend on Gambling, Alcohol, and Intoxicants, with the intention that spend would be redirected to grocery and household goods. It works by quarantining 80 per cent of a working age recipients’ social security payments on a Visa-branded debit card with an associated bank account from which cash cannot be withdrawn. The purpose of our research was to investigate whether aims of the policy and related program were being met using objective data.

As outlined in our research and in a range of other sources the CDC has been evaluated using mostly qualitative or self-report data with mixed conclusions (Hunt, 2018; ORIMA, 2017a, 2017b; Vincent, 2019). ORIMA Research was contracted to evaluate the CDC and it found that an initial evaluation of 34 per cent of the 1850 trial participants reported that they “did not drink alcohol, gamble or take illegal drugs before or after the trial”, 22 per cent reported a reduction in at least one of these behaviours and 43 per cent reported no change (ORIMA, 2017a). Notably, trial participants and their family were more likely to indicate that the CDC made their lives worse in both the initial (worse/better: participants 49%/22%; family members 37%/27%) (ORIMA, 2017a) and final (worse better: participants: 32%/23%; family members not interviewed) (ORIMA, 2017b) evaluations. Non-participant community members, however, were more likely to report it made their lives better (initial worse/better 18%/46%; final 19%/41%) (ORIMA, 2017a, 2017b). Limitations of self-report data are acknowledged by ORIMA, as are selection/response bias, social desirability bias and recall error (ORIMA, 2017a, 2017b). The final evaluation included some objective administrative data and found reductions in gambling, hospital presentations, community patrol pickups and police apprehensions of intoxicated people (ORIMA, 2017b); however, statistical significance was not assessed, nor were underlying trends accounted for.

These earlier evaluations have been criticised for lacking appropriate methodology (Australian National Audit Office, 2018; Gray & Bray, 2019; Hunt, 2018; Tilley & Uniting-Communities, 2018). A 2018 report by the Auditor-General stated “there was a lack of robustness in data collection and the department’s evaluation did not make use of all available administrative data to measure the impact of the trial” (Australian National Audit Office, 2018, p. 8). Despite these problems the earlier results, of ORIMA’s research in particular, are often repeated to support the CDC. Our research sought to more definitively assess the CDC, and our research shows that when the problems with prior research are accounted for, positive impacts are no longer identified.

Our analysis focused on the South Australian trial region (Ceduna and surrounds) as it was the only trial region with suitable administrative data available for a review to be undertaken and its remote location enables confident analysis of local economies. Other trial sites were located in different jurisdictions where there was a lack of administrative data to support appropriate analysis. Government administrative data were obtained for crime rates, emergency department presentations, electronic gaming (pokies), and apprehensions for public intoxication. These were all sourced for substantial periods prior to the launch of the CDC and for the time after its launch. Our analysis accounted for patterns of seasonality and compared against trends that existed prior to the launch of the CDC.

**Across all measures we found NO IMPACT of the CDC. Meaning, neither a decrease nor an increase in measured crime rates, emergency department presentations, electronic gaming (pokies) nor apprehensions for public intoxication.**

There had been many anecdotal reports of increased grocery expenditure as a consequence of the introduction of the CDC. Hence we also sought to assess this potential impact. We obtained the store sales data from a geographically isolated remote community that had a large percentage of community members enrolled in the CDC. These data included periods prior to the launch of the CDC and for the time after its launch. As before, our analysis accounted for patterns of seasonality and existing trends prior to the launch of the CDC.



Our analysis found there was a substantial increase in spend at the sole community store in this community. BUT, the greatest increase in spend was on food classed as discretionary as per the ABS (2014) Discretionary Food List. Discretionary foods should be limited in one's diet as they can be energy-dense and nutrient-poor, displacing nutritious foods (NHMRC, 2017). These foods are often placed in prominent locations in grocery stores encouraging impromptu buys and are purposely manufactured to be highly desirable.

**From this we can conclude that while the CDC increased grocery expenditure, people were more likely to buy unhealthy foods that are known to lead to poorer health outcomes.**

While we find no benefits at the aggregate level we do acknowledge that specific individuals or households may experience some benefit. It is just that these benefits are not common across the majority of people the majority of the time. The estimated cost of administering the Cashless Debit Card is \$10,000 per person per year (Conifer, 2017; Hunt, 2018; Tilley & Uniting-Communities, 2018), although this may decrease as economies are reached. The research shows that this investment by the Federal Government is likely producing a negative return. There are substantial costs, and few benefits.

### **Recommendations:**

This analysis shows that the Cashless Debit Card, as presently implemented, is not delivering the benefits it was originally designed to deliver. It is recommended that:

1. Any further investment by the Federal Government in the CDC program, as presently implemented, be reconsidered, as few benefits are being obtained
2. That mass application of the CDC across whole communities not be undertaken, although specific application to some individuals or households may be of benefit
3. That new or extensions of policies similar to the CDC have clearly pre-defined intentions, and measures of success/failure that use observations of actual behavior across all people in the trial area
4. That self-report data is not used, or used only in conjunction with observational data, as a primary measure for policy success/failure

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