29 September 2017

Senate Standing Committee on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600

By email: community.affairs.sen@aph.gov.au

Re: Social Services Legislation Amendment (Cashless Debit Card) Bill 2017

I welcome the opportunity to make a submission to the Senate Standing Committee on Community Affairs on the proposed Bill. I make this submission as an academic with a disciplinary background in law whose research focuses on issues of public policy, social justice, human rights and Indigenous peoples.

As noted in the Explanatory Memorandum, this Bill is to repeal 'section 124PF of the *Social Security (Administration) Act 1999*, which specifies that the cashless debit card trial will occur in up to three discrete locations, include no more than 10,000 people, and will end on 30 June 2018.' This Bill allows the Cashless Debit Card (CDC) to continue in current trial sites beyond 30 June 2018, allows the card to be expanded to new regions, and allows an unspecified number of government income support recipients to be subject to the CDC.

There are serious concerns with the proposed legislation, each of which will be addressed below. Many of these points are drawn/quoted from my published research on income management to date, and from my peer reviewed journal articles and book chapters on the Cashless Debit Card that are forthcoming.

The Orima Evaluation cannot reasonably be seen as evidence of program success

Although the government claims that the Cashless Debit Card trial is a 'success',[1] the foundation upon which they base such claims is the final evaluation report of Orima, which has significant limitations. Several of these are acknowledged in their report, and they include:[2]

- Recall error – because 'fieldwork was conducted 6-12 months after' the CDC was introduced,

* I wish to thank Professor Jon Altman for his helpful comments on an earlier draft of this submission.
[1] Alan Tudge, 'Media Release: Evaluation finds "considerable positive impact" from cashless debit card', Department of Human Services, 1 September 2017, <https://www.mhs.gov.au/media-releases/2017-09-01-evaluation-finds-considerable-positive-impact-cashless-debit-card>, accessed 22 September 2017.
[2] Department of Social Services, *Cashless Debit Card Trial Evaluation: Final Evaluation Report* (Canberra: Orima Research, 2017) 9.

- Social desirability responses – influencing people to respond 'in a socially acceptable way',
- 'unavailability of adequate time series data to perform robust pre-Trial and post-Trial comparisons',
- 'low numbers of cases' that were volatile over the course of the study making trends difficult to identify,
- 'comparison site data were only available for a limited number of measures', and
- There were 'recording and collection issues with administrative data sets which reduced their reliability'.

The combination of these factors casts doubt on the validity of many of the conclusions reached in the report.

Academic commentators with decades of policy experience warn that the Orima CDC research contains methodological flaws so serious that it cannot be relied on as a foundation for the drastic changes to social security policy proposed by government.[3]

Eva Cox observes that 'Much of the data collected from participants, if carefully examined, is flawed and some of the more qualitative responses reported are also questionable.'[4] Cox notes that qualitative data came 'mainly' from 'local leaders, often white, who supported the introduction of the trials and are not neutral observers'.[5] She states that there were 'sampling problems' in terms of participants being drawn from 'passersby in public places' – which may have affected representativeness of the sample interviewed. Cox points out that payment for participants likely led to 'contamination of responses', as could the requirement to give their ID for a government survey where there may have been concerns about confidentiality being maintained.[6] Importantly, Cox highlights that the type of questions put to participants raise serious ethical issues because answers to these 'could have legal implications and risk child abuse interventions'.

In addition, the Orima research records a large number of refusals for the quantitative component of their surveys with CDC cardholders – with a total of 533 people refusing to participate in the surveys for Wave 1 and 380 refusing to participate in the surveys for Wave 2 across the trial regions.[7] Reasons for refusal to

[3] Eva Cox, 'Much of the data used to justify the welfare card is flawed', The Guardian, 7 September 2017, <https://www.theguardian.com/commentisfree/2017/sep/07/much-of-the-data-used-to-justify-the-welfare-card-is-flawed?CMP=share_btn_link>; Janet Hunt, 'The Cashless Debit Card Evaluation: Does it Really Prove Success?' (*Centre for Aboriginal Economic Policy Research: Topical Issue No. 2/2017*, Canberra: Australian National University, 2017).
[4] Eva Cox, 'Much of the data used to justify the welfare card is flawed', The Guardian, 7 September 2017.
[5] Eva Cox, 'Much of the data used to justify the welfare card is flawed', The Guardian, 7 September 2017.
[6] Eva Cox, 'Much of the data used to justify the welfare card is flawed', The Guardian, 7 September 2017.
[7] Department of Social Services, *Cashless Debit Card Trial Evaluation: Final Evaluation Report* (Canberra: Orima Research, 2017) 17-18.

participate are not noted in the report – but it does raise questions about how representative the samples were for the quantitative component with CDC users. The Orima report also states that results from surveys were 'weighted',[8] but the methods adopted for such weighting may have affected the reliability of report findings. The Orima report acknowledges that the 'weighting aligned the distribution of the CDCT participant response sample with that of the CDCT population' and that 'the reported results of each survey wave were based on balanced population estimates.'[9] Location weighting was also added to this confusion of participant weighting in the calculation of results.[10]

There are equally troubling elements present in what Orima described as the 'qualitative' aspect of their research. In their Final Evaluation Report Orima stated that:

> Where anecdotal/"hearsay" sources were cited, the qualitative research sought to validate this directly from the source. However, when this was not possible or viable, only anecdotes that were heard three times or more from different community leaders, stakeholders and/or merchants have been used as evidence in the evaluation report.[11]

This means that a thrice repeated anecdote from people in positions of power within these communities was treated as evidence in the Orima evaluation. The report's conclusions are heavily reliant upon such anecdotes. However, anecdotes from parties in power thrice repeated do not meet a robust threshold for 'evidence' – they are more accurately described as opinions. The Orima report is heavily reliant upon these opinions in reaching conclusions that drastically affect financial and social inclusion opportunities for people in need of government income support payments. If opinions are to be seen as the overriding factor rather than evidence in government policy making in this arena then the opinions of those subject to the card ought to be given equal weight. Yet a thorough reading of the Orima report reveals that this is not the case. Where feedback by CDC participants conflicted with that given by community power holders the report writers regularly found in favour of the latter. This is deeply concerning. At best the Orima CDC research might be described as providing mixed feedback about various elements of the CDC program from a range of stakeholders, at worst it could be seen as the privileging of particular anecdotes or opinions masquerading as evidence.

[8] Department of Social Services, *Cashless Debit Card Trial Evaluation: Final Evaluation Report* (Canberra: Orima Research, 2017) 19.
[9] Department of Social Services, *Cashless Debit Card Trial Evaluation: Final Evaluation Report* (Canberra: Orima Research, 2017) 19.
[10] Department of Social Services, *Cashless Debit Card Trial Evaluation: Final Evaluation Report* (Canberra: Orima Research, 2017) 21.
[11] Department of Social Services, *Cashless Debit Card Trial Evaluation: Final Evaluation Report* (Canberra: Orima Research, 2017) 24-25.

Despite the previously mentioned deficiencies in the Orima research, it does reveal some troubling consequences for numerous CDC cardholders who participated in the surveys – none of which have been emphasised by government in their media releases/public relations endeavours over the expansion of the card.

The Final Orima Evaluation report indicated that at Wave 2 32% of card users said the CDC 'had made their lives worse'.[12] The majority of participants across both trial sites indicated that violence in their communities had either increased or stayed the same since the CDC commenced,[13] rather than being reduced as per one of the legislative objectives for the scheme.[14] The majority of CDC holders also indicated that humbugging or harassment for money had either increased or remained the same since the CDC was introduced.[15] At Wave 2 48% reported not being better able to care for their children since being on the CDC.[16] At Wave 2 50% of CDC participants report that they have not been able to save more money since being forced on the CDC.[17] In addition, 24% of CDC holders indicated that their 'children's lives were *worse*' under the scheme, which for many was linked with 'not being able to give children cash' and 'not being able to buy goods for their children with cash'.[18]

In Wave 2 of the Orima research the majority of CDC participants reported either no change in alcohol consumption, gambling or illegal drug use since using the CDC or an increase in these behaviours.[19] These two categories combined amounted to a higher figure than the 48 per cent of CDC participants who reported doing one or more of these three behaviours less since the CDC commenced.[20] It is also significant that Wave 1 of the research indicated that many people subject to the card did not experience problematic consumption of these products to start with—34% abstained from them altogether, and the amount initially consumed by the 43% who said that their consumption remained the same post CDC was unclear.[21] This 43% may not have consumed these products in excess. Saying a CDC cohort now consumes less of the three prohibited products and claiming that as a positive is not meaningful if their consumption levels were not problematic to start with. I will return to this issue below.

[12] Department of Social Services, *Cashless Debit Card Trial Evaluation: Final Evaluation Report* (Canberra: Orima Research, 2017) 6.
[13] Department of Social Services, *Cashless Debit Card Trial Evaluation: Final Evaluation Report* (Canberra: Orima Research, 2017) 65.
[14] The *Social Security Legislation Amendment (Debit Card Trial) Act 2015* (Cth) s 124PC(b).
[15] Department of Social Services (2017*) Cashless Debit Card Trial Evaluation: Final Evaluation Report*. Canberra: Orima Research, 77.
[16] Department of Social Services, *Cashless Debit Card Trial Evaluation: Final Evaluation Report* (Canberra: Orima Research, 2017) 79.
[17] Department of Social Services, *Cashless Debit Card Trial Evaluation: Final Evaluation Report* (Canberra: Orima Research, 2017) 71.
[18] Department of Social Services, *Cashless Debit Card Trial Evaluation: Final Evaluation Report* (Canberra: Orima Research, 2017) 80.
[19] Department of Social Services, *Cashless Debit Card Trial Evaluation: Final Evaluation Report* (Canberra: Orima Research, 2017) 43.
[20] Department of Social Services, *Cashless Debit Card Trial Evaluation: Final Evaluation Report* (Canberra: Orima Research, 2017) 43.
[21] Department of Social Services, *Cashless Debit Card Trial Evaluation: Wave 1 Interim Evaluation Report* (Canberra: Orima Research, 2017) 20.

Financial and Social Exclusion

Disturbingly, there are a range of financial stress indicators that CDC participants have experienced, many of which have gotten worse for CDC participants over the life of the trial. This is an important factor ignored by government Ministers responsible for the scheme. Numerous CDC cardholders report running out of money for essential items—and this is indicative of program problems rather than program success:[22]

- At Wave 1 49% of CDC holders reported that they had 'run out of money to buy food', and by Wave 2 the figure had increased to 52%.
- At Wave 1 22% of CDC holders reported that they did not have sufficient money to pay for their housing needs on time (rent or mortgage payments), and by Wave 2 the figure had remained at a concerning level of 19%.
- At Wave 1 32% of CDC holders reported that they did 'not have money to pay some other type of bill when it was due', and by Wave 2 the figure had increased to 35%.
- At Wave 1 32% of CDC holders reported that they had 'run out of money to pay for things that … children needed for school, like books', and by Wave 2 the figure had increased to 45%.
- At Wave 1 31% of CDC holders reported that they had 'run out of money to pay for essential (non-food) items for … children', and by Wave 2 the figure had increased to 44%.
- At Wave 1 50% of CDC holders reported that they had needed to 'borrow money from family or friends' to survive, and by Wave 2 the figure had increased to 55%.

This feedback on financial hardship experienced by people on the card is inconsistent with the government's narrative of CDC policy success. It would be interesting to see if the cost of the card given to people in need might alleviate some of these difficult experiences. The CDC has led to social and financial exclusion problems for many people coerced to use the card—from difficulties buying products meant to be permitted expenditure by the card and difficulties engaging in a range of social settings that require cash. The myth that the CDC is a positive program doing wonderful things for communities must therefore be challenged.

The card is creating numerous difficulties for existing cardholders – it does not work in the manner described by government. The government claims that the CDC 'looks and operates like a normal bank card.'[23] Feedback from trial site participants indicates that this statement is false:

[22] Figures drawn from Department of Social Services, *Cashless Debit Card Trial Evaluation: Final Evaluation Report* (Canberra: Orima Research, 2017) 72.
[23] Social Services Legislation Amendment (Cashless Debit Card) Bill 2017, Human Rights Compatibility Statement, 5.

> Problems with the CDC have arisen in the context of participants needing to 'transfer money to children … away at boarding schools'; purchase second hand goods; make small purchases in 'cash-based settings (e.g. fairs, swimming pools, canteens)'; 'make purchases from merchants … where EFT facilities were unavailable', and purchase petrol.[24]

The Final Orima Evaluation Report noted that 33% of CDC holders had experienced one of these and/or additional challenges as a consequence of the program.[25] A large number of CDC cardholders have reported that the card has made their lives worse because they have been prevented from paying essential 'bills', been unable to purchase desired 'personal items', and have lacked access to sufficient cash.[26]

Paying for housing needs with the CDC is also difficult for some people. Some CDC participants indicate that certain 'private landlords' only accept cash payments or rent paid via 'forms … not easily able to be met by' card holders, 'resulting in difficulties meeting tenancy requirements.'[27] This is a problem that may also affect more people as the card is rolled out to other regions. The rental market is dependent on market conditions, and at present it is a landlord's market, with vigorous competition for rental properties. Landlords have their pick of tenants – and if they have a choice between someone subject to the card and a person who can pay rent in cash they may well choose the latter. The aforementioned difficulties for people paying for their housing needs with the CDC in a timely manner may contribute to this landlord preference. Failure to pay rent on time breaches tenancy agreements and puts people at risk of eviction. The CDC therefore has the potential to exacerbate housing problems/crises for people struggling to survive on low incomes.

It is also important to reflect upon the social meaning attached to money and its capacity to affect social inclusion and exclusion. Professor David Graeber, an anthropologist from the London School of Economics and Political Science with expertise on theories of value, money, and debt, has highlighted that the value of money lies beyond its mere purchasing power. He explains that:

> if value is simply what one considers important, then money allows importance to take liquid form, enables us to compare precise quantities of importance and trade one off for the other. … What is really at stake here in

[24] Shelley Bielefeld, 'Cashless welfare cards: controlling spending patterns to what end?' (2017) 8(29) *Indigenous Law Bulletin* 28, 29 – drawing on my analysis of the First Interim Orima Evaluation.
[25] Department of Social Services, *Cashless Debit Card Trial Evaluation: Final Evaluation Report* (Canberra: Orima Research, 2017) 89.
[26] Department of Social Services, *Cashless Debit Card Trial Evaluation: Wave 1 Interim Evaluation Report* (Canberra: Orima Research, 2017) 34; Department of Social Services, *Cashless Debit Card Trial Evaluation: Final Evaluation Report* (Canberra: Orima Research, 2017) 7; Shelley Bielefeld, 'Cashless welfare cards: controlling spending patterns to what end?' (2017) 8(29) *Indigenous Law Bulletin* 28, 29 – drawing on my analysis of the First Interim Orima Evaluation.
[27] Department of Social Services, *Cashless Debit Card Trial Evaluation: Wave 1 Interim Evaluation Report* (Canberra: Orima Research, 2017) 43.

> any market economy is precisely the ability to make these trades, to convert 'value' into 'values'.[28]

As noted in my 2016 UNSWLJ article on coercive income management schemes:

> Governments who engage in cashless welfare transfers deny welfare recipients a status of parity in terms of exchange value. This discriminatory treatment is based upon negative stereotyping and does a grave disservice to the poor. Regardless of the Australian government's asserted benevolence with income management, its most pronounced effect has been to emphatically reinforce a socio-economic hierarchy. To the extent to which Indigenous peoples are grossly over-represented under income management, the scheme has also reinforced Australia's racist colonial hierarchy. Rather than function as an effective safeguard for welfare recipients or communities with a high proportion of welfare recipients, income management operates as a protective mechanism for 'status hierarchies'.[29]

Power dynamics at work in cashless welfare card schemes often impact with class-based, gendered, ableist and racialised dimensions. Those who experience intersectional disadvantage can be adversely impacted by cashless welfare cards in ways unforeseen by policymakers fixated upon good intentions. For example, Indigenous women experiencing domestic violence can find coercive autonomy denying measures like compulsory cashless welfare harmful rather than helpful. Such concerns have been raised in a range of reports.[30] A number of women in receipt of a disability support pension have also contacted me to express concern about the way the cashless welfare card can negatively affect their autonomy, sense of self-respect, self-determination, social inclusion, and mental health problems such as anxiety and post-traumatic stress disorder. One such person, who wishes to remain anonymous but wants her concerns on the public record, expressed her feelings about the CDC as follows:

> I believe many others feel the same connection to having a few dollar coins, or a few notes - to actually touch and see the money you hand over to pay for something - when you have very little it is actually a small comfort, a sense of personal freedom. A means by which to escape if need be. It is hard to quantify. It is hard enough managing my finances on a welfare entitlement

[28] David Graeber, *Revolutions in Reverse: Essays on Politics, Violence, Art and Imagination* (Minor Compositions, 2012) 74.
[29] Shelley Bielefeld, 'Income Management and Indigenous Women – A New Chapter of Patriarchal Colonial Governance?' (2016) 29(2) *University of New South Wales Law Journal* 843, 873-874.
[30] Australian Law Reform Commission, *Family Violence and Commonwealth Laws – Improving Legal Frameworks*, Report No 117 (2011) 267–8; Equality Rights Alliance, 'Women's Experience of Income Management in the Northern Territory' (Report, July 2011) <http://www.equalityrightsalliance.org.au/projects/womens-experience-incomemanagement-
northern-territory>; for analysis see Shelley Bielefeld, 'Income Management and Indigenous Women – A New Chapter of Patriarchal Colonial Governance?' (2016) 29(2) *University of New South Wales Law Journal* 843-878.

> under Social security law. It feels like my small sense of pride and freedom have been taken away again by [a] professional person in power.[31]

Alcohol related expenditure for social security recipients

Government ministers eager to prescribe compulsory forms of income management for social security recipients have long claimed that it is useful and/or necessary to reduce alcohol consumption.[32] This has been a key government narrative about income management since it was first introduced in 2007 as part of the Northern Territory Emergency Response. However, the most robust evaluation of income management to date found that this simply was not the case.

In the Final Evaluation Report on the operation of income management in the Northern Territory which was a government commissioned university based evaluation, Bray and colleagues concluded 'the evidence is that income management has had no impact on alcohol consumption or alcohol-related harm.'[33] This counters government mythology about income management being an effective mechanism for addressing alcohol related issues in the Northern Territory, the jurisdiction in which most of Australia's income managed social security recipients reside. In their 2012 report Bray and colleagues observed:

> A central rationale for income management is to *reduce the amount of welfare funds available to be spent on alcohol, gambling, tobacco products and pornography* … The majority of survey participants reported that none of these issues were a problem for their family.[34]

As I state in a forthcoming journal article,[35] this finding in the income management evaluation data compares favourably with recent data from the Australian Bureau of Statistics (ABS) revealing that government income support recipients spend a smaller proportion of their total funds on alcohol than do all other Australian households. In the ABS Household Expenditure Survey, households with government pensions and allowances as the main source of their income reported spending 1.8% of their income on alcoholic beverages compared to all households who spent 2.2% of their total income on alcohol.[36] The idea that welfare recipients are the people specifically causing alcohol related harm clearly needs to be revisited – because although some people in receipt of social security payments may have substance abuse problems not all do. Yet social security recipients in income management areas are being treated like social pariahs by a government intent on

[31] Email correspondence from a social security recipient to my ANU email account dated 20/3/2017.
[32] See the Ministerial speeches referred to in Shelley Bielefeld, 'Income Management and Indigenous Women – A New Chapter of Patriarchal Colonial Governance?' (2016) 39(2) *University of New South Wales Law Journal* 844-846.
[33] J Rob Bray et al, *Evaluating New Income Management in the Northern Territory: The Final Report* (Social Policy Research Centre UNSW, 2014) 305.
[34] J Rob Bray et al, *Evaluating New Income Management in the Northern Territory: First Evaluation Report* (Social Policy Research Centre University of New South Wales, 2012) 185.
[35] Entitled 'Government Mythology on Income Management, Alcohol, Addiction and Indigenous Communities'.
[36] Australian Bureau of Statistics (2016) 'Table 5.1 Household Expenditure Survey, Broad Expenditure Groups, Main Source of Household Income', *Household Expenditure Survey, Australia: Summary of Results, 2015-16*, <http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/6530.02015-16?OpenDocument>.

implementing these expensive and ineffective programs. Ample evidence exists that those who do have addiction problems can circumvent the variety of income management schemes now operating in Australia.[37]

In terms of the CDC, Janet Hunt observes that alcohol related data in the Final Orima Evaluation Report contradicts government claims that the card has led to a reduction in alcohol consumption.[38] For example, in the East Kimberley 20 per cent of CDC participants reported more drinking in their community since the CDC was introduced, 18 per cent reported less drinking, 52 per cent reported that alcohol consumption remained the same, and the remainder were unsure as to how much alcohol intake had changed.[39] In Ceduna 14 per cent reported more drinking, 23 per cent said there was less drinking, 37 per cent indicated that alcohol consumption had remained the same and the remainder were unsure.[40] This is too flimsy a foundation to justify continuation of the CDC in the current trial locations – let alone expand it elsewhere.

Stigma and Shame

Although the government has dismissed stigma and shame associated with the CDC as significant issues,[41] they are reported to be significant for numerous people subject to the scheme and this can adversely impact people's self-conceptions as well as perceptions of card holders within the broader community (including people outside of trial sites). Research on shame undertaken by Professor Robert Walker from Oxford University indicates that 'shame not only makes poverty harder to bear but could make it more persistent.'[42] Shame based welfare reforms could therefore exacerbate the problems that the government says it is aiming to address.

The CDC Final Evaluation reports that 'some Trial participants who spent their money appropriately felt as though they were being "penalised" and/or "discriminated" against by being forced to participate. These CDCT participants reportedly felt that there was a stigma and sense of shame associated with having a CDC.'[43] For some this is clearly profound—the CDC has been likened to the

[37] J Rob Bray et al, *Evaluating New Income Management in the Northern Territory: The Final Report* (Social Policy Research Centre UNSW, 2014) 202, 134-135; J Rob Bray et al, *Evaluating New Income Management in the Northern Territory: First Evaluation Report* (Social Policy Research Centre University of New South Wales, 2012) 88; Department of Social Services, *Cashless Debit Card Trial Evaluation: Wave 1 Interim Evaluation Report* (Canberra: Orima Research, 2017) 34-35, 103; Department of Social Services, *Cashless Debit Card Trial Evaluation: Wave 1 Interim Evaluation Report* (Canberra: Orima Research, 2017) 86.
[38] Janet Hunt, 'The Cashless Debit Card Evaluation: Does it Really Prove Success?' (*Centre for Aboriginal Economic Policy Research: Topical Issue No. 2/2017*, *Canberra:* Australian National University, 2017) 1-3.
[39] Department of Social Services, *Cashless Debit Card Trial Evaluation: Final Evaluation Report* (Canberra: Orima Research, 2017) 47.
[40] Department of Social Services, *Cashless Debit Card Trial Evaluation: Final Evaluation Report* (Canberra: Orima Research, 2017) 47.
[41] Social Services Legislation Amendment (Cashless Debit Card) Bill 2017, Human Rights Compatibility Statement, 5.
[42] Robert Walker, *The Shame of Poverty* (Oxford: Oxford University Press, 2014) 184.
[43] Department of Social Services, *Cashless Debit Card Trial Evaluation: Final Evaluation Report* (Canberra: Orima Research, 2017) 7.

historical practice of Australian government officials requiring Indigenous people to wear 'a dog tag around their neck'.[44]

The compulsory nature of the CDC is an injustice that needs to be remedied. This is especially so in light of Australia's discriminatory approach to restricting Indigenous peoples' access to cash throughout the course of colonialism.[45] Learning from past policy mistakes is crucial for healing relationships between Australia's non-Indigenous and First Peoples, rather than replicating the spirit of past paternalistic policy failures, as the CDC does.

As stated in my forthcoming article in the *Feminist Legal Studies* journal, the CDC:

> [S]eems to impose what Athanasiou (2016: 271) refers to as "economic regulatory violence." For instance, the CDC involves a network of regulatory actors – government, Indue Ltd and the community panels to whom welfare recipients must submit detailed personal information about their lives if they want a reduction in the restricted portion of their income managed funds. This information can then be shared between these parties. These regulatory actors work together to construct CDC users as inferiorised subjects. The purchases of CDC users are also closely monitored by merchants whose regulatory role is to ensure that no prohibited expenditure items are purchased with the card. Many CDC users find these processes shameful and are opposed to cashless welfare transfers. There is violence in the unjust slur on the character and capacity of welfare recipients forced to use the CDC and in the arrangements by which they are disentitled to any semblance of a private life simply because they are in receipt of public money. To suggest that this is warranted because it is taxpayer's money is a weak argument, after all, the same scrutiny is not applied to the substantial sums directed towards corporate welfare beneficiaries.

Consultation and Co-design

As stated in my recent article in the *Indigenous Law Bulletin* on the CDC:

> The government emphasises that the CDC has been co-designed with Indigenous leaders in the trial areas via a consultation process, however the nature of what was agreed and the extent to which there was co-design of the CDC has been contested. Some Indigenous elders and community members indicate that the broadly applied mandatory CDC was not the targeted scheme they had supported in consultations, and assert that they do not want

[44] Melissa Davey, '"Ration days again": cashless welfare card ignites shame', *The Guardian*, 9 January 2017, <https://www.theguardian.com/australia-news/2017/jan/09/ration-days-again-cashless-welfare-card-ignites-shame>.
[45] Shelley Bielefeld, 'Compulsory Income Management, Indigenous Peoples and Structural Violence – Implications for Citizenship and Autonomy' (2015) 18(1) *Australian Indigenous Law Review* 99–118.

the card in their community because it fosters shame and causes suffering. For instance, Mimi Smart, an elder of the Yalata community, argues that the trial should be cancelled. She states:

> when it was first talked about … I thought it was going to be for … people that hang out in Ceduna drinking and causing trouble, and not … people living in Ceduna who don't drink and get into trouble. I didn't think it would be for … people who do look after their kids. I thought the cashless card would be targeted.

Problems have also been raised by some stakeholders and community members who maintain that the government had already decided to go ahead with the CDC at the time the consultation occurred.[46]

The fact that the Human Rights Compatibility Statement for the proposed Bill states that 'Similar consultation will be conducted in new sites' is cause for concern. Feedback on the government's consultation and so called co-design in existing trial sites indicates that it left much to be desired. A government decision to proceed with a CDC rollout regardless of what community members say during a consultation is clearly not meaningful consultation. Government 'consultation' with Indigenous peoples often functions as a mechanism to inform them about predetermined policies, with no opportunity for genuine co-design of policy.[47] This practice must change.

Some Indigenous community members who had initially signed up to the CDC have gone on the public record stating that there were important details meant to be part of co-design omitted from the governments' policy formation and implementation.[48] For example, Lawford Benning, one of the Indigenous leaders who had originally supported the CDC in Kununurra has withdrawn support for the cashless card. Benning states that Minister Tudge made several important commitments to the Indigenous leadership in Kununurra, none of which were honoured as part of the actual policy implemented. Benning states:

> The commitments included the local Aboriginal community being:
>
> 1. Provided with sufficient support for wrap around support services for alcohol, drugs and employment issues prior to the introduction of the CDC;

[46] Shelley Bielefeld, 'Cashless welfare cards: controlling spending patterns to what end?' (2017) 8(29) *Indigenous Law Bulletin* 28, 28.
[47] Shelley Bielefeld, 'The Intervention, Stronger Futures and Racial Discrimination: Placing the Australian Government under Scrutiny' in Elisabeth Baehr and Barbara Schmidt-Haberkamp (eds), *'And there'll be NO dancing'. Perspectives on Policies Impacting Indigenous Australia since 2007* (Newcastle upon Tyne, Cambridge Scholars Publishing, 2017) 151.
[48] Mimi Smart in Melissa Davey, 'Cashless welfare card made life worse, half of trial participants say', *The Guardian*, 14 March 2017 <https://www.theguardian.com/australia-news/2017/mar/14/cashless-welfare-card-made-life-worse-say-half-of-trial-participants>; Lawford Benning, 'Media Statement: "My People Have Spoken"', MG Corporation, 22 August 2017, <http://www.mgcorp.com.au/wp-content/uploads/2016/11/170822-MY-PEOPLE-HAVE-SPOKEN-Cashless-Debit-Card.pdf>.

> 2. Given delegated authority to assess and review local service providers of the wrap around services and if necessary shift the funding and support services to a more effective provider; and
>
> 3. Given delegated authority to easily assess and remove CDC recipients from the trial without the process being intrusive.[49]

This suggests that the policy process was not one of actual co-design – as claimed by government. It was merely an opportunity for certain people within the community to be conversational participants in CDC policy discussions. An opportunity to be a conversational participant in policy discussions does not equate to co-design— especially when important matters regarding policy shape, implementation and outcomes are ignored by the dominant entity, in this case government.

The government's claim that the CDC trial was 'community led' also warrants closer examination. In Kununurra 'only four local leaders were consulted, all of whom expressed personal views in support of social welfare reform.'[50] Although these people:

> took a public stance on a highly contentious issue, it does not follow that these four leaders speak on behalf of the entire community. The CDC trial was implemented without widespread consultation and the government now proposes to expand and extend the CDC without effective consultation.[51]

Lawford Benning, one of these original four leaders, states that 'the overwhelming majority' of people in his community are opposed to the Cashless Debit Card.[52] He indicates that while 'some recipients do support the trial as it currently operates and others would support a modified version, they make up a small minority.'[53]

Benning also states that some people 'would rather not be part of the CDC trial and have removed themselves off all Centrelink benefits.'[54] People removing themselves from the system in order to avoid the card are not receiving the social security payments to which they are entitled. It is tragic that such decisions are being made due to the onerous conditions the government chooses to place on access to social security payments for these people.

Others in the Kimberley have also expressed frustration over the government's CDC stance. For instance, Marianne Skeen from the Kimberley Land Council expressed disappointment over the government's CDC expansion, stating:

[49] Lawford Benning, 'Media Statement: "My People Have Spoken"', MG Corporation, 22 August 2017.
[50] Email correspondence from Lawford Benning to my ANU email account dated 27/9/2017.
[51] Email correspondence from Lawford Benning to my ANU email account dated 27/9/2017.
[52] Lawford Benning, 'Media Statement: "My People Have Spoken"', MG Corporation, 22 August 2017.
[53] Lawford Benning, 'Media Statement: "My People Have Spoken"', MG Corporation, 22 August 2017.
[54] Lawford Benning, 'Media Statement: "My People Have Spoken"', MG Corporation, 22 August 2017.

> Here in the East Kimberley, we had Indigenous people & leaders come forward with their stories about the effects of the Indue card & how it's not helping ... But what happens this morning … the PM flies into Kalgoorlie & slaps the cards on them! so much for consultation … We live in a country of Apartheid.[55]

Importantly, several Indigenous community leaders and numerous community members in Ceduna have also called for the CDC trials to cease.[56] They report that the CDC is creating problems for people such as increased financial stress with difficulties paying bills, as well as fostering shame and suffering.

Human Rights

The government's Statement of Compatibility with Human Rights accompanying the Bill states that 'This Bill is compatible with the human rights and freedoms recognised or declared in the international instruments listed in section 3 of the *Human Rights (Parliamentary Scrutiny) Act 2011*.' It also notes that 'The Parliamentary Joint Committee on Human Rights conducted a review of the *Social Security Legislation Amendment (Debit Card Trial) Bill 2015,* which notes that the Cashless Debit Card engages and limits three human rights: the right to social security, the right to a private life and the right to equality and non-discrimination.'

As the Parliamentary Joint Committee on Human Rights (PJCHR) has noted, limitations can be placed on human rights in some circumstances:

> In general, any measure that limits a human right must comply with the following criteria (the limitation criteria):
> - be prescribed by law;
> - be in pursuit of a legitimate objective;
> - be rationally connected to its stated objective; and
> - be a proportionate way to achieve that objective.
>
> Where a bill or instrument limits a human right, the committee requires that the statement of compatibility provide a detailed and evidence-based assessment of the measures against these limitation criteria.[57]

In its scrutiny of the Social Services Legislation Amendment (Cashless Debit Card) Bill 2017, the PJCHR found that these threshold requirements for permissible

[55] Marianne Skeen, Facebook post 1 September 2017, quoted with her permission. We also had a face to face meeting to discuss the impact of the CDC in the Kimberley on 7/9/2017 at the Australian National University.
[56] For example see Smart and Peters in Melissa Davey, '"Ration days again": cashless welfare card ignites shame', *The Guardian*, 9 January 2017 <https://www.theguardian.com/australia-news/2017/jan/09/ration-days-again-cashless-welfare-card-ignites-shame>; and Smart in Melissa Davey, 'Cashless welfare card made life worse, half of trial participants say', *The Guardian*, 14 March 2017 <https://www.theguardian.com/australia-news/2017/mar/14/cashless-welfare-card-made-life-worse-say-half-of-trial-participants>.
[57] Parliamentary Joint Committee on Human Rights (PJCHR), *Review of Stronger Futures Measures* (Canberra: Commonwealth Parliament, 2016) v.

limitations on human rights were not satisfied by the government's assertions in the Human Rights Compatibility Statement accompanying the Bill.[58]

The PJCHR stated that although 'the cashless welfare trial measures may pursue a legitimate objective', the Committee has 'concerns as to whether the measures are rationally connected to (that is, effective to achieve) and proportionate to their objective.'[59] They noted that the interim Orima evaluation findings suggest that the CDC 'trials have not been definitively positive.'[60] As the previous analysis in this submission makes clear, the final Orima evaluation findings also point to this conclusion. The PJCHR stated that when assessing the proportionality of limitations they consider whether there are 'adequate and effective safeguards' that can 'ensure that limitations on human rights are the least rights restrictive way of achieving the legitimate objective of the measure'.[61] The Committee continued:

> the cashless debit card would be imposed without an assessment of individual participants' suitability for the scheme. In assessing whether a measure is proportionate, relevant factors to consider include whether the measure provides sufficient flexibility to treat different cases differently or whether it imposes a blanket policy without regard to the circumstances of individual cases.
>
> As the cashless debit card trial applies to anyone residing in locations where the trial operates who is receiving a social security payment specified under the scheme, there are serious doubts as to whether the measures are the least rights restrictive way to achieve the stated objectives.[62]

The Committee also noted that:

> The compulsory nature of the cashless debit card trial … raises questions as to the proportionality of the measures. In its 2016 Review, the committee stated that, while income management 'may be of some benefit to those who voluntarily enter the program, it has limited effectiveness for the vast majority of people who are compelled to be part of it'. Application of the scheme on a voluntary basis, or with a clearly defined process for individuals to seek exemption from the trial, would appear to be a less right[s] restrictive way to achieve the trial's objectives. This was not discussed in the statement of compatibility.[63]

[58] Parliamentary Joint Committee on Human Rights (PJCHR), *Report Number 9 of 2017* (Canberra: Commonwealth Parliament, 2017) 34-40.
[59] PJCHR, *Report Number 9 of 2017* (Canberra: Commonwealth Parliament, 2017) 36.
[60] PJCHR, *Report Number 9 of 2017* (Canberra: Commonwealth Parliament, 2017) 37.
[61] PJCHR, *Report Number 9 of 2017* (Canberra: Commonwealth Parliament, 2017) 37.
[62] PJCHR, *Report Number 9 of 2017* (Canberra: Commonwealth Parliament, 2017) 38.
[63] PJCHR, *Report Number 9 of 2017* (Canberra: Commonwealth Parliament, 2017) 39.

This is not the first time that government law and policy measures have fallen foul of the proportionality requirement when imposing limitations on human rights that disproportionately impact upon Indigenous peoples.[64] It has become routine for the government to assert rather than demonstrate proportionality in its cashless welfare crusade.

The concept of proportionality is increasingly significant in the human rights domain.[65] Although there are varying ways in which the concept is delineated, it is often considered to involve four key questions:

> 1. Does the legislation (or other government action) establishing the right's limitation pursue a legitimate objective of sufficient importance to warrant limiting a right?
>
> 2. Are the means in service of the objective rationally connected (suitable) to the objective?
>
> 3. Are the means in service of the objective necessary, that is, minimally impairing of the limited right, taking into account alternative means of achieving the same objective?
>
> 4. Do the beneficial effects of the limitation on the right outweigh the deleterious effects of the limitation; in short, is there a fair balance between the public interest and the private right?[66]

The Human Rights Compatibility Statement accompanying the Bill correlates poorly against the above criteria, particularly points 2, 3 and 4. As noted previously, the Final Evaluation Report of Orima indicates a range of significant deleterious effects for many people forced to use the CDC, and people with addiction problems can easily circumvent income management restrictions.

In addition to the less restrictive measures identified by the PJCHR, there are other measures that could have been attempted by policymakers to address the problems they say the CDC is targeting. For instance, in Ceduna no rehabilitation facilities were available for community members prior to the commencement of the CDC trial. Providing essential services for people struggling with addiction issues would have been a logical place to start before imposing the card on vast numbers of people in the region. Indeed this is a classic example of something that would have been a less restrictive measure than the CDC, and it should have been tried long before the CDC was a twinkle in the eye of policymakers and Indue Ltd.

---

[64] Shelley Bielefeld, 'The Intervention, Stronger Futures and Racial Discrimination: Placing the Australian Government under Scrutiny' in Elisabeth Baehr and Barbara Schmidt-Haberkamp (eds), *'And there'll be NO dancing'. Perspectives on Policies Impacting Indigenous Australia since 2007* (Newcastle upon Tyne, Cambridge Scholars Publishing, 2017) 153, 157.

[65] Grant Huscroft, Bradley Miller and Gregoire Webber (eds), *Proportionality and the Rule of Law: Rights, Justification, Reasoning* (Cambridge University Press, 2016) 1.

[66] Grant Huscroft, Bradley Miller and Gregoire Webber (eds), *Proportionality and the Rule of Law: Rights, Justification, Reasoning* (Cambridge University Press, 2016) 2.

As I noted in my 2014 *Griffith Law Review* article, other less restrictive alternatives include the voluntary budgetary support scheme introduced by the Tangentyere Council for their community members prior to the BasicsCard, and the Arnhemland Progress Aboriginal Corporation voluntary FOODCard.[67] Mandatory income management schemes involve the government implementing the most coercive possible measures for people irrespective of their behaviour. This does not honour Australia's international human rights obligations to people in need of government income support.

Further on less restrictive alternative measures, the 2014 Anangu Pitjantjatjara Yankunytjatjara (APY) Lands report sets out a range of voluntary budgetary management tools which may be useful for welfare recipients as alternatives to compulsory income management measures:

- The Key Card is a card issued by a financial institution (e.g. bank) used by account holders to access their money. Community members can set up direct debit payment arrangements with the financial institution to transfer funds to a store or make bill payments via BPAY. The Key Card gives people direct access to the available cash in their account. Particular amounts can be allocated per day so that the person can only spend up to that amount per day and therefore money can be spread over the payment period. This is arranged with the financial institution.
- The Centrepay system is a free bill paying service people can use to make payments to registered organisations directly from their Centrelink payments. Centrepay has been in place for several years prior to the introduction of income management.
- Store accounts or Store Cards. People can arrange for funds to be paid to the store under a pre-paid account system. Some stores will provide clients with a Store Card where these funds are uploaded. The client can arrange payments to the store through Centrepay or through a direct debit arrangement with their financial institution.
- Many people hold accounts in financial institutions which may or may not have Key Card access. People can allocate their funds by arranging direct debits and making bill payments via BPAY.[68]

Blanket CDC measures that apply to everyone receiving a government income support payment in a trial location are clearly not the least restrictive measures that could be adopted to address the problems the government claims to want to address.

[67] Shelley Bielefeld, 'Income Management and Indigenous Peoples – Nudged into a *Stronger Future*?' (2014) 23(2) *Griffith Law Review* 285, 307.
[68] Ilan Katz and Shona Bates, *Voluntary Income Management in the Anangu Pitjantjatjara Yankunytjatjara (APY) Lands* (Social Policy Research Centre UNSW, September 2014) 19-20.

Whilst scrutinising the Bill, the PJCHR also raised concerns about consultation with communities affected by the CDC. They stated that:

> it is not clear from the statement of compatibility that consultation has been held in the existing locations in relation to the *extension* of the trials. It is noted that Indigenous people make up the overwhelming number of participants in both trial sites. While the United Nations Declaration on the Rights of Indigenous Peoples is not included in the definition of 'human rights' under the *Human Rights (Parliamentary Scrutiny) Act 2011*, it provides some useful context as to how human rights standards under international law apply to the particular situation of Indigenous peoples. Under the Declaration, state parties such as Australia are obligated to 'consult and cooperate in good faith' with Indigenous peoples 'in order to obtain their free, prior and informed consent before adopting and implementing legislative or administrative measures that may affect them'.[69]

As of September 2017, there have been no community consultations about an extension of the CDC in the trial locations,[70] and this contravenes article 19 of the *United Nations Declaration on the Rights of Indigenous Peoples* (UNDRIP) (the article referred to by the PJCHR in the quote directly above). As previously noted in this submission, the CDC reproduces injustice. It remains a far cry from Indigenous calls for self-determination to 'freely determine their political status and freely pursue their economic, social and cultural development' in accordance with article 3 of UNDRIP. The issue of lack of human rights compatibility is significant.

Although the *International Convention on the Elimination of All Forms of Racial Discrimination* (ICERD) was not mentioned by the PJCHR in their scrutiny of the Bill, it too is relevant. The vast majority of people currently affected by the CDC identify as Aboriginal or Torres Strait Islander peoples,[71] therefore the CDC measure operates with a racially discriminatory impact contrary to Australia's international obligations under ICERD. The government's consultation process with a select number of Indigenous people in CDC trial locations does not remedy this deficiency. As of 30 December 2016, 81% of 25,033 welfare recipients subject to income management (via the BasicsCard or the CDC) nationwide identified as Indigenous.[72] This reveals that intersectional disadvantage is powerfully at work in affecting who can freely access their social security payment in cash and who cannot. The government seems to be aware that this is an issue, and they acknowledge in the Statement of Compatibility with Human Rights accompanying the Bill that the CDC

[69] PJCHR, *Report Number 9 of 2017* (Canberra: Commonwealth Parliament, 2017) 38.
[70] Email correspondence from Lawford Benning to my ANU email account dated 27/9/2017; and correspondence from Say NO to the Welfare Debit Card Ceduna dated 29/9/2017.
[71] Department of Social Services, *Cashless Debit Card Trial Evaluation: Final Evaluation Report* (Canberra: Orima Research, 2017) 37.
[72] Department of Social Services, 'Income Management Summary Data (30 December 2016)' <https://data.gov.au/dataset/income-management-summary-data/resource/29be27b2-5256-4069-a79c-83df8dc98018> 3-4.

currently has an 'indirect' racially discriminatory impact 'on Aboriginal and Torres Strait Islander people', thus, 'in identifying new sites, priority will be given to including communities with lower Aboriginal and Torres Strait Islander populations.' Yet this is unlikely to render the scheme non-racially discriminatory if its disproportionate impact on Indigenous peoples remains high. The only way to rationalise the limitation on the human right to be free from racial discrimination is if the CDC could be justified as a proportionate measure – and the preceding discussion reveals that this is not possible.

The compounding impact of multiple welfare conditionality programs

Some of my other publications/submissions[73] highlight that there are also significant problems with compulsory income management being combined with the Community Development Program (CDP). This particular combination is held in disdain by many Indigenous peoples because it involves working for 'rations'. This was also noted in the Final Orima Evaluation Report, which stated that 'CDP obligations in combination with the lower appeal of receiving quarantined payments … discouraged CDP compliance.'[74] This working for rations approach resonates with Australia's racist colonial legacy where economic resources were regularly withheld from Indigenous peoples who were portrayed by colonial authorities as too unworthy to access money and exercise financial decision making capacities. This occurred through stolen wages, stolen social security payments, and underpayment of Indigenous labour. Welfare conditionality programs that echo a similar dynamic of disempowerment can create trauma, grief, and frustration.

The Cost of Income Management via the CDC

The Explanatory Memorandum does not specify how much funding will be dedicated to expanding the CDC, but expenditure figures for the CDC to date suggest that the amount will be substantial. As I noted in my recent article on the CDC in the *Indigenous Law Bulletin*:

> Indue Ltd was awarded a contract of $7,939,809 for the trial of the card, and a further contract of $2,870,675.50 for the CDC IT build. These sums are part of a reported $18.9 million allocated to the CDC, with a cost of approximately $10,000 per participant. Indue was contracted to cover the CDC for 'no more than 10,000' welfare recipients from '1 February 2016' to '30 June 2018'. Orima's [First Evaluation] report indicates that Indue had responsibility for administering $10.5 million of welfare payments 'quarantined via … CDC accounts on or before 30 September 2016' for around 1850 card users. Thus

[73] Shelley Bielefeld, 'The Intervention, Stronger Futures and Racial Discrimination: Placing the Australian Government under Scrutiny' in Elisabeth Baehr and Barbara Schmidt-Haberkamp (eds), *'And there'll be NO dancing'. Perspectives on Policies Impacting Indigenous Australia since 2007* (Newcastle upon Tyne, Cambridge Scholars Publishing, 2017) 153-157; Shelley Bielefeld, Submission No 19 to the Senate Finance and Public Administration Committee, *Social Security Legislation Amendment (Community Development Program) Bill 2015*, 5 February 2016, 1-18.
[74] Department of Social Services, *Cashless Debit Card Trial Evaluation: Final Evaluation Report* (Canberra: Orima Research, 2017) 91.

> the amount paid to Indue represents a significant increase in the overall cost of welfare. There is an opportunity cost in this arrangement, as other productive possibilities to empower people struggling with poverty are overlooked. …
>
> It is crucial to ask who benefits most from the CDC regime. Cashless welfare cards will increase the wealth of entities like Indue and the overall cost of social security provision in Australia, but without providing advantages for numerous people subject to these measures and delivering detrimental outcomes to many. In an economic climate where there are routinely calls for increased efficiency—and where programs are often said to be evaluated in terms of their ratio of cost to benefit—income management is an anomaly.[75]

If this Bill is passed, there is a risk of further privatisation of Australia's social security payment processes. 'CDC participants currently experience privatised delivery of 80 per cent of their social security payment.'[76] Based on the government contract figures above, the CDC scheme has involved the allocation of over $10.8 million to deliver $10.5 million of social security payments. Privatisation of social security payment processes via the CDC is a matter that should concern all Australians. This privatisation experiment comes at a cost – absorbing alternative program funding to address the addiction issues the government claims to be addressing by the relatively futile income management programs now operating across many regions of Australia. Such expenditure is poorly placed in Indue Ltd coffers when genuine job creation for those in need is called for in the current economic climate.[77]

Added to the rapidly escalating CDC/Indue Ltd costs, the estimated cost of income management with the BasicsCard was '$1 billion' between '2005-06 to 2014-15'.[78] Income management for government income support recipients living in remote areas is estimated to cost approximately '$6600 to $7900 per annum',[79] which is 'equal to 62 per cent of the $246-a-week Newstart payment.'[80] It is high time the government engaged in more responsible stewardship of taxpayer funds and abandoned compulsory income management measures.

---

[75] Shelley Bielefeld, 'Cashless welfare cards: controlling spending patterns to what end?' (2017) 8(29) *Indigenous Law Bulletin* 28, 30-31.
[76] Shelley Bielefeld, 'Cashless welfare cards: controlling spending patterns to what end?' (2017) 8(29) *Indigenous Law Bulletin* 28, 30.
[77] 'Longman MP hits back at government's "dole bludger" report', Sunshine Coast Daily, 15th Jun 2017, <https://www.sunshinecoastdaily.com.au/news/longman-mp-hits-back-governments-dole-bludger-repo/3189948/>.
[78] Luke Buckmaster, Carol Ey, and Michael Klapdor, 'Income Management: an Overview' (Background Note, Parliamentary Library, Parliament of Australia, 2012) 34.
[79] Australian National Audit Office, *Administration of New Income Management in the Northern Territory* (Audit Report No. 19, 2012–13) 17.
[80] Patricia Karvelas, 'Coalition bid to expand welfare quarantining', *The Australian*, 1 October 2013, <http://www.theaustralian.com.au/national-affairs/coalition-bid-to-expand-welfare-quarantining/story-fn59niix-1226730353663>.

Recommendations

1. **That all mandatory forms of income management Australia wide, including the CDC, be revoked and replaced with a genuinely voluntary scheme for the small minority of social security recipients who find these cashless cards a useful budgetary mechanism.**
2. **That the planned roll outs of the CDC to new locations be halted.**
3. **That the government re-examine the nature of its consultation processes with Indigenous communities and ensure that processes reflect Australia's international human rights commitments.**
4. **That social security payment processes not be privatised – as privatised delivery involves a reckless waste of finite resources.**
5. **That the money currently directed to compulsory forms of income management be redirected to genuine job creation in locations currently affected by income management programs.**

If I can be of any further assistance I would be happy to oblige.

Yours sincerely,

Dr Shelley Bielefeld
Braithwaite Research Fellow
School of Regulation and Global Governance (RegNet)
College of Asia and the Pacific
8 Fellows Road
The Australian National University
Acton ACT 2601 Australia

Appendix A

Shelley Bielefeld, 'Cashless welfare cards: controlling spending patterns to what end?' (2017) 8(29) *Indigenous Law Bulletin* 28-32. (peer reviewed)