



**Central Australian
Aboriginal Congress**
ABORIGINAL CORPORATION | ICN 7823

14 October 2019

Committee Secretary
Senate Community Affairs Legislation Committee
PO Box 6100
Parliament House
Canberra ACT 2600

**Submission to the
Senate Community Affairs Legislation Committee Inquiry into the
Social Security (Administration) Amendment (Income Management to
Cashless Debit Card Transition) Bill 2019**

Dear Sir / Madam,

Please see attached our submission to the Senate Community Affairs Legislation Committee Inquiry into the *Social Security (Administration) Amendment (Income Management to Cashless Debit Card Transition) Bill 2019*.

Due to the short timeframes of the Inquiry, Central Australian Aboriginal Congress (Congress) is not able to provide a detailed submission. However, given the impact of poverty, inequality and the related harmful consumption of alcohol and other drugs on the health of Aboriginal people, we consider it important to raise some key points with the Committee for their consideration.

In summary, we recommend:

1. That the Australian Government focus on reducing poverty and inequality as a key way to increase health and wellbeing for Aboriginal people and meet the 'Close the Gap' targets, including by:
 - increasing the Newstart payment for all participants by \$75 per week;
 - providing an additional loading on Newstart payments for those in remote or very remote areas to address significantly higher costs of living; and
 - redesigning the Newstart program to ensure it is accessible to Aboriginal people.
2. The cancellation of the Income Management scheme in the Northern Territory as an expensive and failed experiment that is associated with increased health risks to children.

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**Aboriginal health
in Aboriginal hands.**

3. That given the potential risks and lack of hard evidence of benefits, participation in any Cashless Debit Card trial in the Northern Territory be voluntary only.
4. National support for the Northern Territory Government's *Alcohol Policies and Legislation Reforms* as an objectively evidenced, world-leading approach to reducing alcohol-related harm at a whole-of-population level.
5. That savings from the implementation of any Cashless Debit Card trial in the Northern Territory be reinvested in Aboriginal community controlled comprehensive primary health care services, as a strongly-evidenced way to deliver improved health and wellbeing and increased employment in Aboriginal communities.
6. That any future trials of the Cashless Debit Card be subject to rigorous and independent evaluation processes that address the flaws in the Cashless Debit Card trial evaluations to date.

Please see our attached submission for details.

Thank you for the opportunity to provide a submission on this important issue; I am happy to provide further detail on request.

Yours sincerely

Donna Ah Chee
Chief Executive Officer



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Submission to the

Senate Community Affairs Legislation Committee Inquiry into the *Social Security (Administration) Amendment (Income Management to Cashless Debit Card Transition) Bill 2019*

Background to Congress

Congress is a large Aboriginal Community Controlled Health Service (ACCHS) based in Alice Springs. We are one of the most experienced organisations in the country in Aboriginal health, a national leader in primary health care, and a strong advocate for the health of our people. Since the 1970s, we have developed a comprehensive model of primary health care that includes:

- multidisciplinary clinical care;
- health promotion and disease prevention programs; and
- action on the social, cultural, economic and political determinants of health and wellbeing.

Congress delivers services to more than 16,000 Aboriginal people living in Alice Springs and remote communities across Central Australia including Ltyentye Apurte (Santa Teresa), Ntaria (Hermannsburg), Wallace Rockhole, Utju (Areyonga), Mutitjulu and Amoonguna.

Key Issues

1. Poverty and inequality drive poor health and social outcomes, not the spending choices of those receiving citizenship entitlements. Absolute deprivation (poverty) and relative deprivation (inequality) are both strongly correlated with poorer health outcomes and with increased rates of addiction including to alcohol and other drugs [1, 2]. There is no equivalent evidence that controlling poor people's expenditure leads to better health and social outcomes [3]. In relation to this, we note that:

- in remote areas across Australia both poverty and inequality are worsening for Aboriginal people, with Aboriginal incomes falling and the income gap to non-Indigenous people widening [4];
- the proportion of Aboriginal people in remote areas who are employed has stalled or is falling, increasing reliance on Newstart and other citizenship entitlements [5];

- between a half- and a third- of the gap in life expectancy between Aboriginal and non-Indigenous people in the Northern Territory is due to socioeconomic disadvantage [6].

We recommend that the Australian Government focus on reducing poverty and inequality as a key way to increase health and wellbeing for Aboriginal people and meet the 'Close the Gap' targets¹, including by:

- increasing the Newstart payment for all participants by \$75 per week;
- providing an additional loading on Newstart payments for those in remote or very remote areas to address significantly higher costs of living; and
- re-designing the Newstart program to ensure it is accessible to Aboriginal people.

2. The Cashless Debit Card and other income management schemes may have negative health consequences for participants. There is strong evidence about the relationship between disempowerment and lack of life-control and poor health and wellbeing [7, 8]. Reducing the capacity of Aboriginal families to exercise responsibility to look after themselves and their children can therefore be expected to have long-term negative effects on health and wellbeing. Significantly, the evaluation of the Cashless Debit Card Trial (CDCT) in the Ceduna and East Kimberly regions [9] found that:

- participants were more likely to report that the CDCT had made their lives *worse* than better: less than a quarter of participants (23%) reported that the CDCT had made their lives better, four out of ten (42%) said that it had made no difference, and a third (32%) reported that the trial had made their lives worse;
- a quarter of CDCT participants (24%) felt that their child / children's lives were *worse* as a result of the CDCT; only one in six (17%) felt their child / children's lives were better; and
- there is no hard evidence of improved health or wellbeing outcomes from the CDCT.

In addition, there is the evidence that Income Management in the Northern Territory – introduced with similar aims to the CDCT – has led to worse birth outcomes in Aboriginal communities, with lower average birth weights and a higher probability of low birthweight, with increased levels of stress amongst mothers due to income management being a likely cause [3]. This is very strong evidence of potential harm.

¹ See Congress' recent submission to the *Senate Community Affairs References Committee Inquiry into the Adequacy of Newstart and related payments* ([accompanying this letter](#)) for details.

We recommend the cancellation of the Income Management Scheme in the Northern Territory as an expensive and failed experiment that is associated with increased health risks to children.

We recommend that given the potential risks and lack of hard evidence of benefits, participation in any expanded Cashless Debit Card trial in the Northern Territory be voluntary only.

3. There are significantly better-evidenced approaches to address alcohol-related harm that are already in place.

A primary aim of the Cashless Debit Card is to reduce the harm from alcohol and other drugs. While the evaluation of the Cashless Debit Card Trial (CDCT) in the Ceduna and East Kimberly regions [9] stated that it had been effective in reducing alcohol consumption, a closer look at the figures reveals that the evidence is not nearly as strong as claimed. For example:

- while 41% of respondents reported drinking less since being on the Cashless Debit Card, these figures exclude those people who did not consume alcohol. Recalculating the figures based on the whole population reveals that the effect is around half of that reported, with around 21% of CDCT participants reporting drinking less;
- there was no attempt to measure population level per capita alcohol consumption or wholesales alcohol purchases in the CDCT regions;
- there is no significant quantitative evidence on alcohol-related harm (e.g. police crime statistics, alcohol-related hospital admissions etc) to support the qualitative feedback from participants;
- the findings are based on self-report by CDCT participants. Self-report is notoriously unreliable in such cases, especially when dealing with disadvantaged populations; and
- it is not possible to distinguish the effects of the CDCT with that of restrictions on alcohol sales introduced in both regions at a similar time given the methodology that was used.

While we do not deny that the CDCT may have had some relatively minor effects on reducing alcohol-related harm for some individuals, there are significantly better evidenced approaches to reducing the harm caused by alcohol.

In October 2019 the Northern Territory Government introduced a package of reforms to deal with the jurisdiction's long-standing issue with high levels of alcohol-related harm. The reforms included a Banned Drinkers Register (BDR) to reduce the access to take-away alcohol by problem drinkers; a floor price to prevent the sale of cheap alcohol; Point of Sale Interventions at all bottle shops in three regional centres; and a New Liquor Act that includes risk-based

licencing and greater monitoring of on-licence drinking. The reforms have included a commitment to high quality, ongoing independent evaluation [10]. These reforms were informed by the best available evidence from around the world on what works to reduce alcohol related harm. The reforms, without yet a full year effect, have already demonstrated with objective data very significant reductions in alcohol-related harm across the Northern Territory including:

- a reduction by almost a third (31%) in alcohol-related Emergency Department presentations;
- a reduction by over a quarter (27%) in alcohol-related assaults;
- a reduction by over one-fifth (22%) in alcohol-related domestic violence assaults.

See graphs in [Attachment](#) for details.

We recommend national support for the *Northern Territory Alcohol Policies and Legislation Reforms* as an objectively evidenced, world-leading approach to reducing alcohol-related harm at a whole-of-population level.

4. The Cashless Debit Card scheme is expensive especially given limited evidence of positive outcomes. The CDCT cost \$18.9M for 2,141 participants over the two sites (Ceduna and East Kimberly), translating to a cost of almost \$9,000 per person [11]. Expanding the trial to Cape York and the Northern Territory will cost another \$17.8M for 23,150 participants (around \$770 per participant). These are significant investments given the lack of hard data to justify them.

However, it should be recognised that Income Management in the Northern Territory is even more expensive, costing approximately \$100M per year or around \$4,300 per participant per year [12]. Implementation of the Cashless Debit Card in the Northern Territory can therefore be expected to lead to significant Australian government savings in the region of \$60M to \$80M per year.

By comparison, the expenditure of all governments on primary health care for Aboriginal and Torres Strait Islander people nationally in 2015-16 was \$2,589 per person [13]. Despite these relatively low levels of funding, Aboriginal community controlled health services, delivering comprehensive primary health care services have been instrumental in reducing low birth weight and infant mortality rates and improving avoidable mortality and providing significant Aboriginal employment².

² See Congress' [accompanying paper](#) on *The effectiveness of primary health care delivered through Aboriginal Community Controlled Health Services*.

We recommend that savings from implementation of any Cashless Debit Card in the Northern Territory should be reinvested in Aboriginal community controlled comprehensive primary health care services as a strongly-evidenced way to deliver improved health and wellbeing and increased employment in Aboriginal communities.

- 5. Any expansion of the Cashless Debit Card trials must be only the basis of rigorous independent evaluation.** An Australian National Audit Office (ANAO) examination of the CDCT found that the evaluation of their effectiveness was deficient in many aspects including lack of robustness in data collection, no attention to scalability, and failure to look at key issues such efficiency and cost [14].

Given the lack of objective evidence about the effects of the CDCT in Ceduna and the East Kimberly and its expense, it is worrying that the Bill proposes to reduce the requirements for evaluation to a desktop exercise.

We recommend that any future trials of any Cashless Debit Card be subject to rigorous and independent evaluation processes that address the flaws in the CDCT evaluation to date.

References

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ATTACHMENT: Effect of Northern Territory Government Alcohol reforms introduced 1 October 2018 on Alcohol-related harm



