The take-up of Income Support and passported benefits for pensioners in the UK: some issues

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1 Introduction

In seeking to understand the factors that lead to non-take-up of means-tested benefits it is important to identify the potential gains from claiming and the possible barriers to making a claim. Generally, the benefit of claiming is considered to be the cash entitlement. The barriers are lack of information, stigma and other claim costs. In any practical exercise based on survey data the picture is blurred – and may be distorted – by measurement error. Hancock and Barker (2003) examine these issues in relation to Income Support (IS) for British pensioners and Pudney (2001) investigates the possible impact of measurement error on estimates of the take-up of this benefit. However, as well as the cash income offered by IS, there are also benefits in-kind that may be received by virtue of being in receipt of this benefit. One example is free dental treatment; another is funeral expenses paid through the Social Fund. Such “passported benefits” may affect all three of the aspects of take-up modelling mentioned above. First, the prospect of being entitled to these additional benefits may make claiming IS more worthwhile: the costs of claiming are more likely to be offset by the gains from a successful claim. Secondly however, there may be additional stigma attached to the receipt of in-kind benefits, thus lowering the likelihood of claiming. Finally, data limitations regarding receipt and valuation of the benefits may introduce additional forms of measurement error.

This note considers how the benefits in-kind passported through receipt of IS might be incorporated in a model of IS take-up based on data for a sample of pensioners from the Family Resources Survey. The following section describes these benefits. Section 3 discusses how they may influence IS take-up and section 4 presents the information that is available on receipt of passported benefits for samples of pensioners in the Family Resources Surveys for 1997-2000. Section 5 explores whether one can identify pensioners who are more likely to use the benefits that may be passported and section 6 estimates the value of a selection of health-related benefits. Section 7 concludes by assessing the prospects for inclusion of passported benefits in an empirical model of take-up based on this data source.

1 I am grateful to the Economic and Social Research Council for financial support under project grant R000239015. Material from the Family Resources Survey, made available by the Department for Work and Pensions via the UK Data Archive, has been used with permission. Thanks are due to Ruth Hancock for helpful comments. However, all responsibility for the analysis and interpretation of the data presented here lies with the author.
2 Passported benefits for pensioners on IS

The period considered in this study is the three years April 1997- March 2000. The benefits in-kind for which pensioners on IS living in private households (not in residential care) might qualify during this time included: 2

- NHS dental treatment
- Sight tests
- Glasses, contact lenses (and repairs to these)
- NHS wigs and fabric supports
- Travel to hospital for NHS treatment
- Legal Aid
- Public transport fare subsidies
- Subsidised fees for adult education, leisure and entertainment facilities
- Social Fund - funeral expenses, cold weather payments, community care grants
- Subsidised charges for domiciliary care
- Housing and insulation grants

For the benefit in-kind to affect the IS take-up decision it must not be available through another route: IS receipt should be a unique passport (a necessary and sufficient condition). The benefit-in-kind must be available to all IS recipients who need it (in the same way as a cash benefit): IS receipt should be a comprehensive passport. In addition, for the benefit to be worthwhile to consider in a model of cash benefit take-up based on sample survey data it must be available to a significant proportion of the pensioner population.

A unique passport?

As well as IS receipt, there may be other “low income” schemes operating in parallel. This applies to Legal Aid and also to most health-related in-kind benefits (dental care, sight tests, wigs etc, and travel to hospital). 3 Although in the period 1997-2000 many local councils did use IS receipt as a passport to free/capped charges for domiciliary care (Audit Commission, 2000), there was no detailed national guidance on how they should charge, and “low income” itself was also sufficient to qualify.

In some cases the benefit may apply to all pensioners, as with Home Insulation Grants and since April 1999, sight tests. As well as IS, Housing Benefit also acts as a passport to entitlement to Social Fund funeral grants. People may qualify for health-related in-kind benefits if they or their relatives have certain medical conditions, regardless of age or income level.

The benefits in-kind described above do not necessarily increase the value of an IS claim, because there are other routes to receiving them without charge. Nor will any stigma attached to their receipt necessarily be associated with IS.

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2 There are additional benefits passported through IS to groups other than pensioners – for example free school meals to families with children. Prescription charges, which are passported to younger adults, are free to all pensioners.

3 For pensioners, the income definition for health benefits is very similar to the IS definition.
A comprehensive passport?
The second issue is whether the benefit-in-kind is available as a matter of right to IS recipients, or whether entitlement is discretionary. This applies to Housing grants which are available on a discretionary basis from local authorities. These are for renovations, repairs and installation of facilities for the disabled. They are “subject to a means test” (CPAG Welfare Benefits Handbook, 1999-2000). This would suggest that IS receipt neither gives claimants the right to the grant (which is discretionary) nor are other low income people ruled out (i.e. neither comprehensive nor unique). Community Care grants are also discretionary.

A related problem arises where there is no uniform national scheme but there are diverse schemes run by local authorities (Public transport fare subsidies and Adult education) and/or private sector companies (Leisure and entertainment subsidies). Some schemes apply to all pensioners and some are more generous or comprehensive than others.

A significant passport?
Some statutory schemes are in fact very limited. To qualify for Funeral expenses through the Social Fund the funeral in question has to be of a spouse/partner or some other person where the case has to be made that the claimant has responsibility for the funeral costs. Between 1997/8 and 1999/2000 there was an annual average of 46,000 awards (63% of applications) with an average value of about £830 (DWP, 2001, page 155). These figures include grants made to non-pensioner households.

Cold weather payments are paid to people on IS following periods of cold weather. An amount (£8.50) is received for each week counting as “cold”. DWP statistics show that there were few such weeks in the years 1997/8 to 1999/2000 with a total of 195,000 payments made in the whole 3-year period (compared with nearly 5 million in 1996/7 alone and 3.5 million in 2000/1). These figures include payments made to non-pensioner households. Claimants have to be already in receipt of IS to qualify and payments are made automatically.

Cold weather payments would in principle be exactly the kind of benefit that one might expect to affect take-up of IS. During the period that we consider few IS recipients would in fact be beneficiaries but the existence of the passported payments may act as “insurance”, enhancing the attractiveness of IS. We return to this in section 6.

Generally, however, it appears that there are few benefits in-kind that satisfy all criteria.

3 Take-up and passported benefits

The value of passported benefits may make taking-up IS more worthwhile. However passported benefits may be associated with additional or different forms of stigma than the cash benefit. Claiming or receipt of the in-kind benefit may be more visible and hence possibly more “shaming” than the process of claiming or the act of receiving a cash benefit. Indeed it is possible that in-kind benefits may even be associated with historical forms of social assistance which relied on in-kind dependency (indoor relief at the workhouse). This

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4 These are distinct from Winter Fuel payments which apply to all pensioner households each year regardless of the weather.
may taint the whole package of IS and passported benefits. It would be part of the explanation of non-takeup of IS.

Aside from stigma, in many cases the additional costs of claiming passported benefits are small. Evidence of IS receipt is usually all that is needed. In some cases information problems are small too – the person concerned is offered the benefit at the point at which it is required – although having to provide evidence of receipt of IS may be stigmatising.

There may also be a separate take-up issue in relation to the passported benefits. A pensioner may claim IS entitlements but not claim the associated passported benefits because of stigma related specifically to these. This would imply that claiming the passported benefits carries stigma or other costs which are at least as great as their cash value.

However, failure to take-up passported benefits because of stigma while in receipt of IS would be hard to distinguish from the case of the pensioner who simply preferred to spend her income on substitutes for the in-kind benefits (a taxi to the hospital, non-NHS dentures) or the case where there was no need or demand for the benefit (no hospital trips necessary). Thus it is not only impossible to identify any negative contribution to the take up of IS, for those not receiving, it is also not possible to identify non-take-up of the passported benefit itself.

The possibility remains to evaluate the positive influence of passported benefits on the value of an IS claim.

4 Data on in-kind benefit receipt

In this section we present the information available on receipt of benefits in-kind by pensioners in the Family Resources Surveys (FRS). The sample that is considered is limited to pensioner units (married couples or single people) where each person is aged at least five years over state pension age and where there are no other people in the household. Some other cases are excluded which present particular difficulties in identifying IS entitlement or receipt: the aim being to reduce the complexity of the IS take-up model.5 There is no reason to believe that the sub-sample of pensioners that we consider would have a pattern of receipt of benefits in-kind greatly different to that for pensioners as a whole.6

The FRS does not include information on all the possible benefits listed in section 2. It does include some information on receipt of Social Fund funeral expenses grants and Community Care grants, and on some health-related benefits. These are considered in turn.

Social Fund benefits
Over the whole three year data period 1997/8 – 1999/2000 there were a total of seven pensioner units who received a Community Care grant (within the previous 6 months): two in 1998/9 and five in 1999/2000. Only five received a funeral grant (one in 1998/9 and two each

5 See Hancock and Barker (2003) for more details.
6 See Sutherland (2003) for a comparison of IS entitlement and take-up for the sub-sample and for the sample of all pensioner units.
in 1997/8 and 1999/2000). One of the five was not in current receipt of IS. These few cases do not provide the basis for any analysis of these benefits.

**Health-related benefits**

In the 1998/9 FRS there are questions on

− visits to the dentist
− eye tests
− visits to hospital
− purchase of spectacles/lenses.

All variables refer to the 4 weeks preceding the interview. The questions are asked in the household questionnaire but answers are requested for all persons in the household. Positive responses trigger questions on whether the treatment was provided free (in the case of dentist visits and eye tests), whether travel costs were refunded (visits to hospital) or whether vouchers were used to cover or part-cover the cost (spectacles/lenses). Then, if so, questions were asked on why these things were provided free. One option is being on IS. (The exception is spectacles where this question is not asked: all spectacle vouchers are received because they are passported through benefit receipt.) Other possible reasons for receiving the benefit-in-kind free are because of specific medical reasons, that the treatment was undertaken in hospital, or that IS entitlement is positive but less than 10p a week.⁷

Table 1 shows the numbers involved at each stage. The numbers are at the individual level: where both people in a couple are in receipt of benefits in-kind they are counted separately. The benefits considered here apply to individual people and it is therefore appropriate to consider them in this way, following Smeeding et al (1993).⁸ However, other benefits in-kind, such as Cold Weather payments, housing grants or, in some circumstances, Legal Aid, would be most appropriately considered at the household level.

<table>
<thead>
<tr>
<th></th>
<th>Any health benefits used</th>
<th>Free/subsidised benefits</th>
<th>Free because on SS benefit or HC2 cert</th>
<th>Free because on SS benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visits to dentist</td>
<td>419</td>
<td>110</td>
<td>89</td>
<td>72</td>
</tr>
<tr>
<td>Sight tests</td>
<td>413</td>
<td>250</td>
<td>96</td>
<td>83</td>
</tr>
<tr>
<td>Visits to hospital (travel)</td>
<td>717</td>
<td>13</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Spectacles/lenses</td>
<td>193</td>
<td>36</td>
<td>36</td>
<td>36</td>
</tr>
<tr>
<td>Any of these</td>
<td>1398</td>
<td>369</td>
<td>195</td>
<td>170</td>
</tr>
</tbody>
</table>

**Note:** An HC2 certificate is given on the basis of “low income” and may cover only some of the cost

**Source:** FRS 1998/9: sample of pensioner benefit units N=4166 which includes 5430 individuals

The proportions receiving health benefits free because of IS passporting are small. Table 2 shows the rate of passporting by recorded receipt of IS. Although in each case there is a higher rate of passporting for those receiving in-kind benefits within this group of IS recipients than within non-IS recipients it is also the case that the majority of those saying they were passported were not in fact in receipt of IS (with the exception of travel to hospital and eye tests).

⁷ In this case there is no IS paid but the person remains entitled to passported benefits.

⁸ Receipt of IS, however, is based on an assessment of the income and circumstances of the unit as a whole.
Table 2: Health benefits for pensioners: rate of passporting through IS

<table>
<thead>
<tr>
<th>% of recipients who say they are passported through benefit receipt</th>
<th>% of passported recipients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>On IS</td>
</tr>
<tr>
<td>Visits to dentist</td>
<td>94</td>
</tr>
<tr>
<td>Sight tests</td>
<td>79</td>
</tr>
<tr>
<td>Visits to hospital (travel)</td>
<td>68</td>
</tr>
<tr>
<td>Spectacles/lenses</td>
<td>5</td>
</tr>
<tr>
<td>Any of these</td>
<td>46</td>
</tr>
<tr>
<td>Total number of pensioners</td>
<td>645</td>
</tr>
</tbody>
</table>

Source: FRS 1998/9: sample of pensioner benefit units N=4166 which includes 5430 individuals

This suggests that there are serious issues about measurement error in these benefit-in-kind variables, particularly the “free because on benefit” responses. More than half those who say they are passported are not in fact in receipt of IS. On the other hand, at least some of the error may be in recorded IS. The fact that many recipients of the in-kind benefits are clearly not passported through IS suggests that we cannot assume that all who say they receive them free do so by virtue of IS receipt.

Thus in the case of the 1997/8 FRS – which only contains information on whether the benefit was received free, not why this was so – the information on free receipt is not a good indicator for passporting. Moreover, there is no information at all in the 1999/2000 FRS.

5 Frequency of receipt

The information in Table 1 applies to the last 4 weeks only. Within the context of take-up measurement we are not interested in recent IS claims but in claims that led to current receipt. Thus we are interested in passported benefit receipt over a much longer time period, although the period that is relevant in each case is unknown.

With the exception (in some cases) of travel to hospital, receipt of these benefits will be less frequent than every four weeks. Thus to extrapolate the information that is available to a longer period we have two choices. We can assume that everyone in the sample is equally likely to receive the benefit over a year, at the same rate as those we observe receiving in the 4 week observation period. Or, alternatively, we can use information on the characteristics of those known to receive to predict the probability of receiving for all members of the sample.

Table 3 shows the proportions of individuals receiving each health benefit at least once in the 4-week period by whether IS was in receipt. Data are taken from 1997/8 and 1998/9 FRS combined. Rates of receipt of the health benefit do not vary much by IS receipt – people are slightly less likely to visit the dentist and more likely to visit hospital if they receive IS. The final column of Table 3 converts the 4-weekly rate of receipt for the whole group into an annual rate assuming that the whole sample is equally likely to receive (simply by multiplying
This suggests that, on average, pensioners visit the dentist and have a sight test once a year; they get new glasses once every two years and visit the hospital once every 7.25 months.

Table 3: Health benefits for pensioners: rate of receiving benefit

<table>
<thead>
<tr>
<th>Rate of receiving health benefit in 4-week period</th>
<th>On IS</th>
<th>Not on IS</th>
<th>All</th>
<th>Annual rate %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visits to dentist</td>
<td>5.8</td>
<td>7.8</td>
<td>7.6</td>
<td>99</td>
</tr>
<tr>
<td>Sight tests</td>
<td>7.7</td>
<td>7.3</td>
<td>7.4</td>
<td>96</td>
</tr>
<tr>
<td>Visits to hospital (travel)</td>
<td>13.8</td>
<td>12.5</td>
<td>12.7</td>
<td>165</td>
</tr>
<tr>
<td>Spectacles/lenses</td>
<td>3.8</td>
<td>3.3</td>
<td>3.7</td>
<td>48</td>
</tr>
<tr>
<td>Total number of pensioners</td>
<td>1329</td>
<td>9515</td>
<td>10844</td>
<td></td>
</tr>
</tbody>
</table>

Source: FRS 1997/8 and 1998/9: sample of pensioner benefit units N=8,295 which includes 10,844 individuals.

An alternative approach is to take account of the fact that the likelihood of needing health benefits may not be uniform across the sample of pensioners that we consider: some pensioners may have higher usage rates than others. We have seen that receipt of IS does not seem to be an important factor. Table 4 uses logistic regression to show the relative odds of usage of each of the four health benefits by marital status and sex, age group and according to whether the pensioner unit is in receipt of IS.

Table 4: Logistic regression of receipt of health benefits by pensioners

<table>
<thead>
<tr>
<th>Mean</th>
<th>Visits to dentist</th>
<th>Sight tests</th>
<th>Travel to hospital</th>
<th>Spectacles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Couple</td>
<td>0.4701</td>
<td>1.242 *</td>
<td>0.999</td>
<td>0.855 *</td>
</tr>
<tr>
<td></td>
<td>(0.162)</td>
<td>(0.121)</td>
<td>(0.079)</td>
<td>(0.146)</td>
</tr>
<tr>
<td>Single female</td>
<td>0.4105</td>
<td>1.182</td>
<td>1.099</td>
<td>0.930</td>
</tr>
<tr>
<td></td>
<td>(0.157)</td>
<td>(0.135)</td>
<td>(0.086)</td>
<td>(0.155)</td>
</tr>
<tr>
<td>Age 70-74</td>
<td>0.3135</td>
<td>0.786 **</td>
<td>1.080</td>
<td>1.000</td>
</tr>
<tr>
<td></td>
<td>(0.085)</td>
<td>(0.141)</td>
<td>(0.100)</td>
<td>(0.156)</td>
</tr>
<tr>
<td>Age 75-79</td>
<td>0.2832</td>
<td>0.681 ***</td>
<td>1.130</td>
<td>1.115</td>
</tr>
<tr>
<td></td>
<td>(0.077)</td>
<td>(0.148)</td>
<td>(0.112)</td>
<td>(0.151)</td>
</tr>
<tr>
<td>Age 80-84</td>
<td>0.1681</td>
<td>0.535 ***</td>
<td>1.233</td>
<td>1.253 **</td>
</tr>
<tr>
<td></td>
<td>(0.073)</td>
<td>(0.174)</td>
<td>(0.136)</td>
<td>(0.149)</td>
</tr>
<tr>
<td>Age 85+</td>
<td>0.1080</td>
<td>0.480 ***</td>
<td>1.504 ***</td>
<td>1.089</td>
</tr>
<tr>
<td></td>
<td>(0.077)</td>
<td>(0.226)</td>
<td>(0.133)</td>
<td>(0.181)</td>
</tr>
<tr>
<td>Receiving IS</td>
<td>0.1226</td>
<td>0.791 *</td>
<td>0.975</td>
<td>1.071</td>
</tr>
<tr>
<td></td>
<td>(0.101)</td>
<td>(0.111)</td>
<td>(0.094)</td>
<td>(0.149)</td>
</tr>
</tbody>
</table>

Source: FRS 1997/8 and 1998/9: sample of pensioner benefit units N=8,295 which includes 10,844 individuals.

*, **, *** statistically significant at the 10%, 5% and 1% levels.

The variables have all been transformed into zero/one dummy variables and the odds ratios that take a value greater than one indicate that the characteristic assigned the value 1 (e.g. living as a couple) is associated with greater likelihood of use of the health benefit. Few of the odds ratios are significantly either greater or less than one (significance is indicated by

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9 This assumes no more than one receipt of each benefit within the 4-week period: an assumption that may underestimate total hospital visits.
Dental treatment is negatively associated with age group (older people are less likely to use dental treatment), whereas people aged 85+ are significantly more likely than others to have sight tests. Pensioners living in a couple are more likely to visit the dentist and less likely to visit the hospital than single pensioners. IS receipt is negatively associated with visits to the dentist. None of the variables are significant predictors of new spectacles.

While it might be possible to refine these predictions of health benefit use by including further explanatory variables (such as existence of long term illness, in the case of hospital visits) it seems unlikely than any large improvement could be achieved. The most plausible conclusion is that the use of these health benefits is generally quite common across all pensioners and that the 4-week observation period identifies a sub-sample of recipients drawn more-or-less randomly. Dental care may be biased towards younger pensioners in couples and travel to hospital towards older single pensioners. But overall, an assumption of uniform probability seems reasonable.

6 The value of receipt

In the case where there is evidence of receipt of an in-kind benefit, its value is in principle straightforward to estimate from the price that would be paid if there was no receipt of IS. For example, this would apply to the cost of travel to hospital or the amount that would have been charged for a particular pair of spectacles. Using this price ignores the fact that the pensioner themselves may place some other value on the benefit-in-kind in question (probably lower), particularly if they feel that receipt is stigmatised. (Use of vouchers, the value of which may be set against the market price of the pensioner’s choice of spectacles is a policy response to this problem.)

However, the specific nature of the health benefits received by each pensioner are not known. How far away is the hospital? How complex are the lenses or dental care required? Is the sight test carried out at home or at the optician’s? In practice the options for valuation include

1. Making ad hoc assumptions about the amount of the benefit consumed, and the price. (Using a methodology similar to that used for free school meals in DWP (2002).)
2. Allocating total spending on the passported benefit across the sample of pensioners deemed to receive. (Using a methodology similar to that used to allocate health and education benefits in-kind in Lakin (2002) or education benefits in Smeeding et al (1993).)

We take the first approach, mainly because data on spending are not available separately for pensioners. Table 5 below provides some ad hoc estimates of the average value of each health benefit, if they are received.

One can combine the information in tables 3 and 5 to arrive at an estimate of the average value of health benefits to the pensioner sample that we consider. This is £106.67 or just over £2 per week per person in 1998/9 prices.\(^{10}\) The value is double for couples: £4. It is the

\[^{10}\] 0.99x£53.72 + 0.96x£14.57 + 1.65x£10 + 0.48x£47.92 = £106.67
average additional value of an IS claim to a pensioner (with the proviso that we ignore the existence of “low income schemes” that also provide entitlement to the benefits in-kind).

Clearly the actual value varies. We have considered variations in usage rates above. In addition, the value of the benefits estimated in Table 5 is based on rather arbitrary assumptions about the type of benefit required. All the values could be lower in many cases and there is scope for them being much larger in some cases. One could imagine larger travel to hospital costs for people living in remote places and substantially larger dental or optical charges for special needs. For example the maximum charge for a single dental treatment in 2002/3 was £366 (£334 in 1998/9 prices). Someone needing expensive treatment would find the value of free dental care added £6 per week to the value of an IS claim in the year the care was received.

Table 5: Estimated average annual value of health benefits

<table>
<thead>
<tr>
<th>Health benefit</th>
<th>Basis of estimate</th>
<th>Value in 1998/9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visits to dentist</td>
<td>Average of (a) cost of “extensive clinical examination” plus “simple scale and polish” (£14.89) and (b) lowest charge for an “upper or lower metal denture” (£92.55)</td>
<td>£53.72</td>
</tr>
<tr>
<td>Sight tests</td>
<td>Cost of NHS sight test (higher cost of sight test at home is ignored)</td>
<td>£14.57</td>
</tr>
<tr>
<td>Visits to hospital (travel)</td>
<td>Arbitrary guess. No information on travel costs to hospital available.</td>
<td>£10.00</td>
</tr>
<tr>
<td>Spectacles/lenses</td>
<td>Optical appliance type E (glasses with bi-focal lens of low/medium power)</td>
<td>£47.92</td>
</tr>
</tbody>
</table>

**Sources:**
1. NHS leaflet HC12 ([www.doh.gov.uk/nhscharges/hc12.htm](http://www.doh.gov.uk/nhscharges/hc12.htm)) provides figures for 2002/3, which have been adjusted to 1998/9 assuming inflation of 9.6%.
3. See NHS circular MISC(2000).15. Annex E. This choice of glasses type is based on DoH statistics on the types of vouchers issued. See various publications at [www.info.doh.gov.uk](http://www.info.doh.gov.uk). The 1999/2000 figure (£49.50) is backdated using a factor of 3.3%

For one benefit in-kind considered in section 2 – Cold Weather payments – information on receipt is not necessary because payment is automatic and fixed in size, subject to specific weather conditions. However, it remains problematic to value the existence of this passported benefit. The average payment over a period of several years (some with qualifying cold weather, some without) would in principle be a straightforward calculation to carry out, assuming one could match qualifying cold weather spells to the geographical location of FRS households. However, it is not clear what the relevant number of years is on average, nor which years are relevant for any individual. Moreover, the insurance value lies in the perceived benefit from the possible payments. This will depend on many factors which we can easily imagine would vary greatly across pensioners according to characteristics that we do not observe. We can conclude that the existence of Cold Weather payments adds to the uncertainty surrounding the value of benefits passported through IS, and probably increases this value.
7 Conclusions

We have estimated the average weekly value of a certain health-related passported benefits to pensioners in a sample used for investigating take-up of IS. This value is £2 per week for a single pensioner, twice this for a couple. In principle these amounts could be added to the value of IS when considering the gains from receipt of IS.

There are several obstacles to the adoption of a less broad-brush approach. Firstly, data are rather sparse. The FRS for 1998/9 provides data on passporting of certain health benefits but 1997/8 FRS data provides information only on whether the in-kind benefit was free (and not why). 1999/2000 FRS includes none of these variables. All data years supply information on Social Fund grants but the numbers involved are far too small to support analysis. Secondly the quality of the available data seems low. As many people claim to be receiving passported benefits while not in receipt of IS as do while in receipt.

Furthermore, the data that are available are rather limited: some passported benefits are not covered at all. The 4-week reporting period poses further limitations.

Even if the data on receipt of passported benefits were adequate there would remain the problem of valuation of the benefits-in-kind. There are conceptual problems (what prices should apply?) but also, difficulties in predicting non-uniform probabilities of receipt and frequency of receipt. It seems likely that the value is small in most cases, but not insignificant for an IS claimant. The insurance value of some conditional passported benefits – particularly Cold Weather payments – adds to the potential gain from making an IS claim. The total value could be relatively large (due to legal expenses or funeral expenses) in a very small number of cases.

Finally even if the value and incidence of passported benefits could be established, any model would need to account for the fact that entitlement to these benefits could both increase the value of an IS claim and increase the stigma (and, to some extent, claim costs) associated with it.
References


