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THE CASHLESS DEBIT CARD TRIAL
EVALUATION: A SHORT REVIEW

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Centre for
Aboriginal Economic
Policy Research
ANU College of
**Arts & Social
Sciences**

CAEPR TOPICAL ISSUE 1/2017

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April 2017



The Cashless Debit Card trial evaluation: A short review

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Topical Issue No. 1/2017

An electronic publication downloaded from <caepr.anu.edu.au>.

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Acknowledgments

I am extremely grateful for valuable comments that Rob Bray provided on an earlier version of this paper and feedback from two anonymous reviewers. Charmaine Crowe also provided useful comments and drew my attention to the gambling statistics for South Australia for which I am most grateful. Thanks also to Hilary Bek for skilful editing. The final document and any errors in it are however my responsibility alone.

Acronyms

ATM	Automated Teller Machine
CDC	Cashless Debit Card
CDCT	Cashless Debit Card Trial
EFT	Electronic Funds Transfer
FASD	Foetal Alcohol Spectrum Disorders
KPIs	Key Performance Indicators
LGA	Local Government Area
NGR	Net Gambling Revenue
TAMS	Takeaway Alcohol Management System

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Introduction

The concept of a 'Healthy Welfare Card', now renamed as the Cashless Debit Card (CDC), was a recommendation of the Forrest Review into Employment and Training (Forrest 2014). It was seen as a development from income management which has been occurring in parts of Australia since the Northern Territory Emergency Response, when it was first introduced for Aboriginal communities there. The CDC appears to operate a little differently from the Basics Card¹ used in the Northern Territory income management program. The CDC is a debit card which can be used for any purchases excluding certain forms of gambling, drugs and alcohol. Unlike the Basics Card, which prohibits purchase of a similar range of goods and services but can only be used in registered stores, the CDC is meant to be acceptable to any retailer for all purchases other than the prohibited categories. Trials of the CDC began in Ceduna region (South Australia) on 15 March 2016, and in the East Kimberley region (Western Australia) on 26 April 2016. All working age income support payment recipients receive 80% of their payments through the card. In March 2017 the Department of Social Services released a 'Wave 1' evaluation undertaken by Orima Research of the CDC trials in Ceduna and Kununurra (Orima 2017). This paper reviews this Evaluation Report.

The Evaluation Report has several sections, including one that looks at whether the Key Performance Indicators (KPIs) have been achieved, as well as a longer section that considers some broader evaluation questions. The five Appendices include a great deal more detailed data from participant interviews and focus groups with community leaders and stakeholders. There is some rich information in the qualitative reports and additional data but not all of it that might be relevant finds its way into the interpretation of some of the quantitative data presented. In this review I have tried to draw on some of this material to interpret some of the quantitative results. There is more one could do with that rich data, which raises as many questions as it answers.

The structure of this paper is as follows. First it outlines the evaluation methods Orima used and provides some comments. Then it follows the Orima Report's structure and examines the evaluation's findings in relation to the KPIs for the program. There are output and outcome KPIs which the evaluation reports on. The next section of this paper examines the evaluation's response to some broader evaluation questions. There is some inevitable overlap between the reporting against the outcome KPIs and the Wave 1 evaluation's reporting against the broader evaluation questions. Following this, the paper

makes reference to some additional data in the many appendices which deserves mention. The paper finishes by reframing the Evaluation Report's conclusions and reflecting on the relationship between evaluation and policy making in this complex space.

The evaluation methods

The evaluation uses three different sources of information:

- administrative data, such as Centrelink payment data and other information from government departments
- interviews and focus group sessions with a total of 73 community leaders and stakeholders in the sites, 85% of the latter being non-Indigenous (which is referred to as the qualitative research), and
- interviews with trial participants (only 9% of whom were non-Indigenous), family members of participants and other community members residing in the regions (referred to as the quantitative survey). An 'intercept sampling' method was used by interviewers at key locations in the communities.

The evaluation was conducted in August 2016 in the Ceduna area and in September/early October 2016 in the Kimberley (Orima 2017:4–5).

The trial participants and the evaluation sample

The Evaluation Report does not give any information at the outset about the actual numbers of participants in the trial at each site. That information is in the Initial Conditions Report which shows that 757 Ceduna and 1247 East Kimberley residents had received income support payments through a CDC by 4 October 2016 (Orima, n.d.:13). The CDC was applied to all working age income support recipients, while those on Age or Veteran pensions or working can voluntarily join the program.² In Ceduna, 45% of Aboriginal and Torres Strait Islander residents had a CDC, and only 6% non-Indigenous residents; while in East Kimberley, 49% of Aboriginal and Torres Strait Islander residents and 10% of non-Indigenous residents had a CDC.³ Evaluations of income management have shown rather different results for the compulsory participants compared to results for voluntary participants (Bray 2016). Clearly, although there was a possibility of opting to join the trial few had, so that the vast majority of participants are compulsorily on the CDC⁴. It would have been useful if basic information about the numbers on the trials at the time of the evaluation had been included in the main text of this report.

Some graphics in the Evaluation Report are hard to comprehend precisely – in relation to the total sample of 552 participants in the evaluation, and 78 family members, as well as 110 non-participant local people sampled (Orima 2017:16) – but it appears that the sample of participants was 91% Indigenous and predominantly women (63%) rather than men (37%). At least in the case of Ceduna, 43% of the non-participants surveyed did not live in the Ceduna area.

Overall the methodology of the study raises many issues. We are told that the results were weighted to reflect the age, gender and Indigenous status of the total number of CDC trial participants in the two regions. Despite the number of evaluation respondents being far greater in the East Kimberley (454) than in Ceduna (286), the weighting ensured the two sites were treated as if their numbers were equal, thus giving greater weight to the responses from Ceduna over those from East Kimberley. There is no explanation given for this weighting decision. The evaluation also relies on subjective perceptions without adequate triangulation with other sources. The lack of adequate baseline data on the outcome measures makes real assessment of change difficult. In addition the results in many cases reflect quite small numbers of people and may not be statistically significant⁵. One small example of the methodological problems is on page E1, where a footnote says that ‘Some participants in the evaluation who were not interviewed for the Initial Conditions Report completed a questionnaire retrospectively’ and this retrospective data was included in the average rating on ‘Issues in the local community’. Such retrospective data is likely to be influenced by recall bias. This is poor evaluation practice.

The ‘intercept’ system for interviewing was to locate interviewers at sites of high pedestrian traffic (in front of shops, for example) and approach every ‘nth’ person⁶. Many were screened out presumably because they were neither participants, nor family members, and there was a much higher number of refusals (almost equal to participants) in Kununurra than in Ceduna. There is no comment on what this might mean for the nature of the final sample. In addition there were interviews with ‘key stakeholders’ and community leaders. None of the survey instruments used are made available for review in this report, which would have been useful for assessing the questions themselves.

Evaluation findings in relation to the Key Performance Indicators

We are told that the trials had a number of *output* KPIs which were largely achieved. That is, participants received their cards, started using them in a timely way, and 80% of their income was quarantined for use on these cards (i.e. only 20% of their income was provided in cash). Community leaders who were interviewed continued to support the trials. Some KPIs were partially achieved, such as people understanding the constraints on the card usage, while not necessarily knowing what to do in certain circumstances (e.g. loss of card [897 cards were lost, pA6], or how to find out the balance on the card). There is no mention of the problems that lost cards may have caused participants, nor how quickly they were replaced. Some 78% reported that they had not changed ‘where and how they shopped’ (p18) since going on the card but 18% (almost one in five) had encountered difficulties accessing some allowable things they wanted to purchase using the card. On pB7 we find that altogether 46% of participants had experienced problems using their card.

The *outcome* KPIs are more important, particularly if there were measurable targets for behavioural changes – however these are not specifically identified. It is necessary to scan the Initial Conditions Report (Orima n.d.) to find these together on pps.A11–19, or search through a lengthy Appendix A of this report to find them. It would have been useful had these been summarised in the body of the Wave 1 Evaluation Report (Orima 2017).

The first outcome KPI obviously related to *alcohol consumption*: 24% of participants thought alcohol consumption had reduced in the community, while 25% reported that their own drinking had reduced (7% reported that alcohol use generally had increased). A higher proportion of community members (41%) thought alcohol use had reduced. However, what is not clear is whether these perceptions are accurate. They may be, as there is evidence of reduced alcohol purchase from the Kununurra bottle shop, but the question is whether the cause of any actual reduction is the CDC or alcohol restrictions introduced in Ceduna in 2015, and takeaway alcohol management and other restrictions operating in the East Kimberley (pC12).⁷ Some Ceduna community leaders interviewed felt that the alcohol restrictions may have had a very significant impact as they had noticed no further changes since the start of the Trial (pC1). A Review of the Takeaway Alcohol Management System (TAMS) trial in the East Kimberley, covering the period January–October 2016, reports that ‘many people could not separate TAMS from the broader welfare reform agenda’

(Codeswitch 2016:13) referring to the CDC; thus the TAMS review recognises the problem of attribution which the CDC evaluation glosses over. So attribution is a problem, as is such a diversity of perceptions. One would think that if there had been a change it would be perceived with a degree of consistency across the community, not just by a minority of 24% (and this applies to other areas where perceptions varied greatly).

In relation to *drug use*, 24% reported less illegal drug use than before the start of the trial. Reliability of data and reported behaviour about illegal activity is always hard to judge. It may be that people are likely to report what they think the interviewer wants to hear in such cases. Further information which is provided later in the report reinforces how difficult it is to get reliable data on drug use.

In relation to *gambling*, 32% of participants reported gambling less and only a handful reported gambling more. In this case, some more interesting data is that poker machine revenue was 15% down on the same period in 2015 in the six months of the trial in Ceduna, which *may* verify these perceptions. However there is no consideration of whether there may be other reasons for this drop in gambling revenue. It is simply assumed that it results from the CDC trial, yet a graph on pA40 shows gambling revenue in the Ceduna region fluctuating considerably month by month both before and after the trial. Furthermore, data for South Australia shows revenue from poker machines dropping in Ceduna Local Government Area (LGA) and across the State over at least a five-year period, making it very unclear what the CDC is contributing.⁸ There are no poker machines in the East Kimberley trial regions, so this poker machine use measure is irrelevant there (pC12).

Other indicators related to whether people were aware of various support services available, such as drug and alcohol services, financial management support etc. The levels of awareness were about double the levels of actual use in both East Kimberley and Ceduna.

Responses to the broader evaluation questions

On page 21 of the Wave 1 Evaluation Report (Orima 2017) we are provided with the key questions the evaluation was to answer:

1. *What have been the effects of the CDCT [Cashless Debit Card Trial] on program participants, their families and the broader community?*

- *Have there been reductions in the consumption of alcohol, illegal drug use, or gambling?*

- *Has there been a reduction in crime, violence and harm related to these behaviours?*
- *Has there been an increase in perceptions of safety in the Trial locations?*
- *Have there been any other positive impacts (e.g. increase in self-reported well-being, reduction in financial stress)?*

2. *Have there been any circumvention behaviours (e.g. participants selling goods purchased with cashless debit cards to obtain more cash, increase in humbugging or theft) that have undermined the effectiveness of the CDCT?*

3. *Have there been any other unintended adverse consequences (e.g. feelings of shame, social exclusion)?*

4. *What lessons can be learnt throughout the Trial to improve delivery and to inform future policy?*

- *How do effects differ among different groups of participants (e.g. men compared to women, people from different age groups)?*
- *Where has the Trial worked most and least successfully?*
- *To what extent can any changes be attributed to the Trial as opposed to external factor such as alcohol restrictions?*
- *Can the contribution of the debit card be distinguished from that of the additional services in the Trial locations provided via the CDCT support package?*

Question 4 has not been answered in this Wave 1 Evaluation Report and is expected to be answered later in the reporting framework, with the exception of the fourth dot point above. Since the additional services had barely commenced at the time of the Wave 1 Evaluation Report, the evaluation would be able to conclude that any effects were related to the CDC itself, not the additional services. Why other issues of attribution are not discussed in this Wave 1 Evaluation Report is unclear. There is some repetition of data used to assess KPI performance in this section of the Orima Report (2017).

Have there been reductions in the consumption of alcohol, illegal drug use, or gambling?

According to the report, 22% of participants reported reduction in at least one of the three 'evils', but notably 34% said they did not practise any of those behaviours before the trial and 43% reported no change. Thus for 77% of participants there has been no positive impact of the trial. Matters to do with alcohol consumption have

been largely covered above. The evaluation reports that perceptions of less alcohol consumption may have been affected by the season as cold weather would drive people indoors. There were indications that illegal drug use had reduced slightly but community leaders in Ceduna did not think there had been any change, whereas Kimberley community leaders thought there had been some improvement. One would expect if there were *program* effects on the drug use, they might be similar in the two locations, suggesting that other factors may also be in play.

There were minimal positive impacts of the CDC on drug use identified by stakeholders. In Ceduna,

concern about methamphetamines ('ice') had significantly heightened among the stakeholders compared to when they were interviewed at the Initial Conditions stage of the research (i.e. in April 2016). Most stakeholders consistently reported ice as being more prominent and easily available at Wave 1 compared to the Initial Conditions stage. (Orima 2017:pC2)

As 'ice' is relatively low cost, it was thought that the CDC would not prevent its use, and there was a suspicion from health workers that marijuana is being laced with ice to generate addiction. Furthermore, 'ambulance presentations demonstrated that there hasn't been a significant change in marijuana and other drug use' (Orima 2017:pC3).

In relation to gambling, poker machines were only available in Ceduna, and people were unable to comment on online or informal gambling which may continue as before, although there was anecdotal evidence of some slight reductions. Whether card games, for example, had simply gone into less public places is hard to know. The question to participants regarding reduction in gambling related to their spending \$50/day or more on gambling, which would certainly be difficult to do on 20% of a welfare payment; 27% said they had done this less since the start of the trial, which could mean they spent less on gambling, but still participated in it. So the question is whether the trial is really about reducing gambling, or gambling expenditure, or both?

Has there been a reduction in crime, violence and harm related to these behaviours?

Police crime statistics are ambivalent on this – there has been no decline in crime overall in the East Kimberley and a suggestion that more children are stealing money there. However, some stakeholders mentioned a

decrease in Automated Teller Machine (ATM) vandalism (this could have been double-checked with the banks) and a reduced number of injuries indicative of domestic violence. Overall perceptions of reduced crime were mixed, and the same was true in relation to whether perceptions of safety had improved.

Stakeholders in Ceduna, 'identified some increase in domestic violence/intervention orders –although it was not clear whether this was due to changes in reporting requirements or increased community awareness, understanding and willingness to take action' (Orima 2017:pC3), or the CDC.

Ceduna community interviewees also noted that ambulance call-outs to public places had reduced, but to private locations had increased, suggesting only that the location of anti-social behaviours had perhaps changed. Thus the outcomes in this area seem quite limited at this stage.

Have there been any other positive impacts?

There is the question of whether there have been any other positive impacts, such as an increase in self-reported wellbeing, or reduction in financial stress. According to the Wave 1 Evaluation Report, community leaders believe that there have been some other positive benefits, including in participants' financial abilities (such as ability to pay bills or buy household items) as well as in nutrition and general wellbeing. However, this data has to be treated with some caution as we are told that community leaders wanted the trial in the first place. They may therefore be more likely to perceive that positive change has occurred. However, some anecdotal examples from other stakeholders seem to substantiate these perceptions at least to some degree, and the participant survey suggests that 31% of participants had been able to save more, and for those 46% with children, 31% of these said they were better able to care for them. This may indicate that the trial is working for these participants. However, since participants knew that this was the intent of the trial there is a risk in such a survey that they would be inclined to say things had improved. Such common social science methodological problems are not discussed in the interpretation of the findings. Nor can an evaluation explore whether alternative programs of financial literacy education and savings clubs might have achieved a similar outcome for the longer term. The results in terms of whether 'humbugging' had reduced are also ambivalent – some participants think it has, others, particularly non-participants who may have more access to cash (and perhaps were the targets of the humbugging), think it has got worse.

The most significant finding is this:

Amongst family members, 27% said the Trial had made their family's life better and 37% that it had made it worse (net -10pp, see Figure 12). Across participants interviewed, 22% said it had made their lives better and 49% that it had made their lives worse (net change -26pp). These figures were fairly consistent across the two Trial sites (Orima 2017:34).

That almost half the participants felt that the trial had made their lives worse is a worrying result, particularly given the rather limited substantiated positive results to date. Though we can welcome the fact that 22% felt their lives were better, the question is, at what cost? Is it acceptable for public policy to make more than twice as many participants' lives worse in order that 22% can say their lives are better? Calculating a so-called 'net' improvement is hardly valid when we are talking about different participants and their families who are experiencing real outcomes.

The reason people felt their lives were worse related to 'Not being able to spend money on things you need to (e.g. bills, appointments) or want (e.g. personal items)'. These sorts of problems may have significant consequences for people's health or ability to retain services. Other reasons given were 'Not being able to send money to kids/family/friends or buy them presents/go on excursions (e.g. the show)' (Orima 2017:p36) which can mean children feel socially excluded, and 'Not being able to see how much money you have' (Orima 2017:p36) and related money management problems. People living on very low incomes have to be careful money managers to survive so making this difficult is not helpful. Of non-participants who said the trial had made their lives worse, the most common reason was to do with a perception of increased stealing and humbugging.

The evaluation found at least eight ways in which participants can circumvent the CDC restrictions, but it is unclear how widely these are being used, and it would be difficult for any evaluator to find out precisely. At the same time it found a number of problems for people wanting to use the cards in perfectly reasonable ways. For example, transferring money to children at boarding schools; making second hand purchases or buying where the seller has no Electronic Funds Transfer (EFT) facility, making small payments like swimming pool entry, retailers outside the trial areas not accepting the card, and problems making automatic payments. While some of these actions should apparently be possible, in practice, people have problems with the CDC in such matters.

After reporting these very mixed findings the conclusions are rather surprising – that the trials have met the KPIs and, 'In particular the Trial has been effective in reducing alcohol consumption, illegal drug use and gambling – establishing a clear "proof-of-concept"' (Orima 2017:p46). It does acknowledge little impact on crime and safety but suggests that it is because it is too soon to see such outcomes yet, which may be true. Furthermore, it provides some evidence and draws conclusions that the positive changes that have occurred can be attributed to the CDC rather than other services that have been put in place. Since these new services had not been operating for very long at the time of the evaluation on that point the evaluation is correct but what it fails to consider is that changes may be attributable to other factors entirely, such as the alcohol restrictions, for example. In future evaluations the ability to differentiate the effect of the CDC from the service provision or any other factor will be even more difficult.

Data in Appendices not discussed

Whilst much in the Appendices provides the detailed results behind the evaluation's more summary findings, there is material within them that appears not to have been highlighted or linked to the interview data and that might have provided important insights. Some of these have already been mentioned above where reference to Appendices is made in reviewing the evaluation's findings. But there are other issues.

For example, data is provided which shows that 55% of transactions on the cards failed due to insufficient funds (Orima 2017: pA6). That is nearly 21,000 transactions, where people were unable to purchase what they wanted. However, only 1% of failed transactions related to trying to use the card for prohibited purchases. This indicates some hardships and poverty and/or the problem that people did not know what their card balance was, indicating the challenge of money management using this card. Another reported problem related to the need to access phones and internet to find card balances, which can cause many problems for those without phones, phone credit, internet access, or not being in a mobile phone or internet server area.

According to the Wave 1 Evaluation Report, stakeholders also identified a range of needs in Ceduna and the surrounding remote communities (Orima 2017:pC7):

- Diversionary programs to provide more opportunity and activities
- Financial counselling

- Domestic violence services including safe houses and community education
- Mental health
- Homeless/transitional accommodation – including for those entering and leaving rehabilitation clinics
- Programs for men
- Programs for 8–12 year olds
- Support services that are located / based in remote communities and not just in Ceduna.

Stakeholders identified the following service needs in the East Kimberley (Orima 2017:pC19):

- Mental health
- Youth programs (including diversion and support), especially for ages 9–16
- Diagnosis of Foetal Alcohol Spectrum Disorders (FASD)
- Staffing of Wyndham services
- Transitional accommodation and holistic support to assist people leaving rehabilitation to re-enter the community and maintain changes in their behaviour
- Rehabilitation – stakeholders reported that this service was only available in Wyndham, not Kununurra
- Diversionary programs
- Employment programs.

Whilst some of these may be developed in association with the CDC trial, it seems strange that services were not provided before the CDC was rolled out across all working age income support payment recipients, at least some of whom did not drink, use drugs or gamble before the trials began.

It also seems that major problems of housing and unemployment in both locations showed no improvement as a result of the trials. This is hardly surprising as the trials were not designed to solve these problems – yet arguably, addressing these problems may be essential to improving a raft of social outcomes in both locations.

Conclusion and reflections

This takes me back to the purpose of the trials, which were ‘aimed at finding an effective tool for supporting disadvantaged communities to reduce the consumption and effects of drugs, alcohol and gambling that impact on the health and wellbeing of communities, families and children’⁹. Whilst these are worthy goals, the issue

that arises is the contexts in which these goals are being pursued. Both Ceduna and the East Kimberley have major social and economic problems which are complex, and have resulted from a range of historical factors as well as contemporary policies. It seems extremely naïve to think that controlling people’s income to the degree now happening in these trials will be the solution to these complex problems. It is ‘silver bullet’ thinking to believe that these simple policy changes, which bring government increasingly into the everyday lives of welfare recipients and reduce their own capacities to control their lives, will solve the challenges they face. The lists of service needs from the stakeholders in each location illustrate the many challenges they are facing. The opportunity costs of undertaking CDC trials rather than using all available funds to provide some of these much-needed services has to be justified, even acknowledging that some effort to improve services is underway. Government resources are finite and the funds dispersed in operating the CDC could instead be spent on a much-needed service.

Clearly, the trials have longer to run and more improvements may eventuate. But the costs and benefits must be clearer – we have no information about the total budget costs for these trials¹⁰, nor the financial costs per participant. Nor can we discount the real costs for participants for whom the trials seem totally unnecessary as they have never participated in the targeted anti-social behaviours, or those for whom the trials have achieved no change or only negative changes in their lives, which is the majority of participants according to the Wave 1 Evaluation Report.

Finally, the Commonwealth Government was quick to highlight the conclusions of the Wave 1 Evaluation Report. Yet a more thorough reading of the Report leads to significantly different framing of the conclusions:

- there has been reduction in alcohol use, but it is hard to identify whether this was attributable to the CDC trial or alcohol restrictions in both locations, particularly TAMS in the East Kimberley
- there have possibly been reductions in illegal drug use although there is little hard evidence; there is concern about increasing access to ‘ice’ and its relative low cost, particularly in Ceduna
- some evidence exists that poker machine income had dropped in Ceduna, but there is no discussion of any other factors that may have caused this, particularly given fluctuations evident before and after the trial commenced and a statewide reduction trend

- in relation to other forms of gambling it is hard make assessments – some public gambling may have moved to private venues and expenditure on gambling may have reduced
- some survey and anecdotal evidence indicates that people are spending more on household items and various other positive expenditures, but there is no ability to track that from store sales data, so it is hard to quantify and verify
- three-quarters of all participants said that the CDC has made no positive change to their lives and almost half of all participants said it had made their lives worse; only one-fifth of participants said it had made their lives better.

Public policy is not well served by research and evaluation which is not nuanced and data which is not carefully interpreted. Politicians are busy and do not always focus on anything but the conclusions; and if those conclusions are what they want to hear they may well look no further. In this case, the Minister announced that he will extend the program indefinitely (Tudge & Porter 2017). This seems to be a very premature decision as the evaluation process will not be completed until June 2017 (Orima 2017:1). The Minister also seems open to expanding the program's coverage in due course (Tudge 2017). But this decision may be a mistake as it may lead to poor public policy and bad public expenditure.

If the CDC is helping some participants that is a good thing, but for most it is apparently making no difference or making their lives worse. Perhaps the critical evaluation question that needs to be asked is *'which people is it useful for, and exactly how is it helping them?'* And perhaps for these people the card would be even more effective with so-called 'wrap around services' added to help them make longer-term changes in their lives. If it really is helpful for some, then the program should be targeted at those whose behaviours demonstrate they need it, and those who feel the program will assist them in the short term. Others who are not in any need of the CDC, and those for whom it is making no difference or making their lives worse may well benefit from quite different programs to improve their socioeconomic conditions. Furthermore the question remains, how long will people be left on this card? In the Northern Territory some have been on income management for almost a decade already. What is the pathway off income management?

There is an also an opportunity cost to any program. If these trials are not helping people who live in considerable poverty and a different program could, then change is required. Positive programs and services to

address the problems, including housing and job creation that could make many more people's lives better (Klein 2017), may offer far greater value for public funds than the CDC program and do more to improve Indigenous lives. The wider public deserves to know how the costs and benefits of programs stack up. We cannot make a final assessment of these trials from this inadequate Wave 1 Evaluation Report, but it raises many questions which the final evaluation report will need to answer, if it can (Cox 2015). Evaluation in complex social settings is difficult, but the increasing encroachment of government into the minutiae of people's lives deserves far greater justification than this evaluation provides.

Notes

1. See www.humanservices.gov.au/customer/enablers/about-basicscard#a4 for a full list of prohibited purchases.
2. See: <https://www.dss.gov.au/families-and-children/programmes-services/welfare-conditional/cashless-debit-card-trial-overview> for details of participation in the CDC trial.
3. There seems to be an error in the text on p13 of the Initial Conditions Report (Orima, n.d.), which states that 24% of Aboriginal and Torres Strait Islander residents in Kununurra had a CDC while Fig 5 (that it refers to) on p14 shows the percentage as 49%.
4. Hidden in an appendix on pB6 we find that 99% of 548 participants in the evaluation were on the compulsory program.
5. Whilst some guidance about statistical significance overall is given on p14, the statistical significance of specific results are rarely mentioned. Unless results are statistically significant they may only result from random variations.
6. The frequency varied according to the density of people at interview locations, but was never below every second person (Orima 2017:12).
7. Alcohol restrictions came into effect on 15 September 2015 in Ceduna (Government of South Australia 2015). Various alcohol restrictions have been in place since 2009 in the East Kimberley (Department of Racing, Gambling and Liquor n.d.), but an additional 12-month Takeaway Alcohol Management System (TAMS) trial began in December 2015 (Codeswitch 2016).
8. See [http://www.cbs.sa.gov.au/assets/files/NetGamblingRevenuegroupedbyLocalGovernmentArea\(Council\),for2011/12-2015/16](http://www.cbs.sa.gov.au/assets/files/NetGamblingRevenuegroupedbyLocalGovernmentArea(Council),for2011/12-2015/16). For Ceduna, the Net Gambling Revenue (NGR) per venue has dropped from \$552 551 in 2011/12 to \$444 444 in 2015/16, showing a clear downward trend, despite a slight rise in 2014/15. A similar downward trend is evident across the state (from \$743 million to \$719 million in aggregate NGR per LGA over the same period).
9. See description of the trial at: <https://www.dss.gov.au/families-and-children/programmes-services/welfare-conditional/cashless-debit-card-trial-overview>
10. The Orima (2017) evaluation does not provide a figure for the cost of the trial but information made public on 2 May 2017 indicates that the trial is costing \$18.9m, approximately \$10,000 per participant (Conifer 2017).

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