



CASHLESS DEBIT CARD TECHNOLOGY REPORT

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minderoo
FOUNDATION

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FOREWORD


The Cashless Debit Card (CDC) marks a fundamental step in helping to break the cycle of drug, alcohol, and gambling abuse amongst eligible welfare recipients. Whilst there are divergent opinions about specific policy settings and the best method of implementation, there is no doubt that the CDC and its package of wrap-around services are providing vulnerable communities with a circuit-breaker to help end the cycle of social harm. Originally envisaged in *Creating Parity - The Forrest Review* as a 'Healthy Welfare Card', the program has achieved key outcomes in the fight to create healthier, safer, and more sustainable communities.

Nevertheless, the current CDC model can be refined to better realise its potential. An integral part of this process involves more effectively utilising the full suite of payments and banking technologies in a way that is pragmatic, participant-focused, and scalable. To this end, the Minderoo Foundation convened an Industry Working Group comprised of many leading retail, banking, and payments organisations across Australia. The Group agreed to compile this report, which advises Government and industry on key steps to improve the technology model behind the CDC. We make 11 recommendations that will reinforce the program's social objectives, improve the participant and merchant experience, and enable it to be applied to a larger number of vulnerable communities.

We would like to thank the members of the Working Group for their strong engagement throughout the compilation process. By leveraging their collective knowledge and industry experience, our recommendations encapsulate strong support from those who will ultimately be responsible for orchestrating change. We strongly urge the Government to incorporate these 11 recommendations as part of any subsequent phases for the program, including the roll out to Hinkler and the WA Goldfields. As representatives from the corporate, non-profit and consulting sectors, we are prepared to help ensure the continued success of the CDC program.



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EXECUTIVE SUMMARY

In response to a request from the Prime Minister, Mr Andrew Forrest AO released *Creating Parity* on 1 August 2014. The review contained 27 interdependent recommendations, but more specifically it identified that a new way was needed to better distribute welfare payments and address issues with the Government's existing BasicsCard program.

Drawing its inspiration from *Creating Parity*, the Australian Government designed the Cashless Debit Card (CDC). Key differences between the CDC and the BasicsCard program included different management frameworks adopted by Government, the restriction model used by each card, and the proportion of payments quarantined. A 12-month trial of the CDC commenced on 15 March 2016 in Ceduna (SA) and surrounds, and on 26 April 2016 in the East Kimberley (WA). ORIMA Research was commissioned to evaluate the trial, releasing an Interim Report in March 2017 and a Final Report in August 2017.

ORIMA's reports were extensive and showed positive results. For card users at 12 months: 41% of drinkers said they were drinking less; 48% of drug users said they were using drugs less; and 48% of gamblers said they were gambling less (see *Appendix - Selected Results* for additional information). However, the reports also found mixed results that underscored technological limitations with the current CDC model. These included the lack of 'item-level', or Stock Keeping Unit (SKU) blocking solutions, the lack of payment terminals across micro-merchants, limited service channels, and the lack of multiple card issuers (including widely known retail banks).

This report details how Government can best implement:

Improving Social Outcomes:

1. **SKU Limiting** – Implementing a SKU limiting solution at major retailers to overcome circumvention via gift card, alcohol, and gambling purchases.
2. **Opt-in Card** – Extending availability of an opt-in card with simple on-boarding and CDC equivalent restrictions for non-welfare recipients, to reduce humbugging.
3. **Analytics** – Expanding the analytics program to capture a broader range of key performance indicators (KPIs), including, by geography: fresh food, alcohol, and gambling sales.
4. **Income Smoothing** – Implementing an opt-in income smoothing feature for CDC transaction accounts.

Improving Participant and Merchant Experience:

5. **Card Terminals** – Promoting micro-merchant card terminal options to increase CDC acceptance.
6. **Online Payments** – Opening online purchases to all domestic merchants by default, blocking restricted merchants via Merchant Category Code (MCC) and, where necessary, via individual Merchant ID.
7. **Message Prompt** – Implementing a message prompt restriction mechanism for non-integrated payment terminals, allowing a manual way to implement SKU-level blocking by merchants.
8. **Improve Experience** – Improving the transaction banking, debit card, and service channel experience.
9. **Enhance Security** – Implementing enhanced security features on cards and transaction accounts.

Creating a Scalable Solution:

10. **Process Automation** – Creating an application to automate transfer limit changes and ‘Pay Anyone’ approvals, whilst also leveraging CDC infrastructure to deliver the BasicsCard program.
11. **White Label Platform** – Transitioning CDC provision from a single-issuer to allow multiple institutions to participate using a ‘white-label’ model (short term) and a ‘decisioning platform’ model (medium term).

We also recommend phasing in accordance with the following implementation periods:

< 6 months	6 – 18 months	18 – 24 months
Rec 2: Opt-in Card	Rec 3: Analytics	Rec 1: SKU Limiting
Rec 5: Card Terminals	Rec 4: Income Smoothing	
Rec 9: Enhance Security	Rec 6: Online Payments	
Rec 10: Process Automation	Rec 7: Message Prompt	
	Rec 8: Improve Experience	
	Rec 11: White Label Platform	

BACKGROUND

INCOME MANAGEMENT AND THE BASICSCARD

Income management (or 'welfare quarantining') is a policy that compulsorily sets aside a portion of the welfare payments of certain individuals so that it cannot be spent on excluded items (e.g. alcohol, tobacco, pornography, or gambling products). The money that is not spent on excluded goods is then available to be spent on 'priority goods and services' (food, housing, utilities, clothing, education and healthcare).¹ The policy was first introduced by the Federal Government in 2007 as a part of the Northern Territory Emergency Response. Provisions for people to have their income managed voluntarily were also included.²

Income management is designed to provide "a key tool in supporting disengaged youth, long-term welfare payment recipients and people assessed as vulnerable, and is aimed at encouraging engagement, participation and responsibility". The stated objectives are to:

- » reduce immediate hardship and deprivation by directing welfare payments to the priority needs of recipients, their partner, children and any other dependents;
- » help affected welfare payment recipients to budget so that they can meet their priority needs;
- » reduce the amount of discretionary income available for alcohol, gambling, tobacco and pornography;

- » reduce the likelihood that welfare payment recipients will be subject to harassment and abuse in relation to their welfare payments; and
- » encourage socially responsible behaviour, particularly in the care and education of children.³

Between 2008 and 2014, the policy was expanded from Northern Territory (NT) Indigenous communities to other locations and groups of welfare participants. These include: Indigenous communities in Cape York; selected communities in Western Australia (WA) for child protection initiatives; the entire NT under the Federal Government's 'New Income Management' scheme; five communities around Australia under a new 'place based' model; and lastly, in selected areas across South Australia (SA) and WA.⁴

Centrelink only places welfare recipients on income management if their circumstances reflect certain criteria or if they volunteer. These criteria are determined by different income management 'measures', each of which operates in different areas, focuses on different groups of welfare recipients, quarantines different proportions of payments (ranging from 50% – 90%) and has its own unique set of conditions and exemptions.⁵ For a snapshot of these different locations, including the relevant rules and conditions that apply for each measure, and for the total number of people exposed to all income management measures, see *Appendix – Income Management Map, Populations and Expenditure*.

¹ Department of Social Services, Australian Government, *Guide to Social Security Law* (1 July 2015) 11.1.1 Overview of Income Management <<http://guides.dss.gov.au/guide-social-security-law>>.

² Luke Buckmaster, Carol Ey and Michael Klapdor, 'Income Management: An Overview' (Background Note, Parliamentary Library, Parliament of Australia, 2012) 1.

³ Department of Social Services, above n 1, 11.1.1.30 Objectives of Income Management.

⁴ Don Arthur, 'Income Management: A Quick Guide' (Research Paper, Parliamentary Library, Parliament of Australia, 2015) 4.

⁵ Ibid 2–4.

The *Social Security (Administration) Act 1999* expressly excludes the purchasing of specific items and services, and identifies 'priority needs'.⁶ It also establishes the framework for Centrelink to play an active role in making decisions about a person's income managed payments.⁷ Regardless of the measure, Centrelink typically arranges to make specific payments on behalf of welfare recipients (bills, etc.) before distributing any excess funds on to the 'BasicsCard', which is designed to be used for other 'priority needs'.⁸

The BasicsCard

The BasicsCard is a pre-paid card that runs on the national eftpos scheme rails. It provides income managed welfare recipients with the option of accessing their managed money through electronic payment facilities at approved stores, businesses and outlets. The BasicsCard is issued by the Department of Human Services (DHS), with Indue Ltd providing the service and scheme sponsorship, and is protected by a 4-digit personal identification number (PIN).⁹ Indue provides the back-end infrastructure, while DHS provides all customer-facing support.

In keeping with the objectives of income management, the BasicsCard cannot be used to access cash, or to buy alcohol, pornography, tobacco, gambling products, home-brew kits and concentrates, and gift cards or vouchers that can be transferred for cash or credit. Purchases are limited to approved stores such as supermarkets, post offices, pharmacies and medical centres, service stations, and department stores. Refunds for items purchased with the BasicsCard are returned to the card.

The BasicsCard is limited to a maximum balance of \$3,000 (adjustable down to \$100 by the user). Card users are free to set their own balance limits within these constraints. The maximum daily spend is also limited to \$1,500. Card users are similarly able to adjust daily spend limits to any amount between

\$20 and the maximum. When spend limits are met, the BasicsCard is deactivated until midnight, whereupon it resets for the next 24 hours.¹⁰

Key Issues

Over the last decade, several income management evaluation reports have been released. Whilst focusing on different income management measures, the operation, functionality and impact of the BasicsCard has been a consistent theme. Three key issues with the BasicsCard raised across evaluations relate to its inherently restrictive (or 'closed-loop') design, the stigma, shame and embarrassment experienced by some card users, and the cost of its administration.

Restriction

The Federal Government limits the acceptance of the BasicsCard to specific merchants. In accordance with the approval framework, if a merchant wants to be eligible to accept the BasicsCard they must "... sell a majority of priority goods and services and ... [s]ales in terms of dollar value of excluded goods and services must be less than 50% of total annual turnover".¹¹

The Place Based Income Management (PBIM) baseline evaluation report highlighted that one of the main concerns about the BasicsCard was its lack of acceptance among retailers and service providers, especially discount stores.¹² This was confirmed in the consolidated PBIM evaluation report, which showed that across both PBIM measures (voluntary and vulnerable) over 50% of respondents reported that there were things they wanted to buy using their BasicsCard but were unable.¹³

The consolidated report stated: "[t]he number and variety of retailers who accept [the] BasicsCard is consistently noted by stakeholders as a key limitation of PBIM. It is suggested that options for expanding the number and variety of retailers where PBIM customers can

⁶ *Social Security (Administration) Act 1999* (Cth) s 123TH-L.

⁷ Department of Social Services, above n 1, 11.1.3.10 Guiding Principles of Income Management.

⁸ Arthur, above n 4, 1, 5.

⁹ Department of Social Services, above n 1, 11.1.5.10 Meeting Priority Needs Using the BasicsCard.

¹⁰ Department of Human Services, Australian Government, *BasicsCard* (5 October 2017) <<https://www.humanservices.gov.au/individuals/services/centrelink/basicscard#group-110>>.

¹¹ Department of Social Services, above n 9.

¹² Deloitte Access Economics, *Place Based Income Management – Baseline Evaluation Report* (Department of Social Services, 2014) 79.

¹³ Deloitte Access Economics, *Consolidated Place Based Income Management Evaluation Report* (Department of Social Services, 2015) 29.

shop are considered. This may simply require that the facility is rolled out across more stores, or that the card mechanism itself is redesigned.”¹⁴

The Final Evaluation Report into the Federal Government’s ‘New Income Management’ for the NT also highlighted the same point, “[m]any retail and service outlets do not accept [the] BasicsCard. This includes major services such as the Post Office and utilities such as PowerWater. While in this latter case they will accept Centrepay deductions and other direct credits, a person who receives a power bill cannot simply walk into the office and pay it with their BasicsCard”.¹⁵

Stigma

Many card users surveyed across evaluation reports also highlighted shame, stigma or embarrassment when using the BasicsCard. The consolidated PBIM report showed that on average across both types of PBIM (voluntary and vulnerable), over 25% indicated that they felt embarrassed when they used the BasicsCard, and over 35% indicated that they felt judged.¹⁶ Some merchants also commented that they thought the requirements of the BasicsCard led to shame or embarrassment for some of their customers:

We have to try and manually check their card to make sure they don’t purchase prohibited items. We didn’t use to [but] since one customer managed to purchase cigarettes on their card, we nearly lost our license to accept the card we have to take this extra step which causes both embarrassment for some customers and even abuse from some customers to my staff. Without having to check their cards, I don’t believe we would have these issues.¹⁷

The Final Evaluation Report into the Federal Government’s ‘New Income Management’ for the NT also showed that nearly 40% of respondents cited ‘stigma / shame’ as at least one of the reasons for why they had tried to leave income management.¹⁸

Cost

The Australian National Audit Office highlighted that, “[t]he service delivery approach required for New Income Management is resource-intensive, differs from the day-to-day processes used for the majority of services provided by [the Government], and consequently is a relatively higher cost service”.¹⁹

In the same report, the DHS advised that it had spent over \$80m for FY11-12 to deliver income management in the NT. As Table 4 in Appendix – *Income Management Map, Populations and Expenditure* shows, roughly 50% of this cost was focused on front-line customer service. The estimated costs per person, per year were: between \$6,600 and \$7,900 for remote areas; between \$3,900 and \$4,900 for rural areas; and between \$2,400 and \$2,800 for urban areas.²⁰ Such an expensive cost has limited the expansion of income management to other vulnerable areas across Australia.

CREATING PARITY – THE FORREST REVIEW

In 2013, the Prime Minister commissioned Mr Andrew Forrest AO to review Indigenous training and employment services across Australia. Mr Forrest consulted widely and received over 300 public submissions from a range of different stakeholders and community members before releasing *Creating Parity – The Forrest Review* on 1 August 2014.

The *Forrest Review* contained 27 interdependent recommendations designed to create parity between Indigenous and non-Indigenous Australians. The recommendations are broad and address many of the contributory factors that influence employment, including: pre-natal care and education, training services, housing, Indigenous land management, and welfare reform.

¹⁴ Ibid v.

¹⁵ See Bray et al, *Evaluating New Income Management in the Northern Territory: Final Evaluation Report* (Social Policy Research Centre, UNSW, 2014) 138; Note, all Australia Post outlets have been able to accept the BasicsCard since August 2012.

¹⁶ Deloitte Access Economics, above n 13, 30-1.

¹⁷ Ibid 39.

¹⁸ Bray, above n 15, 111.

¹⁹ Australian National Audit Office, *Administration of New Income Management in the Northern Territory* (2013) 16.

²⁰ Ibid 94-5.

More specifically, it was identified that a new way to distribute welfare was needed to address key issues with the BasicsCard and so that recipients were better supported to, “manage their income and liabilities, save for the occasional bigger expenses like Christmas or school camps, [and invest] ... in a healthy life”.²¹

The Healthy Welfare Card

Recommendation 5 of the *Creating Parity* called on the Federal Government to implement immediately, “a Healthy Welfare Card scheme in conjunction with major financial institutions and retailers to support welfare recipients [to] manage their income and expenses”.²²

CASHLESS DEBIT CARD

On 14 October 2015, the Federal Parliament passed the Social Security Legislation Amendment (Debit Card Trial) Bill 2015 with bi-partisan support, allowing the Government to establish a 12-month trial of a Cashless Debit Card (CDC) based upon the Healthy Welfare Card. During its passage, the Bill was referred to the Senate Community Affairs Legislation Committee for inquiry and report. The Committee took submissions and evidence from a range of different sources including from community members of future trial sites. Its report was released on 12 October 2015.²³

BasicsCard v Cashless Debit Card

The key differences between the BasicsCard and the CDC include: the management approach adopted by Centrelink, the restriction model used by each card, and the portion of a welfare payment quarantined (with the remainder being cash accessible). The BasicsCard uses a ‘closed-loop’ restriction model, and quarantines between 50-90% of a welfare payment. The closed-loop design means that the BasicsCard can only be used at approved stores (who have entered into a contract

with the Department) to buy approved goods and services. Centrelink also actively determines and pays ‘priority needs’ for welfare recipients before distributing any excess funds to the BasicsCard.

The CDC uses an ‘open-loop’ restriction model and quarantines 80% of a welfare payment. The open-loop design means that the CDC can be used at any Visa Debit accepting store that is not categorised as a supplier of excluded goods and services (regardless of whether they have entered into a contract with the Department). Unlike the BasicsCard, the CDC features a full transaction banking account which can facilitate online purchases, Direct Entry transfers (manually approved by DSS or to other restricted accounts) and BPAY transactions.²⁴ The CDC also uses an EMV chip,²⁵ whereas the BasicsCard uses a magnetic strip (making the CDC inherently more secure and harder to counterfeit). Lastly, Centrelink does not determine and pay ‘priority needs’ for a welfare recipient on the CDC. Card users are empowered to make their own decisions about their needs.

Trial and Key Results

The Federal Government commenced the CDC Trial on 15 March 2016 in Ceduna (SA) and surrounds, and on 26 April 2016 in the East Kimberley (WA) with Indue Ltd being awarded the contract to manage the accounts linked to the Card.²⁶ The trial was designed to, “test whether restricting discretionary cash can reduce the overall social harm which is caused by welfare-fuelled alcohol, gambling and drug abuse ...”.²⁷ ORIMA Research released its CDC Trial Interim Evaluation Report in March 2017, and its Final Evaluation Report in August 2017.

²¹ Andrew Forrest, *Creating Parity – The Forrest Review* (Commonwealth of Australia, 2014) 27-8.

²² Ibid.

²³ Community Affairs Legislation Committee, Parliament of Australia, *Report – Social Security Legislation Amendment (Debit Card Trial) Bill 2015 [Provisions]* (2015).

²⁴ DSS is the abbreviation for the Department of Social Services

²⁵ EMV is the abbreviation for Europay, MasterCard and Visa; See EMVCo, *Overview* (2017) <<https://www.emvco.com/about/overview/>>.

²⁶ Department of Social Services, Australian Government, *Cashless Debit Card Trial – Overview* (2017) <<https://www.dss.gov.au/families-and-children/programmes-services/welfare-conditionality/cashless-debit-card-trial-overview>>.

²⁷ Commonwealth, *Parliamentary Debates*, House of Representatives, 19 August 2015, 8803-4 (Alan Tudge).

The Final Evaluation showed that, for card users at 12 months on average across trial sites:

- » 41% of drinkers said they were drinking less and 37% said they were binge drinking less;
- » 48% of drug users said they were using drugs less and 53% said they were spending less on drugs; and
- » 48% of gamblers said they were gambling less.²⁸

Despite such strong results, some of the findings were mixed and underscored technological limitations with the current CDC model.

Technological Limitations

The CDC was designed to restrict users from purchasing alcohol and gambling products, and prevent users from withdrawing cash. To effectively achieve these aims, the authorisation of checkout sales is contingent upon the acquiring bank's classification of the merchant into a Merchant Category Code (MCC). If the MCC indicates that the merchant supplies alcohol or gambling products, the transaction is automatically declined – regardless of the specific item being purchased.

This 'merchant-level blocking' approach works well for liquor and gambling outlets, but does not solve easily for mixed merchants that sell both unrestricted and restricted items, or merchants that sell secondary forms of credit (such as gift cards). Examples include a mixed-merchant pub that is categorised as a supplier of alcohol, but also has an attached bistro, or a supermarket that sells gift cards which can be redeemed next door at a bottle shop.

DSS has worked with gift card sellers and mixed merchants within the trial communities (supermarkets, service stations, pubs and clubs with a bistro, and other licensed restaurants) to implement operational controls as a fix to the limitations of 'merchant-level blocking'. This has included installing a separate payment device at the local pub for approved bistro purchases, and the training of supermarket staff to recognise a CDC at the point of sale (POS) and manually decline the transaction if it includes a restricted item or a gift card.

Whilst these operational controls have been effective at overcoming some of the technological limitations within the trial communities, it has reportedly been at great financial cost to the Government, albeit significant one-off setup costs were incurred to create the CDC product. In May 2017, the ABC stated that, "the pilot program is costing up to \$18.9 million, excluding GST" which is, "about \$10,000 per participant" (significantly more expensive than income management and the BasicsCard).²⁹ If the Government considers expanding the CDC to other vulnerable communities, including in more urbanised settings, it must invest in technological solutions that allow for 'item-level (SKU) blocking', as well as solve the technical limitations preventing cost effective scaling.

Working Group

To assess the feasibility of addressing these limitations on a national scale, the Minderoo Foundation called on senior executives from across the banking and retail sectors to attend a CDC Innovation Day on 13 July 2017. The purpose of the Day was to create a roadmap for the development and implementation of an 'item-level (SKU) blocking' solution, and to solve other issues hindering the card's acceptance, functionality and scalability.

The Innovation Day participants agreed to create a Working Group and produce this combined report to outline the necessary development work. Three key topics identified for the report included how best to: (1) maintain and improve social outcomes; (2) improve the user experience for participants and merchants; and (3) create a nationally scalable solution.

²⁸ ORIMA Research, *Cashless Debit Card Trial – Final Evaluation Report* (Department of Social Services, 2017) 4, 52.

²⁹ Dan Conifer, 'Centrelink Cashless Welfare Card Trial Costing Taxpayers \$10,000 per Participant', ABC (online), 2 May 2017 <[http://www.abc.net.au/news/2017-05-02/cashless-welfare-trial-costing-taxpayers-\\$10k-per-participant/8488268](http://www.abc.net.au/news/2017-05-02/cashless-welfare-trial-costing-taxpayers-$10k-per-participant/8488268)>.

IMPROVING SOCIAL OUTCOMES

The success of the CDC will ultimately be determined by improvements to social outcomes (generated by both the welfare quarantining measure and wrap around services delivered as part of the rollout package). The Working Group notes the significant positive impact on the trial communities, as demonstrated by ORIMA's Final Evaluation Report. Nevertheless, we believe there are technology improvements that can further improve outcomes by addressing certain circumvention behaviours, providing greater insight into policy effectiveness, and increasing financial literacy and capability among card holders.

REDUCING CIRCUMVENTION BEHAVIOURS

Evidence suggests that some recipients are determined to find ways to avoid restrictions on cash and prohibited goods.³⁰ It is unlikely that a fully 'waterproof' solution can be built, however an approach that deals with most circumvention behaviours and places additional hurdles in obtaining cash or prohibited goods will better support policy outcomes, even if a smaller number of individuals are able to find ways around them.

Major Retailers

Recommendation 1:

Implement a SKU limiting solution at major retailers to overcome circumvention via gift card, alcohol, and gambling purchases.

Several circumvention issues need to be resolved before the CDC program can be extended to a larger number of communities. Major retailers (esp. supermarket chains) need to implement SKU level checking at the POS to ensure that restricted items (e.g. alcohol and restricted gift cards) are not able to be purchased with the CDC.

There are two types of gift cards that have been identified during the trial period as giving CDC holders the ability to circumvent restrictions. These are: (1) 'closed loop' gift cards that can be purchased at an unrestricted merchant (e.g. a Woolworths Group gift card purchased in a supermarket) and then redeemed at a restricted merchant (e.g. Dan Murphy's); and (2) 'open loop' gift cards which can be purchased pre-loaded with an existing face value.³¹ Given that these gift cards effectively operate as a cash-like tender, it is not feasible to regulate their use and we believe they should remain restricted.

³⁰ ORIMA Research, above n 26, 85.

³¹ Note that closed loop gift cards purchased at a restricted merchant (e.g. Woolworths Group gift card purchased at Dan Murphy's) is already restricted by the Merchant Category Code, whilst open loop gift cards without face value (e.g. \$5.95 Visa Debit Prepaid) need to be funded by Direct Entry payment, which requires DSS approval on CDC accounts.

To minimise this circumvention risk, we recommend that a full SKU limiting solution be implemented at major retailers (specifically, those that comprise the bulk of restricted gift card sales and larger mixed merchants). This would encompass:

- » Major supermarket chains (e.g. Coles, Woolworths, Aldi, and Metcash/IGA) including their associated non-supermarket brands;
- » Australia Post; and
- » Major convenience stores and fuel operators (e.g. Shell, Caltex, BP, and 7-Eleven) – if they sell restricted gift cards.

Retailers will face costs in upgrading their POS systems such that they comply with a SKU limiting solution. We recommend that the Government consider partly subsidising the cost of this upgrade as part of the budget for an expanded CDC rollout.

The exact mechanism and amount should be determined by Government, as the cost will likely vary significantly by individual merchant.

As merchants are likely to have their own (often proprietary) POS systems and SKU categorisation methods, we also recommend that they are given discretion in how such a blocking solution is implemented across their specific payments infrastructure. However, the minimum requirements of the solution should be:

- » The ability to identify each SKU used by the merchant within a given product category (e.g. alcohol, gambling, tobacco, pornography, and cash-like products);
- » The ability to apply blocking at the POS or terminal to prevent the sale of restricted goods based on the BIN range of each card type and associated policy setting (e.g. alcohol, gambling and gift cards for the CDC, extending to tobacco and pornography for the BasicsCard);³²
- » The ability for sales clerks to identify the restricted item and communicate this to the CDC holder; and

- » The ability to incorporate future welfare quarantining card types into this SKU blocking infrastructure based on the combination of card BIN range and product category type.

It is noted that the Government is currently engaged in a tender process to implement SKU blocking in certain mixed merchants in the CDC trial regions. Any technical solution for this will likely need to involve:

- » Updates to the data fields and User Interface of merchant POS systems;
- » Updates to the payment application of card terminals across all acquirers;
- » Updates to the payment API by third party integrators;³³ and
- » Merchants to classify each SKU in their respective POS system.

While this effort is achievable for a smaller number of big merchants, the fragmentation of the POS market (up to 500 vendors operating in Australia, many with their product development and headquarters situated overseas) means that a fast and widespread rollout of SKU limiting for medium and smaller mixed merchants is unlikely in the short term. Rather, a staged approach could be taken in which POS vendors progressively rollout the required updates over a given period.

We take the position that major retailers (outlined previously) should undertake system upgrades as soon as practical to enable a complete SKU limiting solution, while smaller mixed merchants (e.g. restaurants, bars, and clubs) use a terminal message prompt approach to allow category restriction in the short term (see Recommendation 7). These two recommendations (1 and 7) can be implemented simultaneously.

We recommend the following implementation steps:

- 1.1 Relevant major merchants** to work with their technology teams and upgrade their POS system to accommodate a SKU limiting model as soon as possible.

³² A Bank Identification Number (BIN) is the series of the first four to six digits on a debit card that identifies the issuing bank; this can be used to identify CDCs from other unrestricted cards.

³³ API is the abbreviation for Application Programming Interface.

- 1.2 Acquirers** to contact in-scope merchants, and together develop requirements to upgrade card terminal payment applications (including any certification required) to allow SKU level blocking.
- 1.3 Australian Payments Network** to coordinate, via the Issuers and Acquirers Forum, the BIN range for each issuer, to allow POS systems to identify the CDC and other welfare quarantining cards.
- 1.4 Government** to publish specific requirements of all restricted categories for each program (CDC, BasicsCard, etc.) via the Issuers & Acquirers Forum.

Humbugging

Recommendation 2:

Create an opt-in card with simple on-boarding and CDC equivalent restrictions for non-welfare recipients.

When a CDC holder can extract cash from family or close community by the application of social pressure, the effectiveness of the card in preventing harm is weakened. This behaviour is particularly prevalent in Indigenous communities (including parts of the CDC trial regions) due to close kinship structures, and is reinforced given that some welfare payments (e.g. age and veteran's pensions) are not compulsorily included in the program. Whilst those in the community whose incomes are not restricted are still able to volunteer for a CDC, this capability has not been marketed widely (outside of age pensioners in the Ceduna district), and may require a more robust origination process to operate at an increased scale.

Where humbugging is prevalent, we recommend that community members not on restricted payments be given the opportunity to easily opt in to a CDC equivalent, with a simple origination process. By choosing the amount of money to transfer into the restricted account, the customer

can determine the quantity of their available cash, while reducing the likelihood of being humbugged.

We recommend the following implementation steps:

- 2.1 Indue** to streamline onboarding of a voluntary CDC, and promote this more widely as an option for community members in CDC areas who are not on welfare.

Other Circumvention Behaviours

There are three specific behaviours that the Working Group believes may be practiced by card holders and should therefore be monitored by CDC issuers. These are:

- » Misuse of BPAY and Direct Entry ("pay anyone") transfers;
- » Deliberate overpayment of bills via CentrePay; and
- » Swapping of CDCs.

Whilst controls are in place to monitor end recipients of BPAY and transfers, this process should continue to evolve, becoming more streamlined and automated (see Recommendation 10). Regarding the deliberate overpayment of bills (and the credited balance being refunded to an unrestricted account), any refunds for payment via a CDC should be returned to the same CDC account.³⁴

Card swapping is likely to continue to be prevalent, particularly in Indigenous communities due to attitudes about community ownership. A biometric (e.g. fingerprint, retina scan, etc.) authentication solution, such as that being implemented in India,³⁵ could minimise this behaviour. However, the lack of a centralised biometric database and the cost of hardware rollout make this solution impractical for the CDC. Rather, enforcement of the existing PIN authorisation and increased community education should be sufficient in the medium term.

³⁴ Specifically, for bills paid via CentrePay and managed by DSS.

³⁵ See Unique Identification Authority of India, Government of India, *Authentication Overview* (2013) <<https://authportal.uidai.gov.in/web/uidai/home-articles?urlTitle=authentication-overview&pageType=authentication>>.

PROVIDING GREATER INSIGHT INTO POLICY EFFECTIVENESS

Recommendation 3:

Expand the analytics program to capture a broader range of KPIs.

ORIMA's CDC Trial Evaluations largely relied on self-reporting surveys. Whilst qualitatively detailing program effectiveness, further quantitative metrics based on KPIs could be used to supplement this data. These metrics should leverage POS integration technology as outlined in Recommendation 1. Whilst the Government is best placed to define KPIs, examples include:

- » the proportion of CDC recipient money being spent on fresh food (reporting via supermarket chains);
- » the per-capita amount spent on alcohol in CDC areas (reporting via takeaway alcohol merchants); and
- » the per-capita amount spent on gambling in CDC areas (reporting via all RSG certified venues).³⁶

Note that any data collected and reported should be at an aggregated level, and not personally identifiable for any individual card holder.

This reporting scheme would likely have to be on an opt-in basis by individual merchants and aggregated to an industry level (to protect commercially sensitive data). Government may decide to specifically mandate reporting in CDC regions, but this will add additional cost and operational burden.

We recommend the following implementation steps:

- 3.1 Government** to engage in consultation with major retailers (specifically: Woolworths, Coles, Aldi, Metcash, major independent liquor and hotel groups, and major gaming providers) to determine voluntary and regular reporting standards to allow greater insight into consumer purchase habits and program success.



³⁶ RSG is the abbreviation for Responsible Service of Gaming.

IMPROVING FINANCIAL LITERACY AND WELLBEING

While restricting access to cash, alcohol and gambling products represents one lever to improve social outcomes, certain transaction account features can also be built into the product that can encourage behavioural change.

Income Smoothing

Recommendation 4:

Implement an opt-in income smoothing feature for CDC transaction accounts.

Anecdotal evidence suggests that some welfare recipients struggle to ensure that income paid into their account periodically (e.g. fortnightly) lasts until the following pay cycle. In some extreme cases, most of the money is spent on the first day or two after payday (due to lack of budgeting control).³⁷ To overcome this, welfare funds could first be paid into an interest-bearing savings account, with small amounts (e.g. \$20 to \$50) automatically transferred into the core transaction account on a daily or bi-daily basis. Alternatively, lower daily spending limits can be set on the transaction account, which should achieve the same effect.

Given the further restrictive nature of this budgeting solution, we recommend that it be an opt-in feature for participants. Basic account analysis can suggest to participants if it may be suitable for them (e.g. if an analytics program detects repeated account depletions on or close to payday, it can generate a prompt in the online banking interface to opt-in).

We recommend the following implementation steps:

4.1 Indue and Government to develop a voluntary income smoothing option for CDC recipients, which may either be implemented in-account (e.g. via a linked savings account) or via increasing the frequency of welfare payments from Centrelink.

Payday Lending

Due to low income levels and reduced budgeting capacity, some CDC holders have turned to payday lending (i.e. short term, high interest loans) to supplement their payments. We do not believe that specific rules regarding payday lending should be targeted to CDC holders, however this may be an area that Government feels additional regulation could be applied more broadly across all vulnerable or low socio-economic groups. This would assist in safeguarding against welfare recipients becoming trapped in a debt spiral. Adopted alongside basic financial education and Recommendation 4, such a measure could help CDC holders to better manage and budget their income. It should also be noted that if the CDC program functions as intended (i.e. card holders reduce spending on drugs, alcohol and gambling), this should reduce demand for payday lending services since more income is left over to spend on essential goods and services.

³⁷ See generally ORIMA Research, *Evaluation of the Cashless Debit Card Trial – Initial Conditions Report* (Department of Social Services, 2017) 20–34.

IMPROVING PARTICIPANT AND MERCHANT EXPERIENCE

The current CDC technology leverages the existing payments infrastructure which has already been rolled out nationally by the banking and financial services industry. As such, the participant and merchant experience is very similar to that of any unrestricted debit card (i.e. it is stable, secure, and convenient for both participants and merchants). We believe that solutions which enable greater CDC acceptance among a larger number of merchants, and that improve the core transaction banking experience linked to the CDC, must be implemented prior to program expansion.

INCREASING CARD ACCEPTANCE

Within the initial two trial communities, CDCs are widely accepted by merchants, both due to the widespread reach of card payment terminals among major retailers, and the installation of new terminals in smaller cash-only merchants (as a part of the rollout plan). For any expanded solution to work as seamlessly as in the trial regions, efforts will need to be made to ensure card acceptance is increased among small, online and mixed merchants (i.e. those that sell both alcohol and other products).

Smaller Merchants

Recommendation 5:

Promote micro-merchant card terminal options to increase CDC acceptance among cash-only merchants.

Given the limited access to cash, it is necessary for CDC holders to be able to use their cards as widely as possible, including at those smaller merchants who may not currently accept debit cards (i.e. market stalls, tradespersons, coffee carts, etc.). Traditional acquiring solutions can require a relatively large commitment by the merchant. This may include a minimum term contract, terminal rental fees, a set up and installation process, and the payment of a merchant service fee per transaction. As technology has progressed, smaller payment devices have allowed merchants to accept debit cards with much lower barriers to adoption (albeit these can charge a much higher per-transaction fee).

Micro merchants can now purchase small electronic payment devices, costing approximately \$20 – \$50 plus a flat fee per transaction, at major retailers (e.g. Officeworks or online). After registering as a merchant via a smartphone app, they can accept card payments either via a dongle that plugs into the headphone jack on a smartphone, via Bluetooth, or soon via an app download with no additional hardware (subject to potential changes in PCI-DSS rules to allow 'PIN on glass' transactions). We recommend micro-merchant specific options are included in the marketing and communication materials (e.g. example hardware and lists of local stockists) as part of the rollout and consultation plan for any new CDC sites.

We note that payment devices targeted towards micro merchants may have higher per-transaction fees; therefore the Government may also consider creating a tender for one or more acquirers which would allow for a discounted merchant fee for CDC transactions and become the default recommended solution.

We recommend the following implementation steps:

5.1 Government to create additional marketing and communications materials in CDC areas, highlighting micro-merchant terminal options as a way for cash-only merchants to accept cards payments.

5.2 Government to tender for a CDC acceptance solution targeted to micro merchants, with a discounted fee structure in exchange for becoming the default recommended provider for new CDC areas.

Online Merchants

Recommendation 6:

Open online purchases to all domestic merchants by default, blocking restricted merchants via MCC and, where necessary, via individual Merchant ID.

With online purchases representing 7.5% of total merchant-based spending,³⁸ it is important for CDC holders to be able to buy a large range of online goods and services without undue restriction. This must be balanced against any potential circumvention behaviours that might undermine the social outcomes of the program. Currently, use of the CDC online is restricted to a small group of pre-approved merchants (including large supermarket chains), while most subsequent merchants are blocked.

Online merchants pose different restriction management challenges for the CDC program when compared to store-based merchants. Specifically, the inability to pass SKU level data between the shopping cart and payment gateway online makes an integrated SKU limiting solution infeasible. This is reinforced by the global nature of most shopping cart software vendors (e.g. Shopify and Magento) and their high market fragmentation.

Instead, we favour a solution in which all domestic online purchases are unrestricted by default, with limiting via MCC only.³⁹ Where there are specific merchants who clearly allow circumvention or purchase of restricted goods, these should be blocked manually using the Merchant ID.⁴⁰ This may include online merchants who sell unrestricted gift cards, or operate mixed alcohol and food delivery services.

In the longer term, a SKU-level blocking solution may be possible for merchants who store user details (including tokenised card details). However, this would require a checkout system rebuild which would allow for the limitation of certain restricted SKUs if a CDC is tokenised within the app. Given the complexity and additional cost to merchants, this approach is not recommended unless the CDC program is rolled out nationally. In addition, consideration should be given to extending online purchases to international merchants, but only if a model for expanded domestic purchases has first successfully been implemented, and circumvention issues can be properly managed by the issuer.

We recommend the following implementation steps:

6.1 Indue to block all international Card Not Present (CNP) transactions using MCC codes, while implementing MCC authorisation (for restricted categories) and Merchant ID blocking (for individual sellers known to sell restricted goods but not captured by MCC) on domestic CNP transactions.

6.2 Indue to set up transaction monitoring analytics to identify purchases of restricted goods using online channels, with the ability to block purchases at individual merchants found to be selling restricted products (merchant identification would be facilitated via the Issuers & Acquirers Forum).

³⁸ See NAB, *Online Retail Sales Index* (August 2017) 2 <<https://business.nab.com.au/wp-content/uploads/2017/10/norsi-august-2017.pdf>>.

³⁹ The current MCC code restrictions used for 'card present' transactions in the trial sites should be used as the basis for online MCC restrictions.

⁴⁰ Where the issuer does not have visibility over the Merchant ID, an individual website or app can be submitted to the Issuers & Acquirers forum to investigate and determine the relevant ID number.

Mixed Merchants (Non-Majors)

Recommendation 7:

Implement a message prompt restriction mechanism for non-integrated payment terminals.

A complete SKU-limiting solution (see Recommendation 1) requires integration between the POS system, payment terminal, issuing, and acquiring banks (with the appropriate software updates). For a handful of larger merchants with the resources to invest, this level of coordination is manageable. For the larger number of small mixed merchants (restaurants, cafes, and other licensed establishments), the fragmentation of the POS market and the difficulty in ensuring merchant compliance mean that such a complete SKU-limiting solution is significantly harder to implement. This leads us to recommend a partial SKU-limiting solution.

There are approximately 131,000 terminals (50,000 integrated and 81,000 non-integrated) across 87,000 mixed merchants in Australia.⁴¹ For these mixed merchants, the primary objective is to enable a CDC holder to purchase an unrestricted good (e.g. a meal) while preventing the purchase of a restricted good (e.g. alcohol). We note that licensed merchants are governed by state-based responsible service of alcohol regulations (which require staff training). These could be leveraged to ensure compliance with a merchant-oriented blocking solution.

The proposed workflow will require an update to all payment terminals nationally (excluding those used by major retailers with complete SKU limiting potential). When a CDC is presented for payment, this update will ultimately prompt sales clerks with a question asking if the items include alcohol, gambling or gift card products:

Terminal prompt – for non-integrated terminals

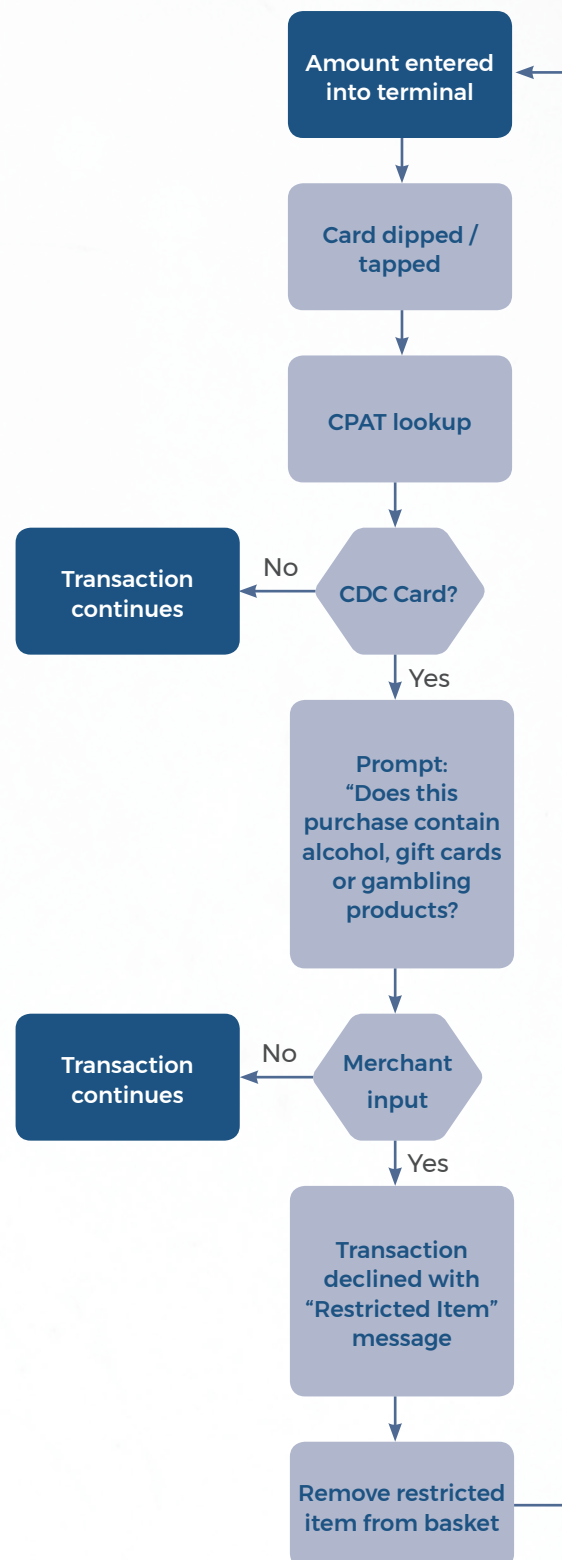


Exhibit 1 - Terminal Prompt Flowchart

⁴¹ Data provided by Australian banks and 70% of acquirers; results have been extrapolated to full market size on a pro rata basis.

This option is significantly cheaper and requires less effort to implement than a complete SKU-limiting solution. However, it relies on correct terminal input from the merchant (which is a circumvention risk). We recommend that if the CDC is rolled out nationally, then training on usage be part of any responsible service of alcohol qualification. Penalties for non-compliance might include loss of liquor licence, or the application of a merchant level block that prevents CDC acceptance. Whilst primarily aimed at mixed merchants in hospitality, this solution may be extended to merchants who sell unrestricted gift cards, although it is noted that most of these sales are via major merchants and therefore will be addressed by Recommendation 1.

We recommend the following implementation steps:

- 7.1 Acquirers** to update all terminals nationally to comply with the above message prompt model, with the exact technical requirements to be facilitated as an industry standard by the Australian Payments Network.
- 7.2 Acquirers** to sufficiently communicate educational material to merchants that allow them to train cashier staff to appropriately enforce restrictions at the POS.

IMPROVING TRANSACTION ACCOUNT PRODUCT AND SERVICE EXPERIENCE

The current implementation of the CDC is a limited trial, with approximately 2,100 participants across two sites.⁴² The transaction banking experience, whilst robust enough to fulfil its requirements, has several areas in which the account issuer can improve. There are also two key ways in which fraud levels can be reduced (further improving participant experience and lowering costs).

Account, Debit Card, and Channel Support Experience

Recommendation 8:

Consider options to improve the transaction banking, debit card, and service channel experience.

The core transaction account linked to the debit card is currently non-interest bearing (like many unrestricted transaction accounts offered by major banks). Nevertheless, there is an opportunity to offer both term deposit and savings accounts linked to the transaction account (in which funds can only be transferred between the transaction account). This implementation (mirroring many commercial products currently in market) would prevent circumvention of restrictions via third party transfers, whilst offering participants the opportunity to earn interest on the money they save.

There are opportunities to improve the use of the CDC itself. As technology has evolved, new form factors have emerged which make payment more convenient for consumers than the traditional plastic card. These include 'pay tags' (smaller sized cards that can be attached to key rings or phones), wrist bands, and tokenised mobile payment solutions (e.g. Apple and Android Pay). The CDC issuer(s) should consider these additional form factors in their product range, particularly as a possible solution to high levels of card loss (approximately 10% of total base issued per month).⁴³

For participants who lose their CDC and are familiar with mobile payment solutions, the CDC could be re-issued in real time to a smartphone (avoiding the 3-5 day turn around normally required to re-issue physical cards). However, we note that there is a cost trade off given the higher per-unit cost of non-traditional form factors, and that this solution may not be applicable to all demographics (e.g. those in remote areas or without smartphones). Currently, temporary cards are available via local partners to shorten wait times for replacement cards.

⁴² ORIMA Research, above n 26, 11-2.

⁴³ Monthly card loss rate in East Kimberley and Ceduna trial sites, as provided by Indue.



Exhibit 2 - Examples of Non-Traditional Debit Card Form factors.⁴⁴

Beyond being a convenient way to pay, card loyalty and incentive schemes can be used to drive consumer behaviour and encourage positive habits (contributing to the social aims of the program). Commercial tie-ins with desirable rewards partners could be used as an incentive to drive savings and purchases of products that satisfy 'priority needs' (ultimately building healthier communities). As an example, the card issuer could launch a version of the CDC in partnership with a supermarket chain and the AFL; when money is spent on fresh food, points are earned by the participant that could then be redeemed for free entry for their family to their favourite club game. This card could carry the branding of both the issuer as well as the commercial partners, helping to reduce stigma associated with an easily identifiable 'welfare card'. It also helps to change CDC positioning from potentially negative (i.e. when users focus on its restrictions) to positive (i.e. healthy purchasing habits lead to rewards).

An enhanced version of this product (including greater rewards mechanisms) could be offered to CDC holders who gain employment (ensuring that participants are not discouraged from achieving financial independence). This enhanced product will likely require Government subsidies and participation from commercial partners as it may not be viable on a purely commercial basis (given lower interchange fees on debit cards).

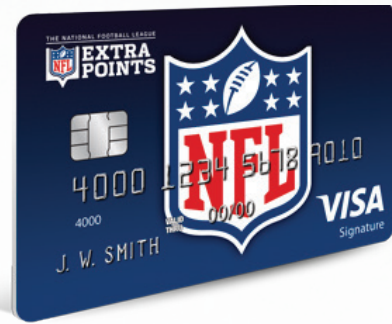


Exhibit 3 - NFL 'Extra Points' Barclaycard offers discounts on official merchandise, points redeemable for game entry, plus additional 'experiences' (like game sidelines passes).⁴⁵

Finally, it should be noted that if the CDC program is expanded beyond current trial sites, additional benefit will be gained by utilising the branch networks of banks and credit unions. This would require sufficient scale to justify change management and retraining of staff, and either be operated using a multiple issuer model (e.g. banks issue CDC and service their customers) or a service-based model (e.g. single issuer remains, but a bank offers selected branches as part of a broader service network).

We recommend the following implementation steps:

8.1 Indue to create a revised product feature roadmap (including the above recommendations, costings and implementation timeframes), and present to Government with funding options.

8.2 Indue and Government to begin discussions with banks, major merchants, and loyalty/rewards platform suppliers to investigate the feasibility of implementing a co-branded card with rewards points.

⁴⁴ See, eg, Bank of America, *Digital Wallets* (2017) <<https://promo.bankofamerica.com/digital-wallets/>>; Westpac, *Stress Less – New Wearables to Tap and Pay* (2017) <<https://www.westpac.com.au/news/making-news/2017/10/stress-less-new-wearables-to-tap-and-pay/>>.

⁴⁵ See Barclays Bank Delaware (Barclaycard), *NFL Extra Points Credit Card* (2017) <<https://home.barclaycardus.com/cards/nfl-extra-points-credit-card.html>>.

Fraud and Customer Protections

Recommendation 9:

Implement enhanced security features on cards and transaction accounts.

There is a fraud risk if the CDC is expanded to more participants due to the relatively lower levels of financial and technological literacy (particularly for those in remote areas). There are two ways in which we believe fraud can be minimised (without sacrificing participant experience or program scalability).

Firstly, it is imperative that PIN controls are maintained for all in-store card transactions and that PIN security messaging is reinforced to participants upon card origination (e.g. that PINs are private and not to be shared with anyone, including family). The card payment flow should be expanded to include contactless 'tap & pay' transactions, however, PIN authentication should continue to be required for every transaction (industry standard is to only require contactless PIN authorisation for purchases >\$100). With that said, the addition of contactless purchases for the CDC may increase card issuing costs.

Secondly, two-factor authentication via SMS should be introduced for all Direct Entry and BPAY transfers using online banking channels (web or app). This should be implemented as an 'opt-out' feature at the time of account origination, with participants being educated on the benefits of further protecting their funds. We note that some participants may not have access to mobile phones (particularly in remote areas). However, this is less likely to be an issue in regional and urban settings (with any individual without their own phone being able to opt-out if required).

We recommend the following implementation steps:

9.1 Indue to implement tap & PIN functionality on all newly-issued cards.

9.2 Indue to implement two-factor authentication on BPAY and 'Pay Anyone' transactions for all new accounts (on an opt-out basis), ensuring during the onboarding process that the participant is aware of the security process and has access to a suitable mobile phone with connectivity.



CREATING A SCALABLE SOLUTION

The initial investment of building a banking platform for the CDC program means that current per-customer costs to Government are high. The 'test and learn' approach has also led to several manual workarounds and operational controls that may not scale in an efficient way. While this intensive focus on the initial trial sites has led to better outcomes (as problems are able to be resolved quickly), it also requires improvement so that a more scalable approach to program delivery is possible. To ensure this, Government should focus on automating many of its manual customer touch points, rationalising infrastructure between the various welfare quarantining programs, and introduce a coherent framework that allows for multiple CDC issuers.

COST OF PROGRAM ADMINISTRATION

Recommendation 10:

Create an application to automate transfer limit changes and 'Pay Anyone' approvals, whilst also leveraging CDC infrastructure to deliver the BasicsCard program.

The Government is currently assessing options to reduce the cost of manual processes in its administration of the CDC. One of the focus areas for streamlining is the process for which participants change transactional account transfer (Direct Entry and BPAY) limits. This process is usually engaged when participants want to establish rent payments, or make larger once-off purchases (e.g. cars, furniture, etc.). Currently,

participants must contact DSS, complete a form outlining the reason for limit change, and supply credentials of the payment recipient (e.g. a letter from a landlord).

We recommend Government create an online service that supplements the current process. This should include the ability to attach supporting documents as evidence which are scanned via optical character recognition with text search. A provisional yes or no response can then be provided to DSS for approval. This will automate a large portion of the manual process currently executed via email and telephone between cardholders and DSS (allowing for scalability and cost savings, as well as faster customer turnaround). Instructions to change limits or approve transfers can be then made by DSS using an admin panel that integrates to the card issuer's back-end controls.

Further savings may also be realised by aligning the BasicsCard to utilise CDC infrastructure (i.e. an 'open-loop' restriction model). This is made possible by the fact that additional rules which prohibit other categories (e.g. tobacco and pornography) and exclude non-participating retailers are compatible with the CDC platform. The application of this could utilise the same framework outlined in this report, e.g. major retailers implementing a complete SKU limiting solution, and smaller mixed retailers using a terminal prompt (with MCC and Merchant ID blocking being implemented for BasicsCard BIN ranges).

We recommend the following implementation steps:

10.1 Government to tender the creation of a web app which allows digitised applications for once-off transfers, as well as transfer limit increases.

10.2 Government to commission a feasibility study that investigates moving the BasicsCard onto the CDC payments infrastructure (i.e. open-loop Visa Debit rails, and issuing via the same central platform provider) to determine potential cost savings and service delivery improvement opportunities.

INTRODUCING MULTIPLE CARD ISSUERS

There are significant benefits in allowing the CDC to be operated by multiple issuers. Firstly, bringing on board major brand names may help to alleviate stigma felt by participants (as their card and account will be similar to unrestricted products). Secondly, making available the branch, ATM, and other support networks of the banking industry will make it easier for card holders to get the help they need to manage the CDC. Thirdly, competition to gain customers may (over the longer-term) lead to greater product innovation.

Options for Introducing Multiple Issuers

Recommendation 11:

Transition CDC provision from a single-issuer to allow multiple institutions to participate using a White-Label model (short term) and also a Decisioning Platform model (medium term).

Beyond simply issuing a debit card and managing the controls around its use, the provider of CDC services currently offers a full transaction banking platform, online banking channels, call centre servicing, and oversight of partner 'shopfronts' to deliver in-person service.

Given that each of the core responsibilities (i.e. transaction account, card, and servicing) can be run independently if based on a common set of standards, it is possible to implement several different multi-issuer models:

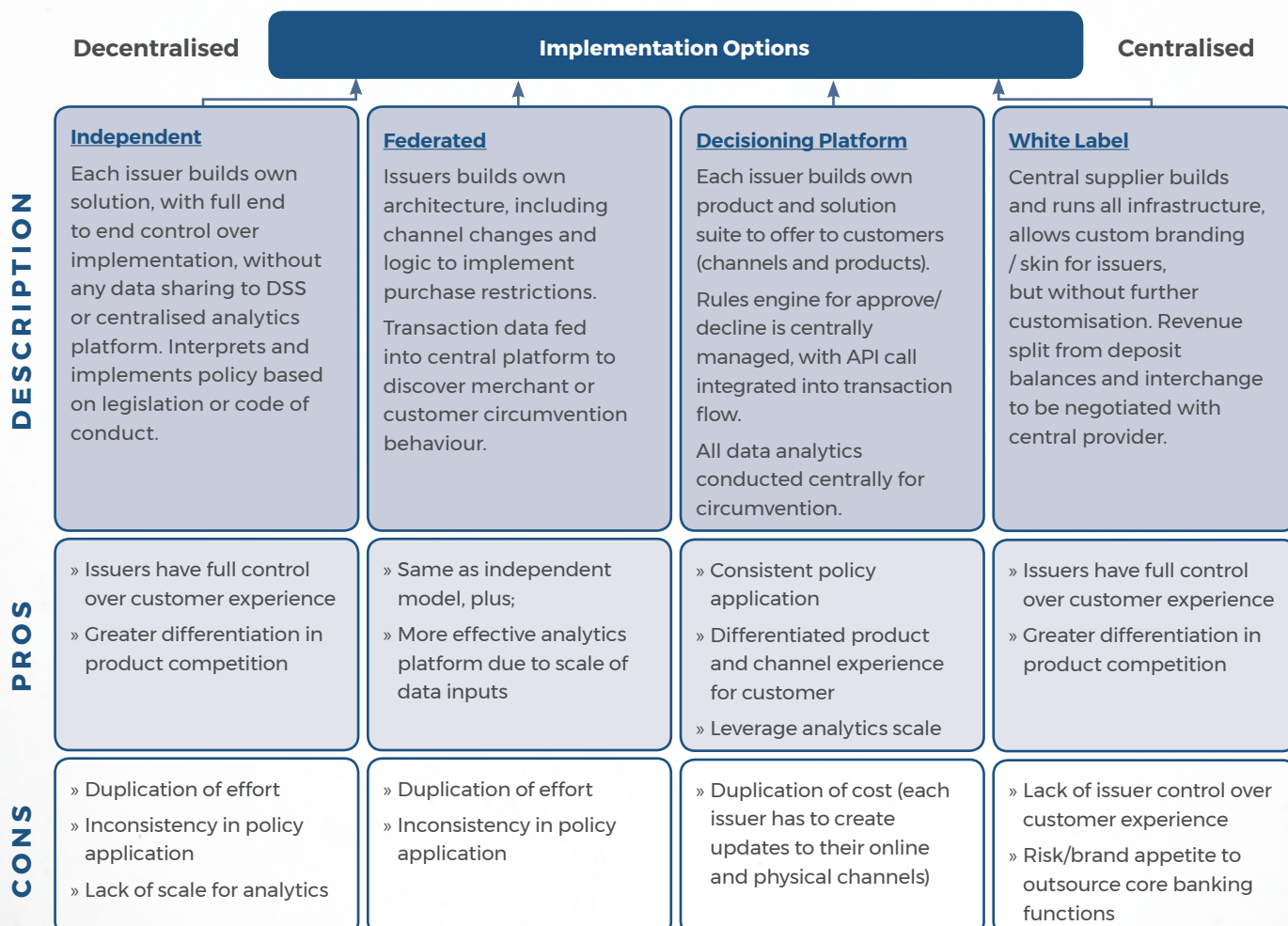


Exhibit 4 - Potential Models for Multiple CDC Issuers

Of the four potential models, we recommend pursuing a 'white-label' model in which one central card issuing platform makes its infrastructure (including transaction account and card restriction logic) available to third parties. These third

parties are then able to offer a CDC package to participants with their own branding (and in the cases of banks, provide basic support via their branch network or call centres).

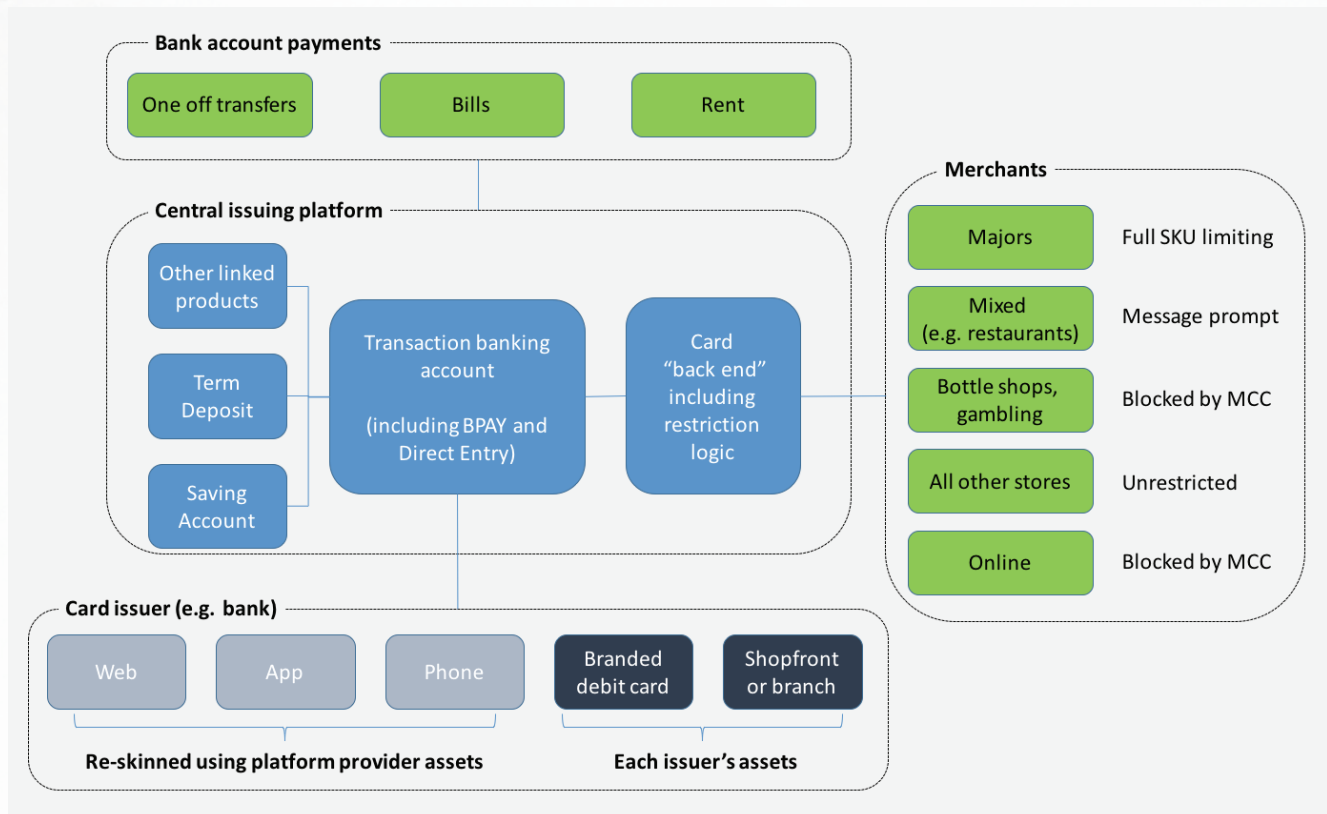


Exhibit 5 - Proposed White Label Conceptual Model

Promoting a white-label model would have the following major benefits:

- » Consistency in application of restriction logic;
- » Lower total cost of build (avoids duplication of effort and systems);
- » Centralised data repository for analytics;
- » Easier communication and change coordination with Government; and
- » Lower barriers (both time and cost) for third parties to issue cards.

We believe it is possible to implement an initial multi-issuer trial in the two upcoming rollout areas (Hinkler electorate and WA Goldfields). This could be achieved with a participating banking institution if further incremental investment is applied to the existing Indue solution (creating the required technology and commercial

management infrastructure).

Any new tender beyond the existing and currently announced sites should be based on an open CDC platform that allows multiple issuers to join (either on a white-label basis, or using the 'Decisioning Platform' model). This will allow a balance of speed-to-market and cost considerations, with the ability for other financial institutions to tailor their product and bring innovation to bear.

We recommend the following implementation steps:

- 11.1 Indue** to create and present a business case to Government that details the costs and benefits of turning the existing CDC banking solution into a white-label platform (allowing for multiple card issuers).

11.2 Banks and Card Issuers to commence discussions with Indue regarding the possibility of becoming a white-label card issuer for the Hinkler and WA Goldfields CDC regions.

11.3 Government to re-tender the central issuing platform contract (once clarity has been established regarding the full geographic extent of CDC rollout).



IMPLEMENTATION

We believe that these 11 recommendations contain a pragmatic mix of measures that can be implemented over a staged period, and that will improve social outcomes, the participant and merchant experience, and broaden the geographic and demographic reach of the program. Where possible, they also leverage existing payments network infrastructure and conventions to ensure the CDC can be a sustainable and ongoing part of the banking and payments landscape. When formulating timeframes for a staged approach, we have considered cost (direct cost to both Government and industry) and complexity to implement (including the level of industry coordination, development complexity, and any associated dependencies) as the key deciding factors.

CRITERIA FOR PHASING RECOMMENDATION

Our two criteria for phasing include:

- 1. Complexity** – the level of industry coordination, technology development work, compliance (including PCI-DSS); and
- 2. Cost** – including economic and labour costs to Government and key players across relevant industries.

Legend

- Do first: < 6 months
- Do next: 6-18 months
- Do last: 18-24 months

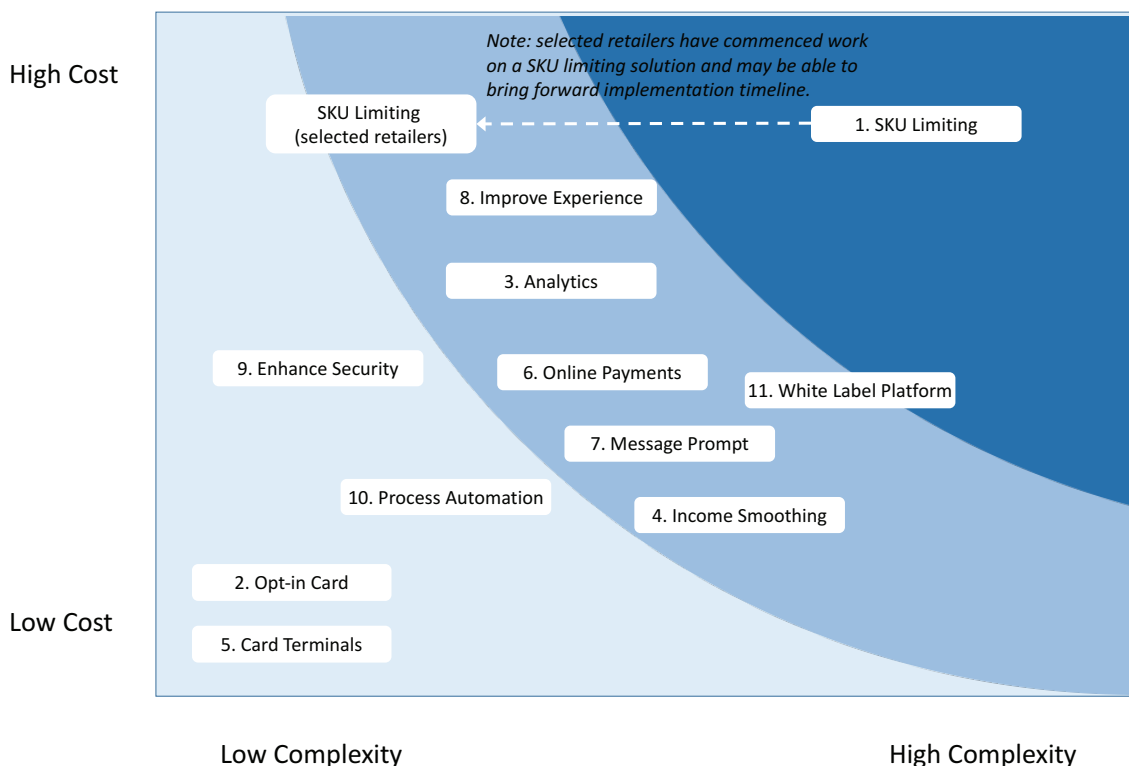


Exhibit 6 - Proposed Phasing of Recommendation Implementation

NEXT STEPS FOR GOVERNMENT

We believe that with the support of the banking, payments, and retail sectors behind the CDC program, the time is right for Government to act and expand the implementation of the Card (where communities opt-in on the basis that they feel it will empower them to break the cycle of alcohol and substance abuse).

In addition to the action items identified along with each recommendation, we recommend the Government take the following steps immediately:

- » Secure legislative clarity and power to roll out the CDC to new communities.
- » Begin the consultation process for a new set of communities for the CDC (beyond the recently announced Hinkler and WA Goldfields regions), selecting from those communities who have already expressed interest.

- » Commence a tender process for a central white-label issuing platform, including setting aside a sufficient budget to allow third parties to leverage this infrastructure.
- » Maintaining an ongoing CDC dialogue with industry partners (leveraging the Australian Payments Network) to determine the common set of issuing and acquiring standards required to implement the report recommendations.

Given the high level of industry coordination required for many recommendations, the Government should ensure it resources for strong project management and industry liaison. In addition to bilateral relationships with industry stakeholders, the Government could appoint an observer to various payments industry bodies (e.g. the Issuers & Acquirers Forum) during discussion of CDC-related agenda items.



CONCLUSION

We believe there is a clear path forward to utilise technology that improves the social outcomes of the CDC program, improves the participant and merchant experience, and creates a nationally scalable solution. The industry is committed to seeing the continued successful rollout of the program, and several Working Group participants have already begun to make investments that align with the future model of the card (as outlined in this report).

It is imperative that the Government, as well as the Opposition, act quickly to provide clarity over

the likelihood of further CDC program expansion. This certainty will allow industry participants to prioritise the required technology investments as part of their planning roadmap, which in some cases includes pre-committed resources and dependencies up to two years in advance.

We look forward to the Government adopting the recommendations in this report, engaging constructively with industry to ensure a seamless rollout of an improved CDC model, and making a lasting and positive change to at-risk communities.

APPENDIX

WORKING GROUP MEMBERS

ORGANISATIONS	
ALDI	Ingenico
Australia Post	Minderoo Foundation
Australian Payments Network	PayPal
Coles	PC EFTPOS
Commonwealth Bank	Smartpay
Department of Social Services*	Systemware
eftpos Australia Limited	The Initiatives Group
Heritage Bank	Visa
iA6	Woolworths
Indue	

The Working Group would also like to thank additional inputs from National Australia Bank and ANZ Bank.

**Note, members of the Department acted as observers.*

INCOME MANAGEMENT MAP, POPULATIONS AND EXPENDITURE

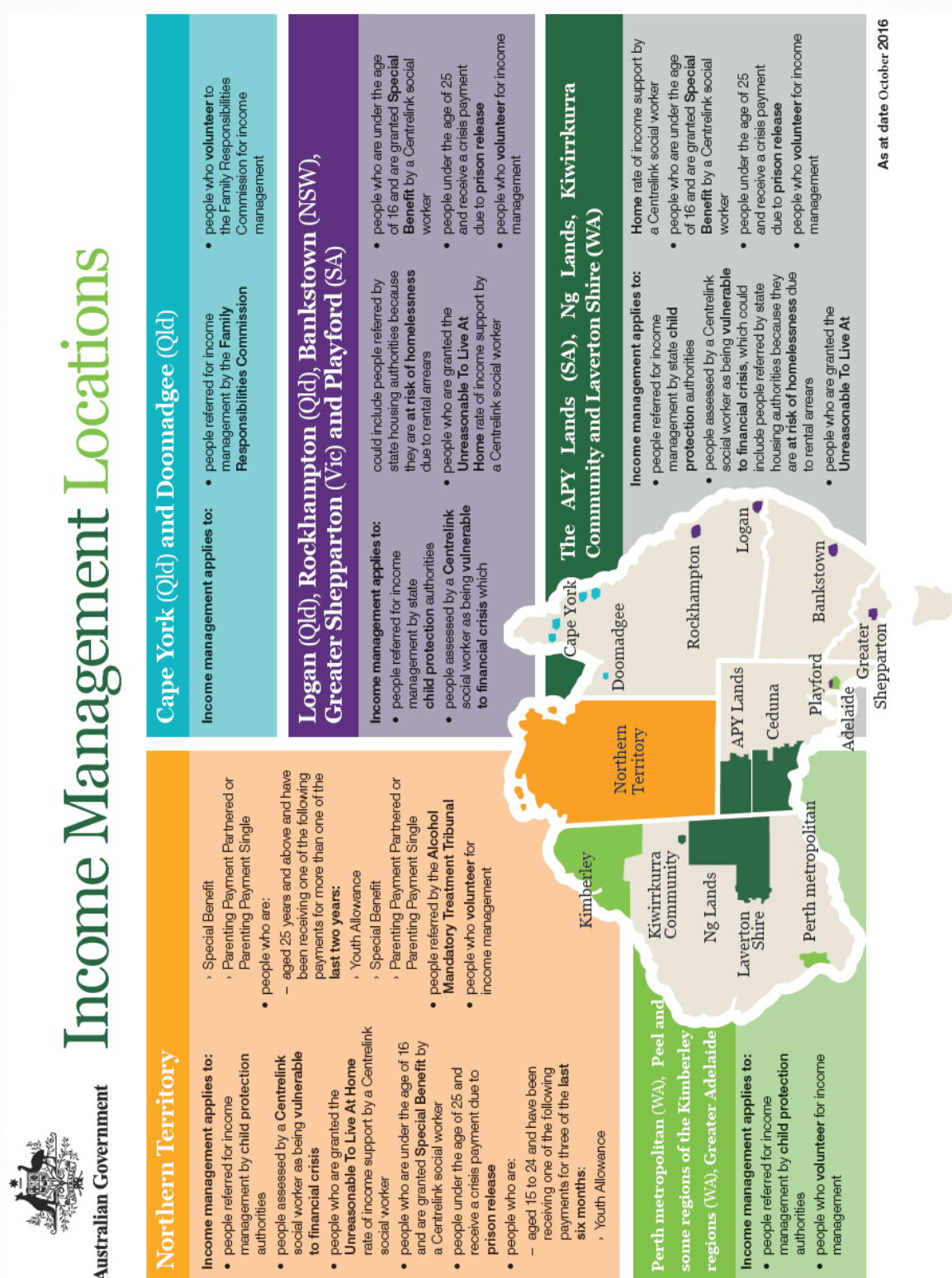


Figure 1 - Income Management Map.⁴⁶

⁴⁶ Department of Social Services, Australian Government, *Income Management Locations* (October 2016) <https://www.dss.gov.au/sites/default/files/documents/10_2016/im_locations-print_0.pdf>.

For more detailed information on each income management measure, refer to the Federal Government's *Guide to Social Security Law*.⁴⁷ Tables 1, 2, and 3 below also show the total number of participants across all income management measures, exemption types, and with an active BasicsCard (as at 30 December 2016).

State/Territory	Total	Per Cent Indigenous
Northern Territory	21,164	87%
Western Australia	1,398	65%
Queensland	1,285	40%
South Australia	703	51%
Victoria	254	17%
New South Wales	167	23%
Australian Capital Territory	<5*	67%
Tasmania	n/p*	33%
Unknown ⁱⁱ	50	78%
Total	25,033	81%

Table 1 - Total Number of People Across All Income Management Measures.⁴⁸

Exemption Type	Indigenous		Non-Indigenous		Total
Full Time Apprentices	2	20%	8	80%	10
Full Time Students	29	6%	472	94%	501
Parenting Requirements	706	42%	995	58%	1,701
Regular Paid Employment	0	0%	1	100%	1
< 25% of Max Payment	8	36%	14	64%	22
Total	745	33%	1,490	67%	2,235

Table 2 - Total Number of Income Management Granted Exemptions.⁴⁹

State/Territory	Total	Per Cent ⁱⁱⁱ
Northern Territory	20,511	97%
Western Australia	1,336	96%
Queensland	1,157	90%
South Australia	615	87%
Victoria	224	88%
ACT/NSW/TAS/Unknown ⁱⁱ	153	n/p*
Total	23,996	96%

Table 3 - Income Managed Recipients with an Active BasicsCard.⁵⁰

* Numbers <5 and not provided (n/p) have been withheld for privacy reasons.

ⁱⁱ Recipients categorised under 'Unknown' did not have an allocated address at the time of data collection.

ⁱⁱⁱ BasicsCard user percentage of all income managed recipients (rounded to nearest whole number).

Table 4 and 5 show a break-down of income management project costs from FY11-12 and more contemporary total costings.

Expenditure	Amount (\$'000)
Project Budget	27,093
National Support Office	3,941
Area Office, Customer Service Centres and Remote Service Teams	29,261
Smart Centre Network	11,690
Corporate Overhead (Accounts, IT, etc.)	8,733
Total	80,718

Table 4 - Income Management Expenditure FY11-12.⁵¹

Expenditure (\$m)*	2016-17	2017-18	2018-19
Department of Human Services	0.1	67.9	67.2
Department of Social Services	-	5.2	5.2
Total	0.1	73.1	72.3

Table 5 - Income Management Expenditure FY16-19.⁵²

*Includes in all current locations (NT, NSW, QLD, SA, VIC and WA)

⁴⁷ Department of Social Services, above n 1.

⁴⁸ Department of Social Services, Australian Government, *Income Management Summary Data* (31 December 2016) 1-2 <<https://data.gov.au/dataset/income-management-summary-data>>.

⁴⁹ Ibid 2.

⁵⁰ Ibid.

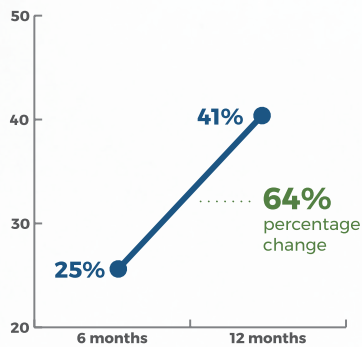
⁵¹ Australian National Audit Office, above n 19, 95.

⁵² Australian Government, 'Budget Measures' (Budget Paper No 2, The Treasury, Parliament of Australia, 2017) 149.

CASHLESS DEBIT CARD TRIAL - INTERIM AND FINAL EVALUATION SELECTED RESULTS⁵³

41%

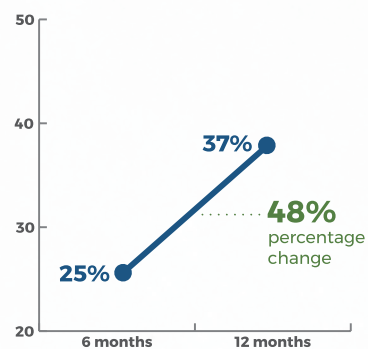
OF DRINKERS ON THE
CARD SAID THEY WERE
DRINKING LESS



Data Set 1 - Alcohol Consumption

37%

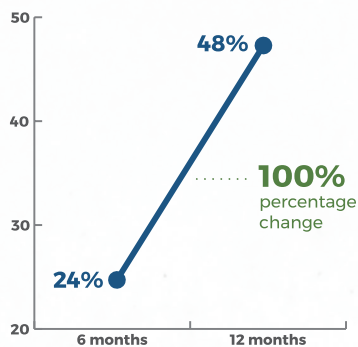
OF DRINKERS ON THE
CARD ARE BINGE
DRINKING LESS



Data Set 2 - Binge Drinking

48%

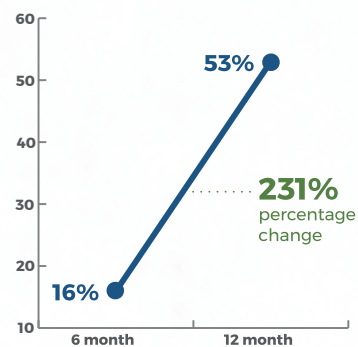
OF DRUG USERS ON THE
CARD SAID THEY WERE
USING DRUGS LESS



Data Set 3 - Illegal Drug Use

53%

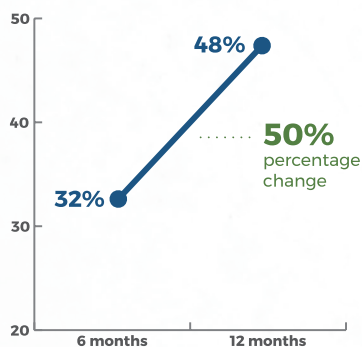
OF DRUG USERS ON THE
CARD ARE SPENDING
LESS ON DRUGS



Data Set 4 - Illegal Drug Spending

48%

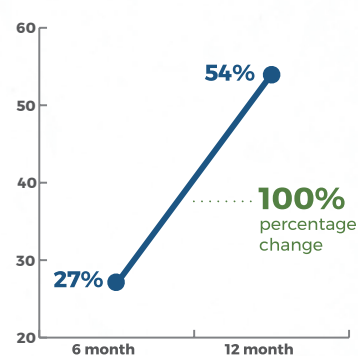
OF GAMBLERS ON THE
CARD SAID THEY WERE
GAMBLING LESS



Data Set 5 - Gambling

54%

OF GAMBLERS ON THE
CARD ARE SPENDING
LESS ON GAMBLING



Data Set 6 - Amount Gambled

⁵³ See ORIMA Research, above n 26; the green 'percentage change' and figures within the graphs listed were calculated by the Minderoo Foundation.

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