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**Non-take-up of
means-tested benefits:
National Report for Ireland**

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1. Introduction

Means tested social assistance aims to ensure adequate provision for the poorest members of society, while limiting the overall cost. A well-known difficulty with this approach is that means-tested benefits are not as effective in reaching the eligible population as universal provision – for which the cost is, of course, much greater. The balance between provision of universal support and means-tested provision, and the design and implementation of means tests must take this into account. Information on the extent to which means-tested benefits are not, in fact, taken up by some of the eligible population is therefore an important input to policy design.

In this report we try to identify the extent of non-take-up of two means-tested benefits in Ireland. The first is Family Income Supplement (FIS). We focus on FIS due to existing evidence suggesting a low take-up rate in Ireland. We also examine the likely extent of a new means-tested benefit, a non-cash benefit entitling recipients to free visits to their family doctor. This is known as the GP Visit card.

Regarding FIS we concentrate on establishing the extent of the non-take-up problem, using new data for 2005 to complement existing work with earlier datasets. While the scope of the scheme has expanded, the number of claimants and the size of the eligible population remain quite small. As a result, the number of recipients in the sample is below 100, and the number estimated as eligible is in the order of 200 cases. This makes it infeasible to undertake a detailed econometric analysis of the determinants of non-take-up; but some analysis of the characteristics of the non-claimant population is provided.

The GP Visit Card was introduced only late in 2005, so we are not able to identify recipients and eligible non-recipients in the 2005 data. Instead we combine information on the eligible population from the survey with information on take-up of the scheme from administrative sources in order to estimate the extent of non-take-up. The lack of combined data on eligibility and receipt in a survey means that analysis of characteristics is not possible in this context.

2. Context

Why is non take-up important? Hernanz et al (2004) discuss three of the main implications of benefit non take-up and why take-up rate estimation is important. Firstly, the aim of most social welfare benefit schemes is often to reduce poverty, particularly child poverty. If the take-up rate of a benefit is low the scheme is failing to reach its target recipients, thus failing to attain its goal. If a governments aim is to reduce poverty through a particular scheme but the target recipients are not claiming the schemes effectiveness will be reduced. Secondly, equity issues may come into play. If take-up is involuntary (for example eligible persons are unaware of the scheme or deem themselves to be ineligible due to a lack of knowledge) this creates unintended inequalities in the welfare system. Thirdly, the costing and financial consequences of potential changes to certain schemes may be difficult to ascertain if uncertainty exists regarding the take-up rate. Even if past take-up rates are known this is no guarantee that future take-up rates will not increase, thus government cost estimates of scheme reforms may be lower or higher than actual costs.

Hernanz et al (2004) also discuss the concept of primary and secondary non take-up. Primary non take-up occurs when the potential benefit recipient decides, for whatever reason, to not make a claim. Secondary non take-up, however, occurs when an eligible person has a claim rejected, most likely due to administrative errors caused, perhaps, by complicated eligibility requirements. Some of the non take-up may be 'temporary' i.e. an application for FIS has been made but has not yet been awarded due to a backlog of claims in the system, thus temporary non take-up may play a part in eligible persons not receiving the benefit.

Riphahn (2001) looks at the take-up of social assistance benefits in Germany. In line with theoretical predictions, she finds that the probability of social assistance take-up increases with the expected benefit amount and duration while it falls with application cost and the stigma associated with the benefit. Currie (2004) examines U.S. and U.K. data and finds that take up is enhanced by automatic or default enrollment and lowered by administrative barriers. This ties in with the suggestion by Callan et al (1995) that, in order to increase the take-up rate of FIS in Ireland, the tax system should be used to identify and, if possible, pay potential beneficiaries. This would help remove lack of knowledge regarding entitlement as a

reason for non take-up and reduce administrative barriers, as applications would be automatic.

In work carried out for the Department for Work and Pensions McKay (2002) looked at the family income support system in the U.K. Family Income Supplement was introduced in 1971 as a means-tested benefit before being replaced in 1988 by a tax credit known as Family Credit. This in turn was later developed into the Working Families Tax Credit. McKay discusses the target effectiveness of the credit system as opposed to the benefit format. The new system was found to have simplified many of the rules, eliminated the worst of the poverty trap, and expanded the number of families eligible to receive it.

3. Family Income Supplement (FIS).

Family Income Supplement is a weekly tax-free payment for families, including one-parent families, at work on low pay. Most social welfare schemes take account of the number of people dependent on the beneficiary. Wages, on the other hand, do not. FIS attempts to compensate for this for low-income workers with child dependants. It is a means-tested benefit and in order to qualify certain conditions must be met, namely you must:

- be an employee in paid full-time employment that is expected to last for 3 months.
- work at least 19 hours per week.
- have at least one qualified child (under 18 years of age or between 18 and 22 if in full time employment) who normally lives with you or is supported by you.
- have an average weekly net family income below the amounts outlined by the system. This amount in turn depends on the number of children in the household.

Extra income from employment (such as payment for overtime, bonuses, allowances or commission), income from occupational pensions and payments from a limited number of social welfare schemes also count as family income and reduce a family's eligibility for FIS but payments such as child benefit, carer's allowance and unearned income (such as rental income) are excluded. The beneficiary receives 60% of the difference between actual income and the relevant income limit. The minimum payment per week stood at €20 in 2005, the year of our analysis. The FIS payment is paid for 52 weeks and, if during this period, the recipients' income increases or decreases the payment remains the same.

FIS had evolved since its introduction in 1986. One of the most substantive changes has been the move from a gross income basis to a net income basis of assessment. Family income for FIS purposes is now calculated as a family's assessable earnings (gross pay minus income tax, employee PRSI, health contribution and superannuation). Other significant changes have been the reduction of the minimum hours worked per week from 30 in 1986 to 19 at present, which increased the numbers eligible for FIS payments, and the increase of the amount of the payment from 33 per cent of the gap between actual income and the relevant income limit to 60 per cent since 1989.

Data and Methodology.

Using data from the EU Survey of Income and Living Conditions (EU SILC) for the year 2005 we examined the number of FIS recipients. Using the same data source and SWITCH, the ESRI tax-benefit model, we calculate FIS eligibility and the amount that would be received per recipient. SWITCH simulates the assessable income for FIS purposes by adding up all the relevant income components and deducting tax and pay related social insurance (PRSI) contributions. Spousal/partner income is also included if relevant. Taking into account the number of child dependants in the household a modelled amount of FIS is arrived at.

Three categories are constructed; ‘eligible and receiving’, ‘eligible and not receiving’ (i.e. non take-up) and ‘not eligible but receiving’. Regarding this last category, as mentioned earlier, the duration of the FIS payment is 52 weeks. This may result in a number of people in the sample showing up as ‘not eligible but receiving’. They may have been eligible at the time of application but a change to their income post application would mean they would no longer be entitled to FIS if assessed today. Changes in circumstances since the time of application are also likely to cause differences in the actual amount being received compared with the amount modelled by SWITCH.

Table 1: Survey-based Estimates of the FIS population, 2005

	<i>unweighted N in</i>		<i>Aggregate</i>	<i>Aggregate</i>
	<i>sample</i>	<i>Caseload¹</i>	<i>Amount:</i>	<i>Amount:</i>
			<i>Modelled</i>	<i>Actual</i>
			<i>€m p.a.</i>	<i>€m p.a.</i>
Eligible and receiving	55	19,143	77.7	52.4
Eligible but not receiving	130	43,637	140.6	-
Not eligible but receiving	30	8,947	-	20.9
Total	215	71,728	218.3	73.3

Source: EU Standards of Income and Living Conditions Survey.

Note: 1. Survey figures grossed-up by weighting factors to represent estimates for the full relevant population.

Table 1 shows the survey-based estimates of the breakdown between those currently eligible and receiving FIS, those currently eligible and not receiving FIS and those currently not eligible but receiving FIS. The small numbers in the sample (215 unweighted) warns against over-interpretation of the results. The second column shows the numbers per category in the

survey sample. The third column again shows the number per category but the numbers are now weighted to estimate the population size. Column 4 shows the aggregate modelled amount for the year. Column 5 shows the aggregate actual amounts reported. Most surveys rely on self-reporting with regard to benefits and amounts received of them. The EU_SILC survey, however, included a request for personal public service (PPS) numbers. If a respondent provided their PPS number then figures regarding the type of benefits and the amount received are likely to be much more accurate, as this information was taken directly from the relevant public authority. Of our three FIS sub-groups above 100% of the ‘eligible and receiving’ group provided their PPS number, 77% of the ‘eligible but not receiving’ group and 87% of the ‘not eligible but receiving’ group did so. In 2005, administrative data tells us that there were 17,448 families receiving FIS and the amount spent stood at €72.2 million for the year. This ties in closely with the €73.3 million figure obtained from the ‘Aggregate Amount, Actual’ total figure in Column 5.

So how do we define take-up? As mentioned, entitlement to FIS, once established, lasts for a period of one year. This means that some of those currently receiving FIS would not qualify if assessed on the basis of current circumstances. Similarly, not all of those who could potentially be receiving FIS at a given date would qualify on the basis of their current circumstances. This leads to two distinct concepts of take-up, as pointed out by Atkinson (1984):

- Those currently receiving FIS as a proportion of all those who could have qualified
- Those currently receiving FIS, whose claims would still succeed if re-evaluated at present, as a proportion of all those whose claims would succeed at present.

In practice, most surveys, including the 1987, 1994 and 2000 surveys used here, can only be used to estimate take-up rates of the second type. They do not contain enough information on income changes during the previous 12 months to be able to estimate the total pool of those who could be entitled to FIS. Thus, they must concentrate on eligibility at the date of the interview.

In Table 2 below we look at the difference between take-up rates calculated on the basis of “caseload” and “expenditure” should be clarified. The term “caseload” is used to refer to a take-up rate that is defined in terms of the number of recipient units and the number of eligible units, including eligible non-recipients. It does not take account of the size of the

potential payment. An expenditure based take-up rate, on the other hand, is concerned with the amount of expenditure on the scheme, as a proportion of the expenditure if all eligible cases received their full entitlement. A higher rate of take-up may be expected for expenditure as against caseload, if, as has been found elsewhere, the rate of take-up is higher for larger entitlements.

Table 2: Estimated Take-up rates for FIS, 2005

Method	Caseload	Aggregate Expenditure
Survey-Based Estimate	30%	36%
Administrative data for recipients, survey estimate for eligible non-recipients ¹	21%	29%
Administrative data for recipients, survey estimate for all those eligible ¹	19%	24%

Source: EU Standards of Income and Living Conditions Survey.

Notes: 1.As mentioned previously not all FIS recipients would qualify for the payment if assessed under their current circumstances. We must, therefore, take this into account when looking at the administrative data. This is done by estimating the proportion of recipients who would qualify under their current circumstances. 68% of recipients were found to be currently eligible, accounting for 79% of expenditure. Using these figures we adjusted the administrative data figures.

Table 2 shows estimates of take-up rates for FIS. The first estimates are based purely on the survey-based estimate. This gives us an estimated take-up rate of 30% accounting for 36% of expenditure. This lies in the fact that people are more likely to claim if they will receive a relatively high amount. If, instead, we use administrative data in respect of actual recipients, adjusting for the fact that not all those in receipt would qualify for benefit if reassessed on the basis of current circumstances, then take-up on a caseload basis is lower, at about 20%.

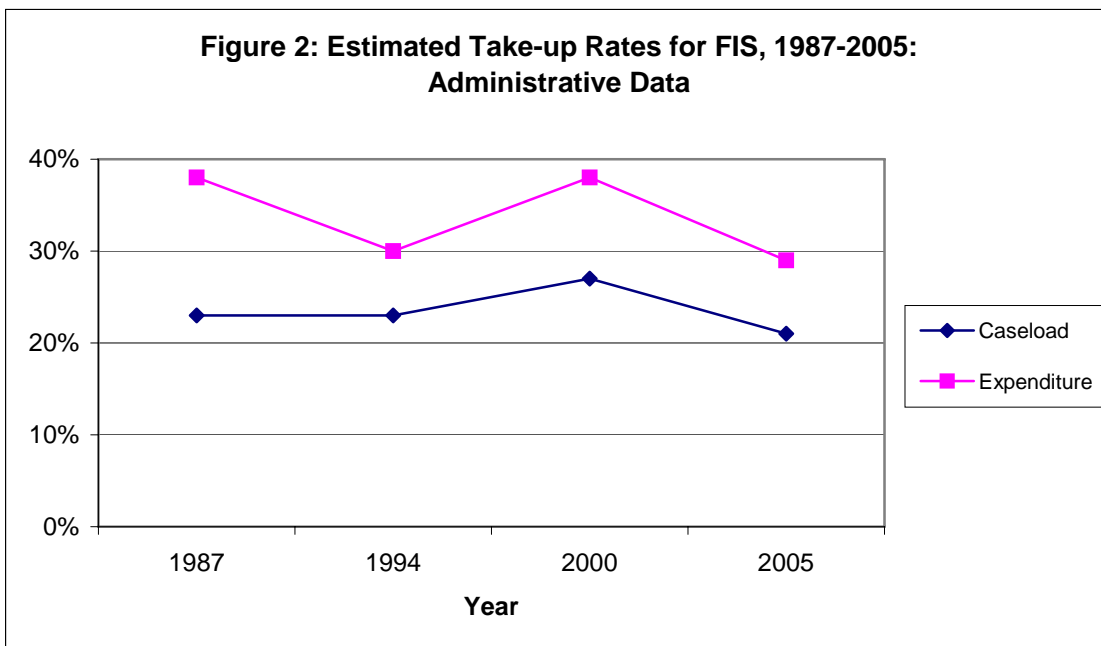
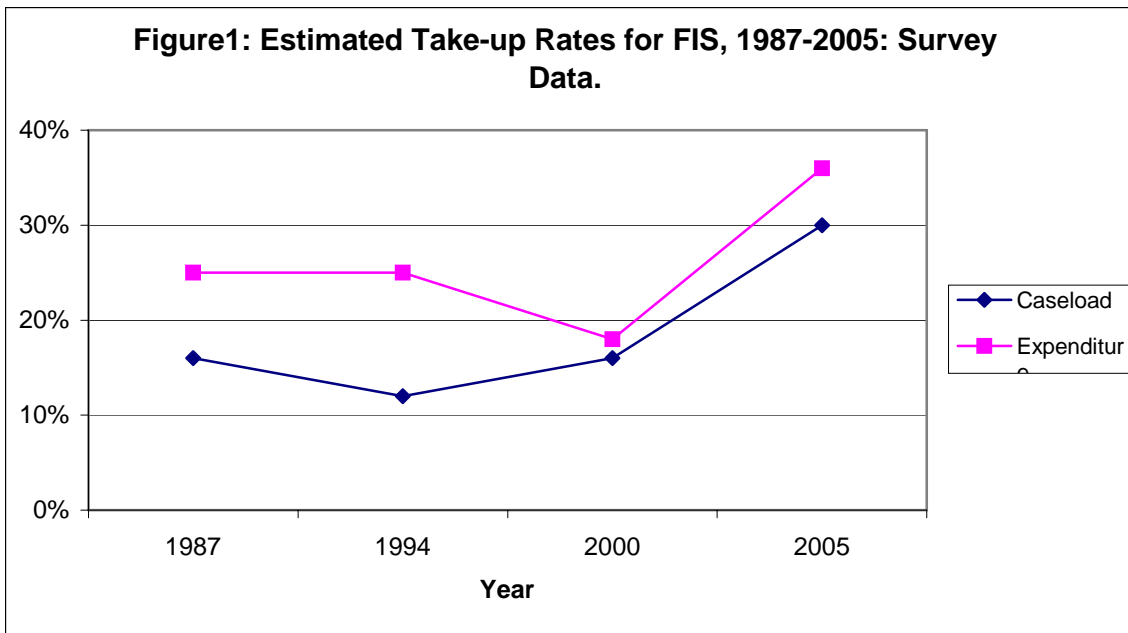
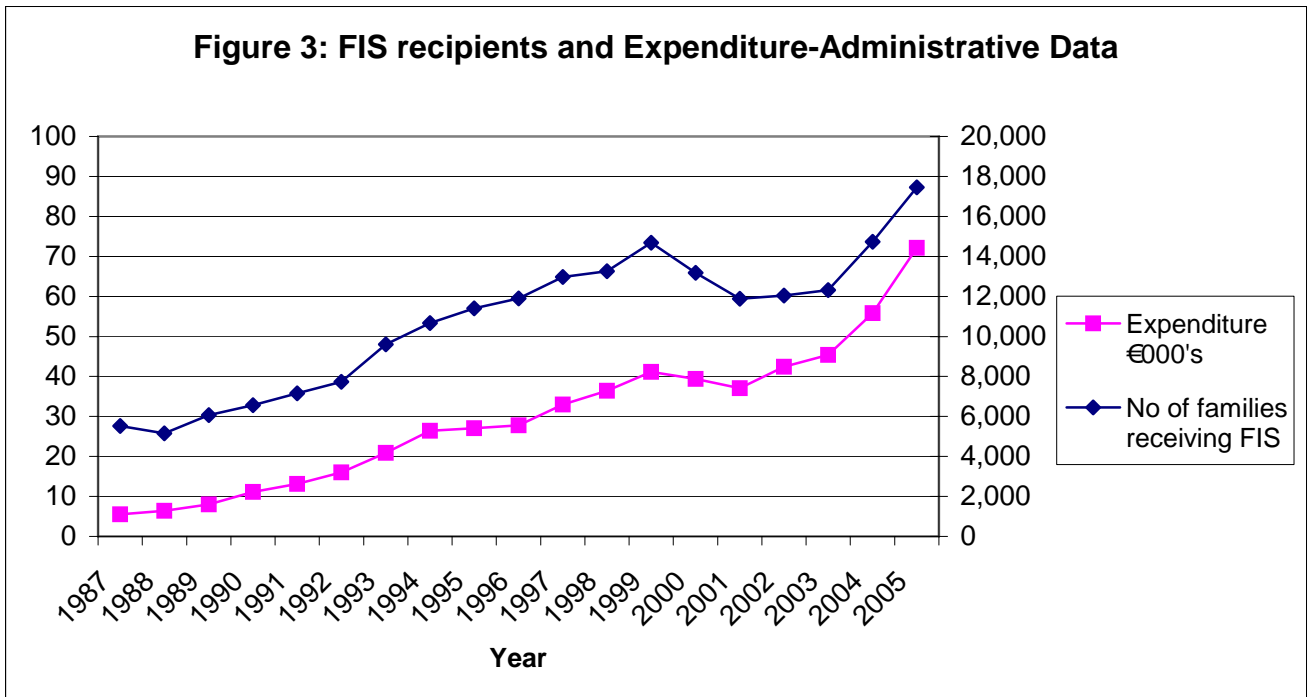


Figure 1 and 2 show the estimated take-up rates for the years 1987, 1994, 2000 and 2005. As mentioned the administrative data rates were adjusted to take into account the claimants who would no longer be eligible under their current circumstances. Given the very small number of cases in payment in the sample these adjustment factors are subject to a high degree of error. Figure 3 below shows the number of FIS recipients per annum from 1987 to 2005 along with the total expenditure for each year. Even though the number of recipients (measured on the right hand axis) is seen to be increasing the number of persons eligible has also increased which helps to explain why the take-up rates shown in figures 1 and 2 have not

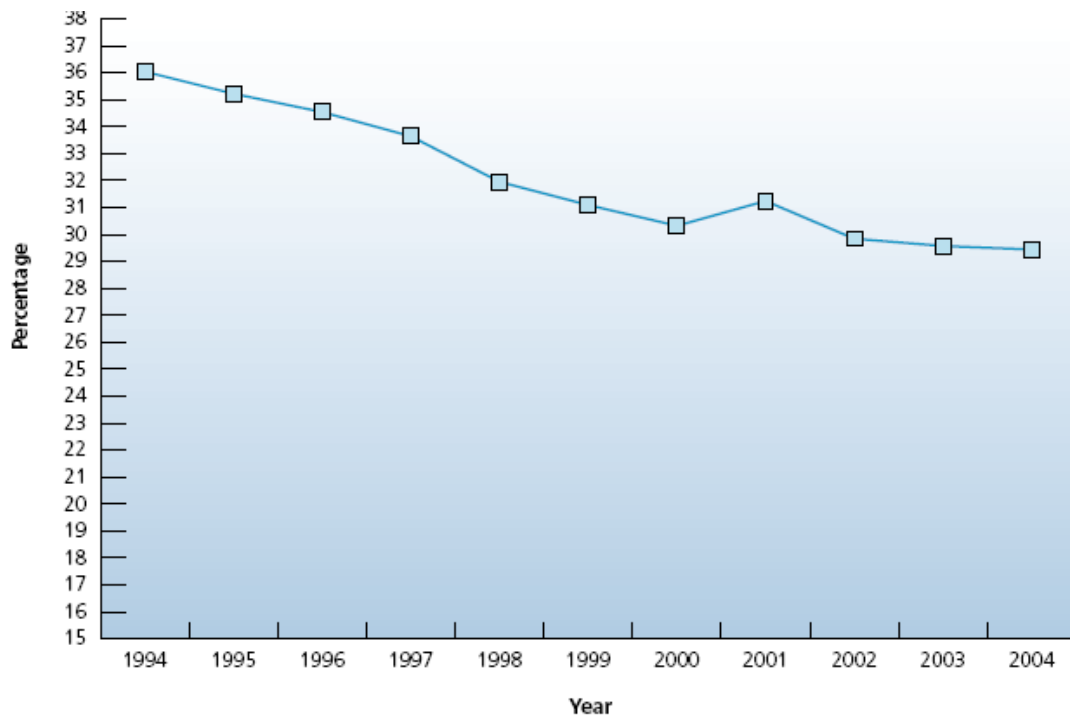
changed substantially between 1987 and 2005 although we do see an increase in the survey data take-up figures for 2005. Take-up still remains relatively low however.



4.GP Visit Card: A Means-tested non-cash benefit

The Irish health care system can be regarded as something of a hybrid between models of mainly public provision (many EU countries) and mainly private provision and financing (including health insurance). While it has a basic level of entitlement to public health services for all citizens, this provides coverage mainly for hospital services, with a modest fee being charged per visit or per hospital night, up to a maximum cost per annum. Low income individuals and families, and all those aged 70 or over, are entitled to a Medical Card, which entitles them to free hospital services, free general practitioner visits and free prescription drugs. For non-medical card holders, the costs of visits to general practitioners (GPs) must be borne privately, likewise the costs of prescription drugs up to a maximum of around €90 per month.

The proportion of the population covered by a Medical Card has fallen from around 36 per cent in 1994 to about 30 per cent in 2004 (Figure 4). This reflects the fact that income guidelines for eligibility were not increased in line with general income growth over the period.

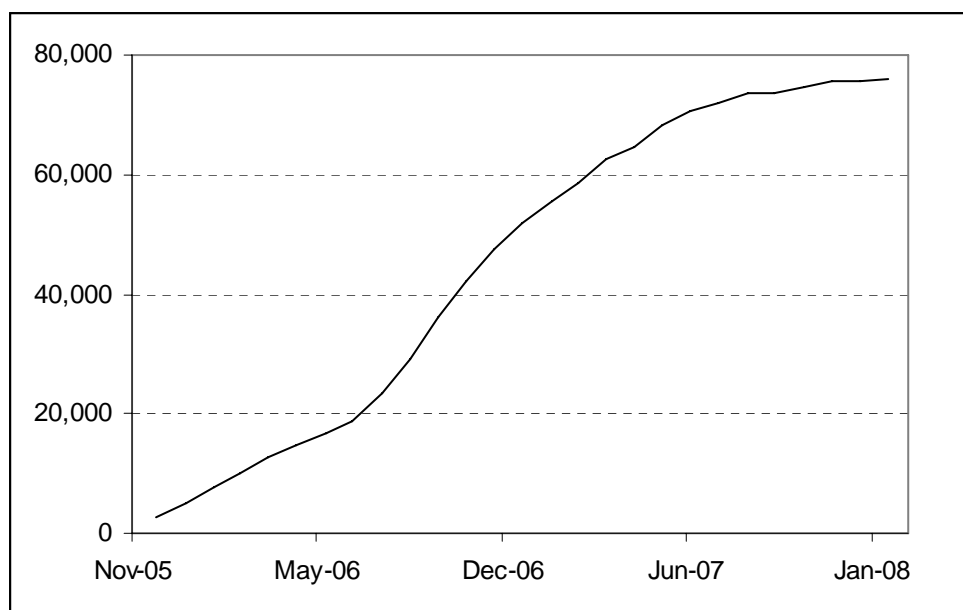


Source: General Medical Services (Payments) Board.

The system was changed because of two main concerns. First, a concern that those who formerly qualified for medical cards but were now ruled out on income grounds might face financial difficulties regarding GP visits. Second, a concern about the sharp benefit withdrawal involved in the structure of the medical card scheme. A scheme for a GP visit card, which would be available to those with incomes up to 25 per cent higher than the medical card guidelines was announced, and following lengthy negotiations with the representative bodies of GPs, the scheme got under way late in 2005. The number of persons expected to be covered by the GP visit card was 200,000:

By mid-2006, the number of persons covered by the GP visit card had reached only 10% of that expected number (See Figure 5 below). At that point, the income limits for the scheme were revised upwards very sharply. The scheme had initially provided eligibility for GP services to those with incomes up to 25 per cent above the income limits for a medical card. The revised scheme raised the income limits to 50 per cent above the medical card limits, thereby sharply expanding the eligible population. Caseload for the scheme then expanded more rapidly, rising by over 4,300 cases per month between mid-2006 and mid-2007. Since then, however, growth in coverage has tapered off, with an average increase of less than 1,000 between mid-2007 and early 2008.

Figure 5: Numbers benefiting from GP Visit Cards, Dec. 2007-Feb 2008



Given the objectives of the scheme, the extent to which the benefit involved is taken up is of particular importance. The expectation that the scheme, as initially designed, would benefit 200,000 people was firmly stated. e.g., “I expect that the Doctor Visit cards will benefit 200,000 people. We will be monitoring the take-up to ensure that the benefits we are funding actually get to people” Mary Harney, Minister for Health¹. The revision of the income limits for the scheme could be expected to raise the number of potential beneficiaries well above this figure. But the number of actual beneficiaries appears now to be stabilising at below 100,000.

In order to analyse this issue, we have extended the SWITCH model to simulate the income eligibility test for the medical card. The income eligibility test for the GP Visit Card uses the same structure, but with a higher income limit. We apply the model to data from the 2005 Survey of Income and Living Conditions (EU SILC) to estimate the eligible population for the GP Visit Card. This estimate of the eligible population can then be compared with the actual numbers in receipt of GP visit cards from administrative data, to provide an estimate of take-up.

The population aged 70 and over can be excluded from our analysis, as all of those above 70 are entitled to a full medical card. It would not, therefore, make sense for these individuals to apply for a GP Visit Card.

We begin by comparing estimates of modelled entitlement to a medical card with actual receipt of a medical card as recorded in the EU SILC. While around 78% of cases are “correctly predicted” by the model, there are substantial numbers in the off-diagonal cells. This applies both to individuals who are modelled as entitled to a medical card, but do not report having one, and those who are modelled as not entitled, but do report having a card. Some of the latter may qualify for what is termed a “discretionary” medical card, despite not meeting the income guidelines.² This would mainly arise in cases of particularly great

¹ Quoted on <http://www.dohc.ie/press/releases/2005/20050623a.html>

² “In certain circumstances where hardship or undue burden is assessed, a medical card or GP Visit Card may be approved for individuals or families whose disposable income exceeds the financial guidelines”

medical need. However the number of persons with discretionary medical cards is well below the number of persons reporting having a card, and modelled as outside the guidelines. Changes in circumstances and measurement errors are more likely explanation for the existence of these large off diagonal elements.

Table 3: Modelled Entitlement versus Actual Medical Card

Actual medical card?	Modelled medical card entitlement?		
	No	Yes	Total
No	2,371,655	367,265	2,738,920
Yes	475,669	545,202	1,020,871
Total	2,847,324	912,467	3,759,791

The GP Visit Card involves raising the income limits by 50%. When this is done, the total population modelled as eligible (Method 1) expands by 445,000. This would be consistent with the initially expected figure of 200,000 persons eligible for GP visit cards if that the density of the income distribution in the range 25% to 50% above the medical card limits is similar to that for the range from the medical card limit to 125% of the medical card limit. An alternative estimate could be derived using simply the change in the estimated population eligible but not in receipt of medical cards (Method 2). This would take account of the fact that some of those in the range just above the medical card limit are already, in fact, in possession of a medical card.

Table 4 summarises the take up rates which arise from combining these alternative estimates of the eligible population with administrative data on the number of persons covered by a GP visit card.

Table 4: Estimated Take-up Rates, GP Visit Card

	GP visit card		
	Method 1	Method 2	Actual
	Modelled & do not		
	Simulated have medical card GP visit		
Caseload	446,879	175,692	76,000
Take-up rate	17%	43%	

The take up rate for GP visit cards can therefore be estimated as between 17 per cent and 43 per cent. On either basis, there is a very substantial element of non-take up. Given the recency of the introduction of the scheme, it will be necessary to obtain more recent data in order to examine this issue further.

5. Conclusion

Evidence of low take-up of Ireland’s Family Income Supplement scheme was reviewed. Such evidence has shaped debate on strategies for child income supports in the Irish context. Sweeney (2007) argues for a new integrated benefit for low income families, irrespective of whether their main income source is a welfare payment or a wage. Such a benefit would be similar in structure, and perhaps in delivery, to the Working Families Tax Credit introduced in the UK. Our analysis of more recent data (2005), using the SWITCH tax benefit model to simulate the rules governing FIS, indicates that substantial difficulties with take-up remain, with no more than half of the benefit being claimed. It cannot be assumed, however, that a shift to a Working Families Tax Credit mechanism would do away with all targeting errors. The UK experience indicates that difficulties can also arise from overpayment of benefit, necessitating a clawback of payments.

The introduction of a new non-cash benefit in the Irish health services system, allowing eligible claimants free visits to their General Practitioner (GP), provided a further opportunity to study the take up issue. Initially it was expected that about 200,000 people would qualify for the benefit. Slow initial uptake led to a sharp increase in the income limits, and the population of potential beneficiaries was therefore increased. Our simulations of the eligible population, when combined with administrative data on the numbers of GP visit cards issued, suggest that the rate of take-up is below 40%, and perhaps as low as 17%. These findings

suggest that attention must be given to gathering up-to-date and relevant data in order to monitor and understand the situation.

Appendix: Details of the GP Visit Card, as revised at June 2006

The main details of the revised scheme were set out in the following press release, issued in June 2006:

”The Tánaiste and Minister for Health and Children, Mary Harney, T.D., today announced that she has increased the basic income guideline for the GP Visit card.

The basic income element of the means test was set at 25 per cent above the medical card income guideline. The Tánaiste has now increased that to 50 per cent.

This increase coincides with a major new advertising and public awareness campaign on GP Visit Cards by the HSE.

The Tánaiste said ‘The Government wants to make it as easy as possible for people to get the new GP Visit Card. The card is designed to help people on moderate incomes to visit their GP free of charge.’

‘Last year, I made significant changes in the means test for the medical card and GP visit card. The test is now after tax and PRSI, and also takes account of all reasonable mortgage or rent costs, travel to work expenses and childcare costs. The basic income guideline is just one element of the means test.’

‘After the change today, the GP Visit Card should be available to the following people with typical outgoings and the following income after tax and PRSI:

- a couple with two children earning about **€1,200** a week, **€6,400** a year;
- a couple with four children earning about **€1,580** a week, **€8,160** a year;
- a single parent with one child earning about **€1,000** a week, **€5,000** a year;
- a single person with no dependants earning about **€426** a week, **€2,152** a year.’

‘The relevant salaries can be well above the average industrial wage.’

‘So far, approximately 18,000 people have GP Visit Cards. The Government has allocated funding this year for 200,000 cards. Many people are only becoming aware that this benefit exists for them. We are still in the early days of this new card.’

‘I encourage more people to apply. The HSE is working to keep the administration simple. I am asking the HSE to review recent unsuccessful applications to see whether they now qualify.’

‘I also welcome the HSE advertising campaign to raise awareness of this important benefit.’

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