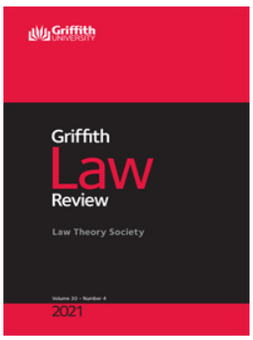

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Cashless welfare transfers and Australia's First Nations: redemptive or repressive violence?

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ABSTRACT

The Australian Federal Government claims that the Cashless Debit Card (CDC) is a necessary 'support' that generates positive outcomes. Despite contrary evidence revealed through independent research and problems with the scheme also apparent in government-commissioned research, the dominant political narrative accompanying the CDC remains intractable. The CDC has been characterised by elites as helpful 'practical love' for those in need of government income support. However, many of those with lived experience of the CDC report that the scheme imposes difficulties with basic bill payment, undermines sound financial management, and stigmatises cardholders. The majority of Aboriginal and Torres Strait Islander organisations who have gone on the public record strongly condemn the scheme in its compulsory iteration, as do prominent First Nations Senators. Taking these issues into consideration, this article examines whether the CDC is best characterised as 'redemptive' or 'repressive violence'. In doing so, it reflects on colonial conceptions of 'care', which are deeply paternalistic, and contrasts this with an approach that promotes self-determination and autonomy. This analysis is situated in the context of neoliberal marketisation of welfare state practices, where heavy handed regulatory frameworks have proven lucrative for industry interests.

KEYWORDS

First Nations; Cashless Debit Card; social security

Introduction

In recent decades western nations such as the United States, the United Kingdom, Australia, and New Zealand have adopted a stigmatising approach to social security payments with intensified surveillance and control.[1] Cashless welfare transfers are part of this general trend, where intensive regulation of government income support recipients is increasingly prescribed to address their presumed shortcomings in 'character and capacity'.[2] In Australia, industry interests have played a key role in the development and expansion of cashless welfare transfer cards[3] that disproportionately impact upon Australia's First Peoples in terms of their regulatory effect. As of 6 November 2020, 40

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[1]Mendes (2020); Monahan (2017); Bielefeld (2016); Humpage (2016); Standing (2014).
[2]Bielefeld (2018c), p 758; Bielefeld (2018a), p 18.
[3]Forrest (2014); Minderoo Foundation (2017).

per cent of Cashless Debit Card (CDC) holders were Indigenous, constituting 4,764 people of the 11,910 people on the card.[4] As of 4 June 2021, just over 38 per cent of CDC holders were Indigenous, comprising 5,655 of the 14,718 cardholders.[5] At the time of writing there are two types of cashless welfare cards operating in Australia, the BasicsCard and the CDC. This paper concerns the latter, which was triggered by the 2014 *Indigenous Jobs and Training Review* led by mining magnate Andrew Forrest.[6] The Coalition government appointed Forrest to undertake this review despite his 'limited policy expertise' and 'lack of experience in using appropriate evidence bases to shape … recommendations',[7] and despite what could be seen as a conflict of interest, with Forrest generating extreme wealth from mining Indigenous lands while also opposing native title claims.[8]

According to its advocates, the purpose of the CDC is to address substance abuse, foster socially responsible behaviour, and incentivise a shift from welfare to work; they claim that '[c]ash from government quickly converts to illegal drugs and alcohol abuse'.[9] Forrest maintains that 'a cashless welfare system is not only possible, but with refinements to existing technology, completely practical'.[10] However, as Calavita explains, 'the law as it is written and advertised to the public is often quite different to the way it looks in practice, [and] law and society scholars have long had an interest in studying that gap'.[11] This article continues this scholarly tradition by exploring the gap between the redemptive idealism embedded in the CDC law and policy narrative versus the repressive reality encountered by many of Australia's First Peoples affected by the card. Although the legislation allows for people to volunteer to be on the CDC under limited circumstances,[12] the vast majority of people who are on the card have been coerced to use it.[13] As one cardholder who did not want to be on the CDC explained, card activation occurs 'under duress'.[14]

Reflecting on social justice, this article will analyse injustice that has arisen for Australia's First Peoples in the context of the CDC. Young conceptualises 'social justice' as 'the elimination of institutionalized domination and oppression'.[15] This view of social justice is concerned with redressing institutional domination embodied in 'colonial violence'[16] and 'repressive violence'.[17] Although the Federal Government stresses that the CDC evolved from a 'community driven, bottom-up approach',[18] this article will explore how the scheme reproduces dynamics of domination through the social security system along racialised and class-based contours. The CDC allows the restriction of a large

[4]Australian Government (2020), p 1.
[5]Australian Government (2021), p 1.
[6]Forrest (2014).
[7]Cox (2014).
[8]Welcome to Country (2017); McGlade (2017); Higgins and Sas (2020).
[9]Forrest (2014), p 103.
[10]Forrest (2014), p 104.
[11]Calavita (2016), p 9.
[12]*Social Security (Administration) Act 1999* (Cth) ss 124PH, 124PGE (the latter section applying to the CDC in the Northern Territory).
[13]Australian Government (2020), p 1.
[14]Marston et al (2020), p 90.
[15]Young (1990), p 15.
[16]Watson (2009), pp 45–46, 48.
[17]Povinelli (2011), p 127.
[18]Commonwealth (2019a), p 13176.

percentage of a person's social security payment on to the card,[19] providing 'pilloried "in-kind"'[20] welfare that has created significant problems for many of those forced to use it.[21] Although people subject to the CDC in Ceduna and the East Kimberley can apply to a Community Panel to have their restricted portion reduced to somewhere between 50 and 80 per cent,[22] applications for such reductions do not always lead to the outcomes sought by cardholders. As of 6 November 2020, Indigenous cardholders comprised 67 per cent of those in Ceduna and 70 per cent of those in the East Kimberley whose applications for a reduction in their restricted portion were denied.[23] Regaining greater autonomy over their finances is an arduous undertaking for those put on the CDC.

This article adopts a law and society approach, which analyses law as 'a social construction' and 'the influence on law of forces *outside*' the traditional jurisprudential 'box of legal logic'.[24] It is an examination of law in the context of the society in which it is created.[25] This includes analysing the political, historical, cultural, economic and social influences on the development of law. Calavita explains that a key concern for law and society scholars is 'the gap between the law-on-the-books and the law-in-action'.[26] This article adopts a law and society methodology by examining this gap, which requires consideration of the content of law, 'law as it is written', how this law has developed, and how such law 'actually works' in 'everyday' life.[27] Examining everyday experiences of law is an interdisciplinary inquiry, and, in this article, includes consideration of policy evidence embedded in research reports, submissions to parliamentary inquiries, media, and parliamentary debates. This article foregrounds Indigenous voices on the CDC reflected in these numerous sources, and draws on scholarship falling within Critical Indigenous Studies and Indigenous Studies in undertaking analysis of the CDC. This article does not adopt a 'settler colonial' framework[28] due to this framing being contested by numerous First Nations scholars.[29] For example, Konishi, a descendent of the Yawuru people of Broome in Western Australia, explains that there are First Nations scholars who strongly critique 'settler colonialism', who prefer instead to use the terminology of 'colonialism', 'colonial domination', and 'imperialism', and who do not want to underplay the important 'role of Indigenous agency and resistance' in evading '"eliminationist" endeavours'.[30]

Part 1 of this article explores the background to the CDC and the legislative framework authorising its implementation, together with the legislative criteria for accessing CDC exemptions.[31] Part 2 explores CDC outcomes, which are evident from

[19] *Social Security (Administration) Act 1999* (Cth) s 124PJ(1), 80 per cent of fortnightly payments for those on the CDC under sections 124PG, 124PGA, 124PGB or 124PGC, and 50 per cent of fortnightly payments for people in the Northern Territory who volunteer to transition from the BasicsCard to the CDC. There are also other variable amounts discussed in s 124PJ depending on location and payment type, for instance, 100 per cent of lump sum payments are quarantined to the card.
[20] Bielefeld (2018a), pp 18–19, 10.
[21] Marston et al (2020), pp 84–97, 101–112, 116–118; Klein and Razi (2018), pp 89–93; Vincent (2019), pp 9–17.
[22] *Social Security (Administration) Act 1999* (Cth) s 124PK.
[23] Australian Government (2020), p 2.
[24] Calavita (2016), pp 7, 4.
[25] Mather (2011), p 289.
[26] Calavita (2016), p 9.
[27] Calavita (2016), pp 4, 37.
[28] Wolfe (2006).
[29] Konishi (2019).
[30] Konishi (2019), pp 286, 290, 292–295, 298, 300.
[31] Calavita (2016), p 9.

government-commissioned CDC evaluation reports and independent studies of the CDC undertaken by academics. Part 3 critiques the manner in which colonial lawmakers have glorified their socio-economic missions as redemptive enterprises, even when such intervention has created suffering for First Nations Peoples.[32] This part contends that the CDC continues this governance strategy, but does so in conjunction with powerful industry interests reflecting neoliberal influence.[33] It will be argued that this combination perpetuates repressive outcomes for numerous people on the CDC who are denied day to day autonomy over their expenditure and subjected to stigma. The article contends that an ethical response requires a radically different approach that responds to human needs by understanding and promoting a person's 'self-determined ends' and upholding their agency.[34] Indigenous scholars have long expressed concerns about colonial authorities undermining the self-determination and autonomy of First Peoples and the need to redress this through dignity enhancing alternatives rather than with 'excessive regulation'.[35]

Part 1: background to the CDC and legislative framework

In 2014, Forrest recommended 100 per cent cashless social security payments to be distributed via a 'Healthy Welfare Card',[36] a measure swiftly criticised by a range of community welfare organisations and Indigenous organisations.[37] Forrest claimed that Australia had 'increased the risk to its most vulnerable by paying all welfare benefits in cash' enabling an 'incoming tide of drugs and alcohol', especially in remote Indigenous communities.[38] Forrest asserted that the Card would incentivise individuals to 'move to employment more quickly' and that 'emergency relief payments and crisis services would be reduced through a longer-term reduction in welfare reliance'.[39] This narrative is contentious, and overlooked key structural impediments to Indigenous employment that include a limited employment market in remote locations, as well as colonial legacies and continuities.[40]

Despite this, the Australian Federal Government implemented aspects of Forrest's Review via the *Social Security Legislation Amendment (Debit Card Trial) Act 2015* (Cth), with some slight modifications, including a name change from the 'Healthy Welfare Card' to the CDC. As previously mentioned, substance abuse and gambling are key government rationalisations for the CDC[41] which unjustly stigmatises cardholders as addicts in need of persistent paternalistic intervention. The CDC prohibits the expenditure of restricted funds on alcohol and gambling products,[42] and more recently, 'some

[32]Watson (2011) p 154; Altman and Russell (2012) p 11.
[33]Klein (2016); Bielefeld (2018a); Bielefeld (2018b).
[34]Miller (2012), p 79.
[35]Watson (2011), pp 148, 157–158, 154; Watson (2015), pp 90–91; Watson (2009), p 55; Moreton-Robinson (2009), pp 65–66; McGlade (2017); Marshall (2011), p 25.
[36]Forrest (2014), pp 103–108.
[37]Australian Association of Social Workers (2014).
[38]Forrest (2014), p 102.
[39]Forrest (2014), p 105.
[40]Altman (2013), p 18; Watson (2018), pp 1–4; Watson (2015), p 13; Klein and Razi (2018), p 88; Bielefeld (2018b), p 157.
[41]Commonwealth (2015), p 2; Commonwealth (2019a), p 13176.
[42]*Social Security (Administration) Act 1999* (Cth) s 124PM(a)(i)-(ii).

gift cards',[43] described under legislation as a 'cash–like product that could be used to obtain alcoholic beverages or gambling'.[44]

Since the enactment of the *Social Security (Administration) Amendment (Continuation of Cashless Welfare) Act 2020* (Cth) ('Cashless Welfare Continuation Act 2020'), the CDC objectives under section 124PC of the *Social Security (Administration) Act 1999* (Cth) are to: (a) reduce the amount of cash 'available to be spent on alcoholic beverages, gambling and illegal drugs', (b) 'support program participants and voluntary participants with their budgeting strategies', and (c) 'encourage socially responsible behaviour'.

What began as a short term 'trial' has since continued, facilitated by a steady stream of CDC expansion legislation.[45] The Australian government introduced the CDC in the trial sites of Ceduna in South Australia in March 2016 and the East Kimberley in Western Australia in April 2016 via the *Social Security Legislation Amendment (Debit Card Trial) Act 2015* (Cth). Further extension of the CDC into the Goldfields in Western Australia in March 2018 was facilitated under the *Social Services Legislation Amendment (Cashless Debit Card) Act 2018* (Cth). Further legislation was passed to extend the card to the Hinkler region (including Bundaberg and Hervey Bay) in Queensland in January 2019 via the *Social Services Legislation Amendment (Cashless Debit Card Trial Expansion) Act 2018* (Cth).

In Ceduna, the East Kimberley, and the Goldfields, the CDC applies to a broad range of social security payments defined as 'trigger' payments.[46] In the Hinkler region the card applies to people who are thirty-five and under who receive a 'jobseeker payment, youth allowance … or parenting payment'.[47] The majority of people on the CDC have been forced on the card irrespective of their individual behaviour or budgetary capability. There has been little voluntary CDC participation.[48]

More CDC legislation was enacted in 2019, the *Social Security (Administration) Amendment (Income Management and Cashless Welfare) Act 2019* (Cth), extending the card until 30 June 2020, and introducing an exit possibility for some cardholders. The exit and exemption criteria are set out under sections 124PHA and 124PHB of the *Social Security (Administration) Act 1999* (Cth), and give the government considerable discretion as to whether someone can exit the CDC scheme. Further legislation specifying criteria for this exemption process was enacted under the *Social Security (Administration) Amendment (Cashless Welfare) Act 2019* (Cth). Under section 124PHA(1) the government may permit a person to exit the CDC where satisfied that there is 'a serious risk to the person's mental, physical or emotional wellbeing'. There is no definition of what constitutes 'a serious risk' under the social security legislation or detail about what type of medical or other documentation will suffice for the wellbeing exemption. This can present insurmountable barriers for people wanting to escape CDC restrictions. For example, if the government requires a letter from a medical specialist in order to demonstrate the claims made by a CDC applicant, but the visit to a specialist

[43]Department of Social Services (2020).
[44]*Social Security (Administration) Act 1999* (Cth) s 124PM(a)(iii).
[45]For a list of most of these Acts see: Regulation Impact Statement, Social Security (Administration) Amendment (Continuation of Cashless Welfare) Bill 2020, pp 11–12.
[46]*Social Security (Administration) Act 1999* (Cth) ss 124PD, 124PG, 124PGA, 124PGB.
[47]*Social Security (Administration) Act 1999* (Cth) s 124PGC.
[48]Australian Government (2020), p 1; Mavromaras et al (2019), p 83; Orima Research (2017b), p 3.

requires hundreds of dollars, this can present an insurmountable cost burden to social security recipients on low incomes. Additionally, at times there is no local access to such specialists within the CDC trial sites. Where substantial travel is required to access a medical specialist, this requirement is difficult, and at times impossible, for people with disability-related mobility restrictions to satisfy. Importantly, the government provides no additional resources to assist CDC holders in meeting the wellbeing exemption criteria. Such cost and travel burdens can be prohibitive for cardholders.

Under section 124PHB(3)(a) the government may facilitate exit from the CDC where satisfied that 'the person can demonstrate reasonable and responsible management of the person's affairs (including financial affairs)', considering the following: (i) 'the interest of any children for whom the person is responsible'; (ii) 'whether the person was convicted of an offence against a law … or was serving a sentence of imprisonment for such an offence' within the previous twelve months; (iii) 'risks of homelessness'; (iv) 'the health and safety of the person and the community'; (v) 'the responsibilities and circumstances of the person'; and (vi) 'the person's engagement in the community, including the person's employment or efforts to obtain work'. The person is also required to satisfy criteria the Minister may choose to set out in a 'legislative instrument',[49] giving the Minister discretion to add more elaborate (and difficult to satisfy) criteria in future.

The criteria listed to date ensure that most people put on the card will find it difficult or impossible to exit the scheme. For example, for some participants being placed on the CDC and being required to use the Indue Ltd system can heighten their risk of experiencing housing insecurity due to problems paying rent.[50] Numerous cardholders have experienced technology problems with rent payments bouncing back into their accounts leading to delayed rent payments and breach of their contractual obligations to pay rent on time.[51] The idea of what is needed for community 'health and safety' is extremely broad, with such concepts previously deployed by racist and fascist regimes to oppress politically unpopular minorities.[52] Numbers of CDC 'reasonable and responsible management' exits remain low.[53] Importantly, there is no legal *right* to exit the scheme. There is merely an opportunity to try to exit the CDC provided that the application is submitted 'in writing using a form approved by the Secretary' and 'accompanied by the documents and other information required by the form'.[54] The exit requirements are proving especially difficult for First Nations Peoples wanting to get off the CDC.[55]

Rather than being applied to all social security recipients, the CDC program was initially trialled predominantly in communities with high numbers of First Nations welfare recipients: Ceduna, Kununurra, and Wyndham. As of 2016, First Nations Peoples comprised 565 of the 752 people subject to the CDC in Ceduna, and 984 of the 1,199 people on the card in the East Kimberley communities of Kununurra and Wyndham.[56] First Nations Peoples on the CDC remain grossly overrepresented – making up over 38

[49]*Social Security (Administration) Act* 1999 (Cth) s 124PHB(3)(b) and (6).
[50]Marston et al (2020), pp 10, 36, 103.
[51]Marston et al (2020), pp 10, 36, 103.
[52]Foucault (2004), p 255; Noakes and Pridham (1975), p 266.
[53]Australian Government (2021), p 3.
[54]*Social Security (Administration) Act 1999* (Cth) s 124PHB(2).
[55]Aboriginal Peak Organisations Northern Territory (APO NT) (2020a), p 7; Change the Record (2020), p 7.
[56]Aboriginal and Torres Strait Islander Social Justice Commissioner (2016), pp 91–92.

per cent of cardholders in June 2021[57] – despite comprising only 3.3 per cent of the overall Australian population.[58] In 2015 the Federal Government claimed that the CDC would not be a racially discriminatory measure.[59] The Federal Government continues to deny that the CDC violates the right to non-discrimination, stating that it does not target Indigenous peoples with *direct discrimination*.[60] However, the CDC scheme arguably constitutes *indirect discrimination*. In accordance with the principle of *indirect discrimination*, measures that are racially discriminatory in 'effect' still violate international human rights standards, under Article 1 of the *International Convention on the Elimination of All Forms of Racial Discrimination*. That the CDC delivers racial discrimination in 'effect' has been raised by the Australian Human Rights Commission,[61] numerous Aboriginal and Torres Strait Islander Peak Organisations,[62] and First Nations Senators Patrick Dodson, Malarndirri McCarthy, and Lidia Thorpe.[63] For instance, Senator Lidia Thorpe has criticised the CDC as 'racist and colonial nonsense' that is 'demeaning to us, a proud people'.[64] Minister Linda Burney has similarly stated that the CDC is 'structurally racist'.[65]

The Parliamentary Joint Committee on Human Rights (PJCHR) states that limitations on human rights, including the right to non-discrimination, may be permitted 'where a measure seeks to achieve a legitimate objective, is rationally connected to (that is, effective to achieve) that objective, and is proportionate to that objective'.[66] Numerous reports by the PJCHR since the CDC's commencement have found that the scheme fails to meet the criteria of rational connection, because research indicates problems with the CDC's efficacy in achieving policy objectives, and that there is no evidence the compulsory CDC satisfies the requirement of proportionality, given that the least rights restrictive means is not used to achieve policy objectives.[67]

However, the trend of Indigenous overrepresentation on the CDC looks set to continue, with the Federal Government pursuing program expansion. During the COVID-19 pandemic, the Federal Government decided to introduce the Cashless Welfare Continuation Act 2020, which, in its original iteration, proposed to impose the CDC as a permanent measure across all current trial sites, the Northern Territory and Cape York, transitioning all BasicsCard holders in the latter two jurisdictions on to the CDC without their consent or input.

There was no consultation with affected community members in the Northern Territory on the Cashless Welfare Continuation Act 2020 before it was hurriedly drafted and presented to Parliament on 8 October 2020.[68] This was an exercise in top-down

[57]Australian Government (2021), p 1.
[58]Australian Bureau of Statistics (2018).
[59]Statement of Compatibility with Human Rights for the Social Security Legislation Amendment (Debit Card Trial) Bill 2015, p 3.
[60]Statement of Compatibility with Human Rights for the Social Security (Administration) Amendment (Continuation of Cashless Welfare) Bill 2020, p 33.
[61]Australian Human Rights Commission (2020), pp 5–6.
[62]National Aboriginal and Torres Strait Islander Legal Services (NATSILS) (2020), pp 6–7; APO NT (2020a), p 3; National Aboriginal Community Controlled Health Organisation (NACCHO) (2020), pp 3–5.
[63]Commonwealth (2020b), pp 19–21; Commonwealth (2020c), pp 9–10; Commonwealth (2020d), pp 14–15.
[64]Commonwealth (2020d), p 15.
[65]Commonwealth (2020a), p 33.
[66]Parliamentary Joint Committee on Human Rights (PJCHR) (2020), p 44.
[67]For example, PJCHR (2018), pp 34–37.
[68]APO NT (2020a), p 5.

policymaking not welcomed by Northern Territory Aboriginal communities still deeply affected by the 2007 Northern Territory Emergency Response. As John Paterson from Aboriginal Peak Organisations Northern Territory explained:

> The bill is a new Intervention. It will perpetuate the torment of our powerlessness. It denies our basic freedom to control our lives. It locks the many of us who live below the poverty line out of the cash economy and undermines our small businesses that rely on cash payments.[69]

Due to pandemic related travel restrictions in 2020, the Federal Government was unable to engage in consultation with affected community members before presenting the Bill to Parliament. After heated parliamentary debate in December 2020, it became apparent that the Federal Government would not get sufficient votes to pass the Cashless Welfare Continuation Act 2020 with the CDC embedded as a permanent measure. Their compromise was to extend the CDC in current trial sites for a further two years, to extend the CDC into Cape York using the Family Responsibilities Commission model, and extend the CDC into the Northern Territory on a voluntary basis. Thus, in the Northern Territory, BasicsCard holders are given a choice to transition to the CDC – but not a choice to escape the strictures of cashless welfare card payments altogether. While it is beyond the scope of this article to elaborate on the complexities of the government issued BasicsCard, research indicates that this form of cashless welfare has been equally problematic.[70]

Part 2: CDC outcomes

The Australian Federal Government has heralded the CDC a success, regularly claiming that its 'positive impact' warrants expansion.[71] In doing so they relied on[72] Government commissioned consultancy research undertaken by Orima,[73] despite this having received appropriate criticism from the Australian National Audit Office (ANAO).[74] The ANAO determined that the government's CDC 'monitoring and evaluation was inadequate', and that it was impossible to conclude that the CDC has resulted in 'a reduction in social harm' or 'a lower cost welfare quarantining approach'.[75] The ANAO also pointed to other weaknesses with the CDC implementation and program performance. These include poor risk management practices, no cost–benefit analysis, weak use of administrative data, inadequate review of key performance indicators, no baseline data collection, no evaluation built into the program design, problematic procurement of the CDC provider and evaluator, and an inadequate 'evidence base'.[76]

Despite shortcomings in the government commissioned Orima research, it revealed that numerous CDC holders encountered significant barriers and burdens in terms of

[69]APO NT (2020b).
[70]Marston et al (2020); Campbell (2019); Bielefeld (2018a); Bielefeld (2015); Bray et al (2014); Marshall (2011); Moreton-Robinson (2009).
[71]Explanatory Memorandum (2019), p 19; Explanatory Memorandum (2018), p 4; Statement of Compatibility with Human Rights (2017), p 3; Explanatory Memorandum (2020), p 4.
[72]For example, see the Explanatory Memorandum (2020), p 28.
[73]Orima Research (2017a); Orima Research (2017b).
[74]Australian National Audit Office (ANAO) (2018), pp 8–10.
[75]ANAO (2018), p 8.
[76]ANAO (2018), pp 8–9.

accessing their everyday needs.[77] At Wave 1 of the evaluation 49 per cent of CDC holders who participated in the research indicated that overall the card 'had made their lives worse'.[78] At Wave 2 of the evaluation 32 per cent of cardholders indicated that overall the CDC 'had made their lives worse'.[79] Reasons given as to why the CDC made peoples' lives worse included being prevented from paying for necessary items such as 'bills' and 'appointments', being unable to spend money on desired 'personal items', and lacking access to enough cash.[80] Some people on the CDC reported a range of problems paying for everyday needs such as petrol, housing, food from school canteens, and purchase of second-hand goods.[81] These detrimental outcomes have been trivialised by the Federal Government. Their focus has instead been on the smaller percentage of cardholders who indicated that the CDC led to some improvements, the 22 per cent at Wave 1 and 23 per cent at Wave 2 who reported that the CDC 'had made their lives better'.[82] The public have been presented with a partisan policy narrative to smooth the pathway towards privatisation of social security payment processes, which is proving very profitable for Indue Ltd, the non-Indigenous financial services entity administering the CDC, as will be discussed further in Part 3.

Although politicians responsible for the CDC emphasise that the card is only meant to prohibit access to alcohol, illicit substances, gambling products, and 'open loop gift cards',[83] the government's own evaluation evidence demonstrates that the card has not been universally accepted at venues where social security recipients needed to make purchases.[84] The CDC has been 'declined at stores both within and outside the Trial sites, and … some cases … involve merchants telling cardholders that they cannot use the particular card'.[85] This finding has also been confirmed in independent academic CDC research conducted across multiple CDC trial sites.[86] As a result, financial exclusion and social exclusion has been experienced by affected social security recipients and their dependent children. Despite these findings, the government still claims that the CDC 'looks and functions like any other debit card',[87] revealing a deep gap between law's 'talk' and law's 'walk'.[88]

A further government-commissioned evaluation report undertaken by Mavromaras and colleagues on the CDC indicates that cardholders in the Goldfields encountered similar problems to those experienced by CDC holders in the first trial sites.[89] For example, as one person explained:

> I can't even get my kids school lunches at the canteen … It's cash, yeah … And their excursions. … I can't even pay that because it's got to be paid in cash. And they've just missed out on swimming lessons because I couldn't pay it out of the card. And that's … $80 per child. And I couldn't cover that with the 20% they give me in my bank account'.[90]

[77]Orima Research (2017a), pp 34, 36, 42–43; Orima Research (2017b), pp 72, 89.
[78]Orima Research (2017a), p 32.
[79]Orima Research (2017b), p 6.
[80]Orima Research (2017a), p 34.
[81]Orima Research (2017a), p 36, 43.
[82]Orima Research (2017b), p 6.
[83]Regulation Impact Statement (2020), p 5.
[84]Orima Research (2017a), p 42; Mavromaras et al (2019), pp 70–71, 77.
[85]Orima Research (2017a), p 42.
[86]Marston et al (2020), pp 101–103; Klein and Razi (2018), pp 92–93.
[87]Regulation Impact Statement (2020), p 29.
[88]Calavita (2016), p 109.
[89]Mavromaras et al (2019), pp 70–71, 77–78.
[90]Mavromaras et al (2019), p 77.

The evaluation conducted by Mavromaras and colleagues explained that although both non-Indigenous and Indigenous social security recipients commonly experienced 'stigma and shame' because of the CDC, 'several Indigenous respondents situated their perceptions of the CDC in an historical racial context'.[91] For example, one Indigenous cardholder explained how the CDC evoked negative feelings resonating with Australia's earlier racist colonial era:

> Make you feel useless. Make you feel like you can't spend your own money. Useless. And it's like they're rationing our money. Like back in the days, so I feel the white people telling us how to spend our money when we know how to use our money ourself.[92]

Another Indigenous CDC holder also made clear that the card has a stigmatising and racist effect:

> As soon as they see a grey card they can't serve you … Now that means they push us right back to where we used to be under the Gum tree, instead of moving forward with us. They pushed us right back where my people used to work for tobacco and sugar, and tea bags … they pushed us right back where they used to be.[93]

In addition to the previously mentioned problems, a range of 'systems-based technological difficulties' have been reported with the CDC.[94] Blackouts and EFTPOS failures have occurred many times since the CDC was introduced – leaving hundreds of people without access to essentials due to technological troubles.[95] During power outages people on the CDC are less likely to have sufficient cash to pay for their needs because a large percentage of their income is restricted to the card. These problems reveal that the CDC can thwart rather than support social security recipients 'with their budgeting strategies', contrary to the legislative objective embedded in section 124PC(b) of the *Social Security (Administration) Act 1999* (Cth). The government has been made aware of these issues over many years of the CDC's operation.

Access to the technology required for managing finances via the CDC has also presented problems for social security recipients, an issue that arose in both the Orima research[96] and the evaluation being conducted by Mavromaras and colleagues.[97] Some CDC holders do not own mobile phones, or if they do have mobile phones, often lack funds to purchase 'phone credit'.[98] The CDC has presented problems for card users with 'limited internet access', limited 'digital literacy', and 'limited English levels'.[99] People forced on the CDC are left to absorb extra technology costs needed for card activation and access to card balances despite their low incomes. These extra costs were reported to be burdensome, as one CDC holder explained:

> One thing that really bugged me is that you need internet … I don't have a computer and I don't have the transportation to go down to the local library to function these things and you

[91] Mavromaras et al (2019), p 76.
[92] Mavromaras et al (2019), p 76.
[93] Mavromaras et al (2019), p 76.
[94] Mavromaras et al (2019), p 7.
[95] ABC Editorial (2016); Hirini (2019).
[96] Orima Research (2017a), pp 157–158, 170–171.
[97] Mavromaras et al (2019), pp 6–7, 70–71.
[98] Orima Research (2017a), p 157.
[99] Orima Research (2017a), pp 157–158.

> pay to use the internet. You get the first 15 minutes free but that limited 20%. I'm not going to spend that. That's my money.[100]

The most recently released government-commissioned consolidated CDC research report by Mavromaras and colleagues found that card holders experienced 'a large decline in the level of autonomy and control' due to the program.[101] This research reported that the majority of CDC holders experienced 'feelings of discrimination, embarrassment, shame and unfairness as a result of being on the Card … across all trial sites'.[102] Out of 1963 valid responses, 74 per cent of survey respondents said they wanted to come off the CDC.[103] Mavromaras and colleagues reported that 50 per cent found it harder to manage their money once they had been put on the CDC, and 52 per cent found '[s]aving money' harder once they were put on the CDC.[104] In addition, 29 per cent found it harder '[h]aving enough money' to pay 'for food' once they were put on the CDC, and 34 per cent found it harder to have 'enough money to pay rent' once they were put on the CDC.[105] Furthermore, 41 per cent found it harder to know how much money they had available to them once they were put on the CDC, and 41 per cent found it harder to look after their families once they were put on the CDC.[106] This is not indicative of program success, rather, it is a sign of regulatory failure. Indeed, there is no evidence that the compulsory CDC leads to generalisable benefits across the captured cohort of cardholders.

In addition to these findings in government-commissioned research, a recent quantitative analysis of the impact of the CDC in the Ceduna region was undertaken by Greenacre and colleagues.[107] This independent research drew upon administrative data, and the authors concluded '[t]here was little evidence that showed that the Cashless Debit Card affected targeted behaviours. Measures of gambling and intoxicant misuse show no significant change after the CDC's introduction'.[108] Greenacre and colleagues explained that although there was some increase in food purchased, this included an increase in less healthy discretionary foods. They also found that there were 'no substantive positive externalities … for crime or Emergency Department presentations'.[109]

Taken together, this evidence reveals a different picture about the CDC to that contained in the Explanatory Memorandum and accompanying documents rationalising CDC legislation. Many of these factors relate directly to continued academic, Non-Government Organisation and community criticism of the CDC.[110] Nevertheless, the government has displayed a troubling tendency to disregard all negative feedback about the CDC in order to extend the program. A central component of the CDC policy narrative is that the card reflects 'care' and 'support' for those on whom it is imposed, an issue to which the article now turns.

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[100]Mavromaras et al (2019), p 71.
[101]Mavromaras et al (2021), p 3.
[102]Mavromaras et al (2021), p 3.
[103]Mavromaras et al (2021), pp 191, 2.
[104]Mavromaras et al (2021), p 93.
[105]Mavromaras et al (2021), p 93.
[106]Mavromaras et al (2021), p 93.
[107]Greenacre et al (2020).
[108]Greenacre et al (2020), p 9.
[109]Greenacre et al (2020), p 10.
[110]Klein and Razi (2018); Vincent (2019); Marston et al (2020); Hunt (2017); Bielefeld (2017), APO NT (2020a); NACCHO (2020); NATSILS (2020); Milingimbi Community (2019).

Part 3: Cashless Debit Card narratives: redemptive or repressive violence?

The CDC involves privatisation of social security payment processes for affected welfare recipients who are coerced to have a contract with financial services provider Indue Ltd.[111] Cards are delivered to social security recipients without their consent, functioning as an anomaly in Australia's financial services landscape.[112] Social security recipients in CDC trial sites are informed that they must activate these cards if they want to access a large proportion of their payments. The experience of needing social security in a CDC trial site is therefore linked to the commodification of cardholders' everyday expenditure. This is consistent with neoliberal marketisation of welfare state practices, where boundaries are increasingly blurred 'between the market, civil society, and the state'.[113] As Povinelli makes clear, neoliberalism has ushered in 'new, commodifiable forms of repressive violence',[114] and the implementation and extension of the CDC reveals that this dynamic works in conjunction with longstanding oppressive colonial hierarchies. 'Repressive' is defined by the Oxford English Dictionary as 'inhibiting or restraining personal freedom' or 'oppressive'.[115] The adverse CDC outcomes referred to in Part 2 of the article indicate that the CDC is repressive in both senses. Although the word 'violence' can be understood in various ways, in this article violence refers to economic domination where those victimised by structural inequality experience constrained agency.[116] David Theo Goldberg also theorises violence as 'wrenching life's possibilities from some in order to elevate those of others'.[117] Such violence is reflected in the removal of rights and freedoms for people coerced to use the CDC in ways that prop up financial services industry profits. The 'contract value' for Indue Ltd from the CDC is '$70,340,628.60', covering the period 2015–22, with expenditure of '$44 million' occurring from 2015 to December 2020.[118] This has been for a small cohort of cardholders in any given year.[119]

Nevertheless, the state seeks to construct 'cognitive coherence' in its law and policy narrative on cashless welfare cards, inventing 'a logic that connects their account of the world, the legitimacy of their power, and the virtuous nature of their actions'.[120] The government narrative of 'redemptive care' via the CDC is a key aspect of this process, but it is important to question what is being redeemed and for whom. Politicians advocating the CDC have discursively framed the card as a 'support',[121] 'stabilising' and 'helping',[122] and as 'an exercise in practical love' and 'compassion'.[123] Portrayal of the CDC as a fundamentally caring gesture works to bolster the scheme and deflect criticism away from the unsavoury CDC outcomes experienced by many coerced trial participants. The dominant CDC discourse asserts that this is allegedly for their own good – whether

[111]Bielefeld (2017), p 30; Tilley (2020), pp 28, 32.
[112]Nehme (2019), pp 121–126; Tennant and Brody (2020), p 17.
[113]Schram (2018), pp 215, 221.
[114]Povinelli (2011), pp 127, 17.
[115]Stevenson and Waite (2011), p 1221.
[116]Farmer (2005), pp 7, 40.
[117]Goldberg (2002), p 131.
[118]Commonwealth (2021), p 98.
[119]See for example: Aboriginal and Torres Strait Islander Social Justice Commissioner (2016); Australian Government (2020); Australian Government (2021).
[120]Mulgan (2007), p 102.
[121]Ruston (2019).
[122]Porter and Tudge (2017).
[123]Turnbull in McCulloch (2017).

they realise it or not. For First Nations cardholders this repeats age old power patterns of so-called colonial 'care' that resulted in stolen children, land and labour.[124] There is a longstanding '*colonialist* care discourse' rationalising asymmetrical power relations, and yet what constitutes 'care' in colonial contexts is often contested by those who are subject to these arrangements.[125] As Narayan points out, 'care discourse can sometimes function ideologically, to justify or conceal relationships of power and domination'.[126] Miller likewise explains that some of what is labelled 'care can be the territory of brutal neglect and violation, deeply demeaning those who experience need'.[127] These dynamics are apparent in the context of the CDC where policymakers maintain that it would be uncaring to leave social security recipients without the card,[128] despite the reality that many cardholders experience this as a form of unwelcome stigmatising surveillance and coercive control.[129]

Less acknowledged by policymakers and card advocates is the fact that the CDC narrative of 'care' fosters a new form of commodification which is profitable for industry interests. Whilst political efforts have always been directed towards making poor people economically useful – seen in the Victorian era poor houses and in modern workfare regimes[130] – the commodification of poor people's spending patterns (and all the data captured in this process) shows that the welfare state has hit a new 'low' point in terms of corporate capture and regulatory politics. This reflects a broader international trend of prioritisation of industry interests over those of social security recipients. Hatcher describes this phenomenon as the 'poverty industry', where poor people are turned into 'revenue generators' and their personal information and personal experiences become data to be extracted, controlled and managed through outsourcing arrangements that benefit big business.[131] Hatcher is critical of the way that 'the poverty industry often leaves the poor with inadequate care and services'.[132] He contends that '[t]he poverty industry profits from poverty as the needy are left with unmet needs'.[133] Importantly, when peoples' experiences of poverty are rendered profitable for industry interests there is no incentive to eradicate poverty, instead there is a concerted push to maintain a 'captured' cohort of people to bolster the poverty market, setting up a system suitable for 'poverty profiteers'.[134]

Poverty surveillance has become a burgeoning global industry. As noted by Torin Monahan, 'conditions of abjection are increasingly viewed as problems to be managed with surveillance'.[135] Therefore 'the poor on welfare' are forced to 'submit to scrutiny of their purchases, as they are enmeshed in systems designed to detect transgressions and exclude or punish those who are found unworthy'.[136] It is important to note that

[124]Bielefeld (2015), pp 100–104; Bielefeld (2016), pp 851, 868.
[125]Narayan (1995), pp 133–134.
[126]Narayan (1995), p 135.
[127]Miller (2012), p 3.
[128]Ruston (2019); Porter and Tudge (2017); Turnbull in McCulloch (2017).
[129]Marston et al (2020); Bielefeld et al (2020); Klein and Razi (2018).
[130]Standing (2001), pp 173–174.
[131]Hatcher (2019), pp 1–6.
[132]Hatcher (2019), p 2.
[133]Hatcher (2019), p 2.
[134]Bielefeld (2017), p 31.
[135]Monahan (2017), p 191.
[136]Monahan (2017), p 191.

Forrest's 'vision' for the cashless welfare card involves 'existing data mining technology' being 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'.[137] Such surveillance induces further insecurity and instability into the daily lives of those on the lowest incomes. Thus, as Povinelli makes clear, there are good reasons to be 'skeptical' of the so-called 'compassion of market neoliberals'.[138]

Povinelli explains that 'the *arts* of caring for others always emerge from and are a reflection on broader historical material conditions and institutional arrangements'.[139] Colonial 'care' for First Peoples is often heavily weighted with demands for changed behaviour.[140] Colonial 'care' has also been coercive and infantilising in its historical manifestations, with demands that those being 'cared' for 'acquiesce to relationships of domination'.[141] Colonial 'care' dictates that Indigenous peoples be constructed as inferiorised subjects for the benefit of non-Indigenous interests, which then serves as the rationale for an endless cycle of 'interventions' that are 'masked by the illusion of missionary goodwill'.[142] The CDC continues these power dynamics in the existing trial sites. Thus people on the CDC are reported to 'need babying … [b]ecause they can't think for themselves and … they have to be forced' to behave appropriately.[143] Such infantilisation places affected First Peoples in a position of permanent pupillage. Under the banner of CDC 'care' the government can increase welfare state spending whilst ensuring that the dollars dedicated to such 'assistance' principally benefit the elite. This model of 'care' contrasts sharply with peoples need 'to be self-determining'.[144] The compulsory application of the CDC also falls short of the standards desired by many First Nations Peoples.[145] As Senator Patrick Dodson explains, 'First Nations peoples have been subjected too long to bad policy. They're fed up with government interference in their lives and they're fed up with being branded as irresponsible, lazy and unable to manage their own affairs'.[146]

The Federal Government's commitment to the project of social security system transformation via the CDC merely furthers neoliberal goals. What ends up being redeemed in this process is a recession proof income for the financial services industry, which is particularly important to them post the global financial crisis and amidst the economic fallout evident during the COVID-19 pandemic. Foucault makes clear that the goal of neoliberal governance is 'regulation of society by the market',[147] and Povinelli points out that neoliberalism involves the construction of 'new kinds of markets and market instruments (or "products")'.[148] This is apparent with the CDC – where this new financial 'product' has proven costly to the state and to those forced to use it.[149] In July 2019

[137]Forrest (2014), p 107.
[138]Povinelli (2011), p 184.
[139]Povinelli (2011), p 160.
[140]Bielefeld (2015), p 110.
[141]Narayan (1995), p 136.
[142]Watson (2009), p 52, 45.
[143]Mavromaras et al (2019), p 46.
[144]Miller (2012), pp 4.
[145]McGlade (2017); Commonwealth (2020b), pp 19–21; Commonwealth (2020c), pp 9–10; Commonwealth (2020d), pp 14–15.
[146]Commonwealth (2020b) p 21; also see Moreton-Robinson (2009) and McGlade (2017) on this point.
[147]Foucault (2008), p 145.
[148]Povinelli (2011), p 17.
[149]Bielefeld et al (2020), pp 1–34.

Labor Senator Carol Brown opined that the Government had 'failed to be up-front about the full cost of implementing the cashless debit card', including opportunity costs.[150] She stated in 2019 that 'over $160 million' budgeted for the CDC could 'instead … have been allocated to employment and economic development, early intervention services, and to drug and alcohol treatment'.[151] In 2017, Conifer reported that the CDC cost approximately $10,000 per participant per year to administer.[152] In 2018 the ANAO reported that the CDC was estimated by the Department of Social Services to cost between $3280 and $3713 per person per year to administer depending on whether it was rolled out in urban, regional and remote locations or just two remote locations (with the latter more expensive).[153] Up to the end of the 2019–20 financial year, the CDC had cost $79.754 million, inclusive of departmental and evaluation costs,[154] with significant employment and other opportunities lost to people in these regions. If extended beyond the current December 2022 sunset clause embedded in the latest CDC legislation, the scheme will divert further substantial resources away from other poverty alleviation possibilities, including those that have been expressly requested by Aboriginal peak organisations.[155] Government investment in these CDC costs reflects a new type of surveillance orientated 'poverty capitalism' that 'enacts forms of structural and symbolic violence against marginalized Others'.[156] The CDC makes a considerable profit for Indue Ltd,[157] who are reaping the 'spoils of … neoliberal governmentality'.[158] The CDC commodifies the poverty of the poor, and renders it an asset for Indue Ltd.

The CDC is a mechanism by which the unemployed/underemployed become participants in unique commodity relationships, albeit unwillingly, and with peculiar customer conditions: these are customers deprived of choice, coerced customers for Indue Ltd, essentially, the CDC holder becomes a 'conscript'.[159] Welfare recipients subject to the CDC recall a lost era of non-stigmatised cash payments, where they could enter into contracts for goods and services of their choice with merchants of their choice. However, the CDC ushers in 'new justifications for belonging'[160] so that contractual freedom is only given to those meeting moralistic objectives imposed from above. For First Nations Peoples in Australia, curtailing contractual freedom has a lengthy colonial history and has long been rationalised on the basis of good intentions.[161] Although it is colonists who benefitted most handsomely from these arrangements, the ruse of 'redemption' has been a powerful force in paternalistic policy affecting First Peoples.

The narrative of redemption through cashless welfare frames the policy problem as one of lack of will power, an inability to engage in self-regulation, on the part of those whose incomes the government seeks to coercively manage.[162] Indigenous peoples in

[150]Commonwealth (2019b), p 1222.
[151]Commonwealth (2019b), p 1222.
[152]Conifer (2017).
[153]ANAO (2018), p 38.
[154]Accountable Income Management Network (2020).
[155]APO NT (2020a); NACCHO (2020); NATSILS (2020).
[156]Monahan (2017), pp 191–192.
[157]Bielefeld (2018a), pp 15–16.
[158]Povinelli (2011), p 18.
[159]Tennant and Brody (2020), p 17.
[160]Povineli (2011), p 19.
[161]Bielefeld (2015), pp 100, 105–106.
[162]Bielefeld (2018c), pp 758–759.

Australia have long been stereotyped with 'racialised ascriptions of defective will-power'.[163] Their defective will power is portrayed as the reason for substance abuse and addiction to welfare payments.[164] Povinelli maintains that such framing has 'long been an alibi of … neoliberalism', where the idea of defective 'will becomes a way of holding those who suffer accountable'.[165] According to its advocates, the CDC is meant to harness the unruly will of social security recipients. Thus, their consumer rights, human rights, and choice over which financial services products to use are sacrificed allegedly to facilitate the redemptive end of sobriety, work readiness and thrifty discipline.

That such regulatory power is frequently experienced as repressive violence by First Nations Peoples seems unimportant to government advocates of the CDC. In October 2019, the Senate Standing Committee on Community Affairs heard from the Central Land Council (CLC), representing over 24,000 Indigenous people in the southern part of the Northern Territory, that compulsory cashless welfare cards are 'harsh and punitive', treating 'all people on income support as though they are a burden to society, unable to manage their lives or care for their families'.[166] The view was expressed by Maimie Butler, the Ngaanyatjarra, Pitjantjatjara, Yankunytjatjara (NPY) Women's Council chairperson, that the CDC would 'take us right back to when our ancestors first walked into the missions and [were] … fed by rations'.[167] Butler argued that the proposed CDC extension to the Northern Territory was considered violent rather than supportive, stating 'we are the poorest people on the earth and you're still attacking us'.[168]

From the perspective of many of those to whom the government sought to impose the CDC scheme, cashless welfare cards can be seen as a form of repressive violence.[169] The cards stigmatise social security recipients, casting aspersions on their character and budgetary capacity. They bolster asymmetrical power relations that mirror those of earlier periods in Australia's colonial history.[170] Cashless welfare cards have often been combined with mandatory workfare obligations for Indigenous peoples under the Community Development Program, so that people labour for 'rations', as has occurred under past paternalism. The cards individualise responsibility for structural violence and market failure, while imposing economic domination along raced and classed contours.

As concerns the Northern Territory, although the Federal Government consulted some communities over *how* transition from the BasicsCard to the CDC would occur[171] they refused to consult over *whether* this transition would occur. There has been no consultation providing an option to transition off compulsory cashless welfare cards altogether, and no 'free, prior and informed consent' as required under Article 19 of the *United Nations Declaration on the Rights of Indigenous Peoples*. This failure to engage in human rights compliant consultation has led to calls in the Northern

[163]Nicoll (2012), p 184.
[164]Bielefeld (2018c), p 749.
[165]Povinelli (2011), p 33.
[166]Douglas quoted in NITV (2019).
[167]Butler quoted in Heaney (2019).
[168]Butler quoted in Heaney (2019).
[169]The Senate Community Affairs Legislation Committee (2019), pp 25–26, 40–41; Milingimbi Community (2019).
[170]Bielefeld (2015).
[171]The Senate Community Affairs Legislation Committee (2019), p 2.

Territory from Milingimbi community members to 'ask us don't tell us' and 'treat us like humans'.[172]

Significantly, the government's earlier claims that the CDC was 'co-designed' 'with local leaders'[173] was contested when Indigenous leaders from the Ceduna and East Kimberley trial sites went on the public record in 2017 stating that the scheme imposed by government was considerably different to what they had thought would be introduced. Mima Smart from Yalata in the Ceduna region stated that she thought the CDC would be targeted for people with alcohol problems rather than compulsory for everyone, and that the broadly applied mandatory CDC was causing 'suffering' and needed to be cancelled.[174] Lawford Benning, Chairperson of MG Corporation in Kununurra, stated that key conditions stipulated by the four Indigenous people consulted were absent from the CDC model imposed by the government.[175] These conditions included that the local Indigenous community be provided with resources for wrap around services before the trial commenced, and that they be in charge of a non-intrusive CDC exit process.[176] Benning was one of the original four consulted, but stressed that others in the community were not, that they should have been, and that the 'overwhelming majority' of people on the CDC in his community did not support the continuation of the program.[177] Rather, the CDC is seen as a 'top-down imposition' by government that has 'resulted in an erosion of individual liberty' where cardholders 'have lost the capacity to control their own lives'.[178] In claiming that there is ongoing support by the leadership in the Ceduna and East Kimberley regions the government treats these people as though they had never spoken.

In the parliamentary debates on the Cashless Welfare Continuation Act 2020 it became apparent that the Federal Government had overestimated the degree of community support for the CDC. Whilst in the form of a Bill, this proposal had been the subject of a parliamentary inquiry before the Senate Standing Committees on Community Affairs, which elicited 145 submissions, the vast majority of which were opposed to the mandatory CDC as a permanent measure. Strong opposition to the scheme was apparent from numerous First Nations organisations who were not convinced by the Federal Government's description of the CDC as a non-discriminatory measure.[179] As the Northern Land Council explained, the government's plan for 'introducing [the] CDC based on high levels of welfare dependence and community harm in an area utilises inequality to rationalise discrimination'.[180] Several Indigenous groups have indicated deep disappointment following the passage of the Cashless Welfare Continuation Act 2020.[181]

Conclusion

Although the government's dominant discourse describes the CDC as a supportive mechanism for welfare recipients – one capable of addressing their addictions and

[172]Milingimbi Community (2019).
[173]Porter and Tudge (2017).
[174]Smart quoted in Davey (2017).
[175]MG Corporation (2017), pp 1–4.
[176]MG Corporation (2017), p 2.
[177]MG Corporation (2017), pp 2–4.
[178]MG Corporation (2017), p 4.
[179]APO NT (2020a), p 3; NACCHO (2020), pp 3–5; NATSILS (2020), pp 6–7.
[180]Northern Land Council (2020), p 3.
[181]Collard (2020).

building a bridge to their 'redemptive end'[182] of 'responsible' socioeconomic behaviour, 'care' is defined in terms of colonial authorities and neoliberal entrepreneurs rather than reflecting views of numerous people subject to these cards. This repeats a disempowering dynamic that resonates strongly with Australia's racist colonial legacy. While Australia has a lengthy history of restricting access to money for First Peoples,[183] contemporary social security law in Australia is also influenced by global trends of poverty surveillance that underpin the 'poverty industry'.[184] Thus the CDC props up profits for the financial services industry at the expense of social security recipient's budgetary autonomy. The card disproportionately impacts on First Peoples who have been portrayed as inherently problematic spenders, as opposed to people with problems produced by the impoverishing conditions of colonialism. Cashless Welfare Cards reduce access to cash only merchants and service providers, add costs to goods and services by merchant-imposed card transaction fees, increase social exclusion and stigma, create additional difficulty in providing for family needs, and undermine the autonomy of welfare recipients.[185]

However, the dominant discourse promotes powerful players as moral entrepreneurs and champions of technological innovation via cashless welfare cards – what ends up being redeemed via the CDC is elite privilege – whilst simultaneously creating significant problems for the people subject to these measures. The unfortunate tendency of government is to disregard the voices of those genuinely struggling under the strictures of compulsory cashless welfare cards, yet these people have more experience living on low incomes than wealthy technocrats. Meanwhile, other productive possibilities to empower people struggling with poverty are overlooked; and as Mulgan states, '[a] government that is wasteful, or that squanders resources that are badly needed elsewhere, or that succumbs to the temptation to serve the provider rather than the person in need, is acting immorally whatever its claimed virtues'.[186]

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[182]Povinelli (2011), p 12.
[183]Bielefeld (2015), p 100.
[184]Hatcher (2019).
[185]Bielefeld et al (2020), pp 2–26.
[186]Mulgan (2007), p 146.

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