



Australian Government

Department of the Prime Minister and Cabinet

Office of Best Practice Regulation

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Ms Liz Hefren-Webb
Deputy Secretary
Families and Communities Division
Department of Social Services

Dear Ms Hefren-Webb

Regulation Impact Statement – Second Pass Final Assessment – Reforming the Cashless Debit Card and Income Management

Thank you for your letter submitting a Regulation Impact Statement (RIS) for formal Second Pass Final Assessment. I note the RIS has been formally certified at the Deputy Secretary level consistent with the *Australian Government Guide to Regulatory Impact Analysis* (the Guide).

I appreciate the Department's constructive engagement on the RIS. The Office of Best Practice Regulation's (OBPR's) assessment is that the quality of the regulatory impact analysis in the RIS is adequate.

To be assessed as good practice under the Guide, the RIS would have benefitted from deeper analysis to appraise the Government's investment in the new program given there are potential downside risks to voluntary participation levels, and more detail as to how participants will be supported to transition off the Cashless Debit Card program within short timeframes. The OBPR also notes that the approach to co-designing support services makes it difficult to determine the social and economic impacts of these services at this stage given precise design is yet to occur. In addition, the monitoring and evaluation plan could be more articulate, which may have downstream implications for the Department's ability to collect evidence to inform future policies changes.

Next steps

After a final decision has been announced, I ask that your agency work with the OBPR to finalise this material for public release. This includes providing a copy of the RIS in Word and PDF format for web accessibility purposes. The RIS must be included in any Explanatory Memorandum or Statement giving effect to the proposals in the RIS.

If you have any further queries, please do not hesitate to contact me.

Yours sincerely

A handwritten signature in black ink, appearing to read 'J Lange', with a large, stylized initial 'J'.

Jason Lange
Executive Director
29 August 2022

Further advice – Reforming the Cashless Debit Card and Income Management

General comments:

- The OBPR has several redline comments that need to be addressed in order for the OBPR to fully understand the policy and assess the impact analysis. Until this information is included, the OBPR is not in a position to advise that the RIS is adequate to inform a government decision.
 - The RIS must provide a clear justification for the expected number of voluntary participants, and articulate any downside risks to this participation rate. If participation is significantly lower than anticipated, it would call into question the net benefit and cost effectiveness of the voluntary program and proposed Enhanced BasicsCard.
 - The RIS must better explain the mechanics and nature of the community referral system, especially what other checks and balances will exist to ensure it is run in the best interests of participants.
 - The RIS must articulate the broad scope of the wrap-around support services and whether they will be available in IM communities. The impact of these support services, especially if they will adequately support participants when they roll off mandatory CDC or IM, is unknown until they are better articulated.
 - The RIS must clearly articulate the transition arrangements to demonstrate the government can intervene successfully, mitigate any implementation issues, and minimise any adverse impacts associated with people ‘falling through the cracks’ when they leave CDC and IM. While this draft improves of the last version, it does not clarify:
 - whether both people leaving the CDC and IM programs will have access to the same support,
 - why there is an option to forgo the transition interview (ie there is an option for some people to just receive a text message),
 - whether participants will be triaged,
 - why the average interview time is assumed to only be 20 minutes and if this is sufficient, and
 - whether Services Australia has the trained resources ready to deliver this program.
 - The previously provided evaluation plan is not included in this certified version of the RIS. The RIS would be improved if detail on how data will be collected and how outcomes will be assessed was included. This is particularly pertinent given the ANAO report noted monitoring and evaluation had been inadequate to date.

Note: For each of the comments below OBPR has included specific comments on what needs to change in the PDF version of the RIS accompanying this assessment letter.

What is the policy problem you are trying to solve?

- Tighten the problem statement narrative, ensuring all writing and evidence links directly to the problem statement articulated in the introductory paragraphs.
- Ensure that any existing support services under the current CDC program (listed at Appendix D) are excluded from the scope of the ‘other programs’. The purpose of the table is to note schemes outside of the program that achieve the same objectives.

What is objective of Government action?

- OBPR suggest that a social or health policy objective may need to be included, especially as the wrap-around support services are meant to achieve similar objectives to the compulsory CDC and IM programs (i.e. (or is it ‘e.g.’?) reduced drug and alcohol consumption). If not, explain why it has been omitted.
- Include as a ‘barrier’ that the uptake of the voluntary scheme may be lower than expected, and explain the implications for whether the government should invest.
- Ensure the constraints and barriers align with the description of how DSS and Services Australia will address these challenges in answer to RIS Q7.

What are the options?

- Clarify if the IM technology is being updated/enhanced or replaced.
- Explain why some participants will only receive a text message or letter, and others will get a phone call and/or face to face transition interview.
 - What are the criteria to determine who gets what level of service? Is there an explicit triaging strategy?
 - What are the approximate numbers of participants that receive intensive transition support, compared to those who do not?
- Clarify the new process for merchants transitioning from CDC to the former IM system to the new IM system. Diagram 6 suggests all merchants will need to sign an agreement, whether or not they sell restricted items, which could place a far higher burden on merchants than is currently calculated.
- Include a description of the types of support services that will be funded, following co-design with communities and noting this process will inform the exact scope.
- Make it clearer who has access to support services, especially whether people on income management receive access to supports.
- Better explain the mechanics and nature of the community referral system, including answering the following questions:
 - How will communities opt in?
 - What support will communities receive to set up a referral commission?

- What checks and balances will be in place to ensure that the commission makes decisions in the genuine interests of the individual and community?
- What kind of criteria will these community councils consider i.e..(or is it ‘e.g.’?) which participants within these regions are likely to be captured under this system?
- Is there an appeals process?
- Include additional information on the transition of mandatory IM participants off the scheme and onto voluntary IM. Including:
 - A diagram similar to the CDC transition diagrams explaining the process.
 - Information on the interviews and referral to support services to confirm that these supports will also be available to these participants.
- Include additional information on the Child Protection and SPaR cohorts, such as why they will still be captured by a mandatory scheme and whether this is a continuation of the status quo for them.
- Update the communications strategy to include merchants. Demonstrate how they will receive notice of the changes and support to transition off the CDC and IM programs and onto the enhanced BasicsCard.
- Update the communications strategy to include more detail on the targeted communications that stakeholders have requested, such as communications for youth, older people, or those in very remote regions.
- The ‘ability of the option to address the problem’ sub-sections needs to focus on how the option addresses, or does not address, the problems under both CDC and IM.
- Check the comparison table accurately reflects the current scope of option 2.

What are the impacts of the options?

Option 1

- Ensure the impact analysis touches on both CDC and IM, or if only one program is analysed, make that clearer.

Participants

- Check the growth of the CDC and IM program assumptions are correct, and adjust the baseline and regulatory burden calculations accordingly.
 - For example, under CDC there are only 17,500 participants on the program (as of March 2022). If 8,500 people consistently join the program each year, and assuming 15% leave the program each year that means the following baseline may be incorrect?. This is a high rate of growth (nearly doubling in 4 years), especially for an established program that is not expanding to new locations under the current? status quo.
 - Y1: 17,500

- Y2: 23,000
 - Y3: 27,000
 - Y4: 30,000 etc.
- Update the status quo regulatory costs include the cost to IM participants of exiting the program (the current costs only include CDC participants).

Merchants

- Improve the status quo merchant impacts section, including by using bold text to identify the key costs and benefits, and differentiating between CDC and IM impacts.
- Better articulate the assumptions supporting the merchant calculations, and check several calculations, including:
 - Why is there an assumption of 53 merchants adopting PLB per year in the text, and then why in the calculation is it assumed 53 merchants sign up over 5 years?
 - Where is the cost of \$10 per pin pad for a small number of merchants in the calculations? What is a 'small number of merchants'?
 - There are two maintenance assumptions in the text – 1 hour or 10 minutes. Which is correct? Or when do the different maintenance assumptions apply?
 - The number of mixed merchants using PLB subject to ongoing regulatory costs are inconsistent with the number of merchants adopting PLB above. The text states that only 80 merchants already have PLB, so if 13 join in the first year, then only 93 merchants are subject to maintenance costs in the first year (the table states 320 participants).
- Check that the cost of signing the agreement is in the regulatory costs. It might be included in the 'time cost of completing the application', but if so, please clarify.
- The baseline number of IM merchants needs to increase by 10 each year, unless a similar number of merchants leave the program each year in which case that needs to be noted in the assumptions/explanation below the table.
- The net benefit conclusion should only focus on the status quo, and clearly highlight whether there is a net cost or benefit placed on merchants, and how that cost differs for CDC compared to IM merchants.

Government

- Link the first point in the benefits section back to what it means for the objectives and expenditure of government.
- Clarify that the regulatory costs calculated in the government section have not been included in the total regulatory costs table, as per the Regulation Impact Analysis Framework.

Community organisations

- Explain the assumptions supporting the regulatory cost calculations.

Option 2

- Use a consistent approach to articulate the quantifiable regulatory impacts. The sections that include a table that sets out the calculations then an explanation of the assumptions to inform the calculation below, then finish with a 10 year table, are the easiest to understand and verify.
- Ensure all regulatory cost and benefit figures have an explanation of the key assumptions and calculations.
- Where the benefit reflects a reduction in costs from the status quo, still include a brief explanation of the drivers of these cost reductions. Also ensure that any feedback on the status quo calculations is reflected below.

Individuals

- Regarding the anticipated number of voluntary and community referred participants –
 - 4,400 is 11% of the current CDC and IM program participants combined, but the text notes that only 400 CDC participants will volunteer for IM. Therefore, this figure should be 11% of current IM participants (approx. 2,500) and 400 former CDC participants, totalling 2,900 participants.
 - Further, a total of 400 CDC participants moving to voluntary IM means that 100 participants on voluntary CDC move to voluntary IM, and 300 participants on mandatory CDC move to voluntary IM. Explain what this assumption is based on, for example, are these the older participants more likely to face family extortion (humbugging?) who have expressed interest in staying on the card.
 - Explain the assumption that 1,300 participants will join through community referrals. If there are sensitivities in naming a specific community, maybe take the average smaller community size and assume a certain % (based on Cape York referrals) would be referred under a similar scheme.
 - Explain the assumption that only 100 participants are referred through SPaR and Child Protection.
 - Does this align with current referrals for these welfare groups?
 - Articulate the downside risks of the participant number calculations, and the implications for the cost effectiveness of the program. For example, as the enhanced BasicsCard will not be in place before CDC participants transition, will few choose the IM scheme? Will CDC and IM participants consider the new support services sufficient and choose them over the card?
- Include a brief description of the participants being analysed in each sub-section before discussing the impacts. For example, in the first sub-section it's unclear if this section only relates to people leaving a CDC and not moving onto IM, or if it covers participants leaving CDC all together.
- Justify the 20 minute transition interview assumption. There is an assumption that transition interviews will take an average of 20 minutes, however given the scope of the interview, including helping people to set up new bank accounts and/or CentrePay,

transitioning them onto voluntary IM, referring to the right support services and more, 20 minutes seems insufficient.

- Include an additional regulatory cost to former CDC participants moving to voluntary IM because participants will need to learn to use the BasicsCard, then will need to learn to use the Enhanced BasicsCard.
- Explain what Services Australia and DSS can do to support vulnerable people to access, and retain access, to the voluntary program. One of the benefits of the voluntary scheme is reduced financial abuse from friends and family, but this assumes that the family and friends will not be able to stop the participant from volunteering in the first place.
- Update the analysis of impacts on the Northern Territory cohort to include all costs from utilising the BasicsCard until the enhanced card comes in, and all the costs from remaining on mandatory IM for 18 months until the transition to voluntary is made. The regulatory burden of transitioning to voluntary IM, including the exit interviews, needs to be included in the regulatory impacts table.
- Update the analysis of the Cape York referrals, other community referrals, and SPaR and Child Protection cohorts to include the impact of being on a mandatory program when other participants are on a voluntary scheme, and the impacts of any potential flaws in a scheme that is based on community referral (e.g. people placed on a card outside their best interests, with potentially limited remit to appeal). They will also need to learn to use the new BasicsCard, a cost that is not currently included.

Merchants

- If merchants need to sign an agreement (see comment under the options above) include the cost of signing those agreements, and the number of merchants impacted.
- Clarify in the diagram that under the new voluntary IM system, merchants can either install the technology or sign an agreement and train staff.
- Better explain whether there are a sufficient number of IM merchants to support CDC participants if they move to voluntary IM. The IM merchant analysis and table suggests there are enough merchants compared to participants at a high population density? level, but not whether there are enough merchants in remote locations, where people may have to drive for hours to get supplies (assuming vehicular transport is available).
- Clarify which group of merchants is being analysed under each header (use the same language as the diagram above). It is difficult to verify if all regulatory costs and benefits have been captured for a specific group of merchants or? have been considered using the current format.
- It is unclear why it is assumed there is no impact on CDC merchants transitioning to IM ahead of the BasicCard technology being introduced.
- The cost of onboarding the mixed merchants onto the enhanced BasicsCard is not included in the text, but is included in the table. Please add an explanation of the assumptions and calculations.

Government

- Include the fiscal cost of the new program (especially the enhanced BasicsCard) so that decision makers can understand the cost-effectiveness of the scheme, especially compared to the potential number of participants.

Community organisations

- Remove the impact on community organisations from being able to refer participants onto IM as a benefit. This will be the same in the status quo and option 2, therefore it's not a benefit as a result of the new policy.
- Provide a clearer explanation of the benefits of the program.

Who has been consulted?

- If previous consultations are to be noted in the RIS, then the RIS needs to explain what the Department heard in these engagements and how it informed the development of option 2.
- Clarify if the Ministers will have consulted with every CDC and IM location by the time Ministerial visits have concluded. If not, why not, and what additional research or Department level engagement was or will be completed to supplement the Ministerial visits.
- Note any dissenting views.

What is the preferred option?

- Better articulate how Option 2 meets the objectives of Government intervention outlined in response to Question 2, to demonstrate why it is the preferred option.
- Summarise the evidence and consultation feedback above to demonstrate how it meets these objectives.

How will this be implemented and evaluated?

- State and territory governments and communities seem to play an important role during the transition and implementation process. The RIS needs to better articulate what their roles will be.
- The evaluation plan is missing from this draft. Please refer to early drafts to understand the detail required here, including the objectives of the evaluation, frequency of reporting, how data will be collected and who will be responsible for this process.

Status of the RIS at each major decision point

- The RIS needs to include a short statement describing the status of the RIS (e.g. draft or subjected to early assessment by the OBPR) at each major decision point along this decision pathway.