An Roinn Coimirce Sóisialaí
Department of Social Protection

ESRI ECONOMIC & SOCIAL RESEARCH INSTITUTE

Social Transfers and Deprivation in Ireland: A study of cash and non-cash payments tied to housing, childcare, and primary health care services.

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Research Briefing

This briefing summarises our research into the association between three specific types of social transfer and deprivation, understood as the inability to afford basic goods and services, for social risk and social class groups. Throughout we will consider both cash and non-cash transfers tied to specific areas of need including housing, childcare, and medical care. We also consider the impact of these three types of transfers together.

The analysis draws on data from SILC (Statistics on Income and Living Conditions, 2017), PCRS (Primary Care Reimbursement Service) and ESRI's SWITCH model (Simulating Welfare Income Tax Childcare and Health) to simulate the effects of transfers. First, we consider housing supplements (rent supplement and mortgage interest supplement) and housing benefits (housing benefits package) recorded in the SILC dataset[1]. Second, we assign a monetary value to medical and GP cards, which do not take the form of a cash transfer but provide a crucial resource to families. Third, we consider childcare supports and childcare schemes. These supports are especially important for lone parents and households with a person with a disability, but also do not take the form of a cash transfer.

The report is an output of the Department of Social Protection and the Economic and Social Research Institute research programme on monitoring poverty trends.

[1] Housing Assistance Payments are not included in our report, as this data was unavailable in SILC's 2017 wave.

Main Findings

- Most households received some type of transfer (69 per cent). A significant portion, 22 per cent of households, received two or more types of transfer.
- The vulnerable social risk groups were the most likely to qualify for transfers. Most households with an adult with a disability and most households with older adults qualified for at least one transfer. Lone parents were most likely to qualify for two transfers.
- Vulnerable social classes were also more likely to receive transfers, particularly those in the lower service/unskilled social class and those in the unemployed/never worked social class. Roughly one quarter of these social classes received some housing transfer and a medical or GP visit card.
- A microsimulation model examined the impact of social transfers on deprivation.[2] Overall these transfers were associated with lower chances of deprivation, even when controlling for a range of factors. Those who received two or more transfers saw the greatest fall in their predicted probability of deprivation. This effect was greatest among lone parents (3 percentage points fall in deprivation) and households with a person with a disability (2.5 percentage point fall in deprivation) in terms of social risk. Across social classes, the effect was greatest among the unemployed/never worked (a 4 percentage point fall in deprivation).
- Breaking down the transfers more broadly, we find that 44 per cent of people received some type of **housing transfer** in 2017 usually the smaller (in monetary terms) housing benefit (40 per cent). A small group received housing supplement only (1.5 per cent), and a smaller group received both (1.3 per cent).
- Housing transfers were associated with a 2 percentage point fall in deprivation. This effect was greatest for lone parents (6 percentage point fall) and households with a person with a disability (3 percentage point fall) in terms of social risk. In social class terms, the effect was greatest for the unemployed/never worked social class (5 percentage point fall) and the lower service/unskilled social class (2.9 percentage point fall).

[2] Deprivation involves an inability to afford basic goods and services, including adequate food, clothing, home heating and basic social activities.

- Regarding **medical and GP cards**, we find that the most vulnerable were the most likely to receive these transfers. Most lone parents (67 per cent), adults with a disability (60 per cent), and adults over 65 receive a medical card (71 per cent), while most working age adults received neither a medical card nor a GP visit card (75 per cent).
- Again, looking at the impact on deprivation, lone parents (0.76 percentage points) and households with a person with a disability (1 percentage point) saw the largest fall in deprivation. This result is different for social classes, where the unemployed/ never worked (1 percentage point), the service/unskilled social class (0.7 percentage point) and the middle social class (0.83 percentage points) see a similar fall in deprivation after we account for both cards.
- Regarding **childcare transfers,** we note that transfers apply to most households with children. We find few differences in the use of childcare between social risk groups and social classes, but wider differences in the hours per week of childcare used between the two types of group. Lone parents (17 hours per week) and those with a person with a disability (16 hours per week) report the lowest duration of formal childcare for children aged 0-5. Regarding social class, middle social class groups (13 hours per week) and lower service/unskilled social classes (16 hours per week) report the lowest duration of childcare use.
- We again assign a cash value to these transfers, and again find that vulnerable social risk and social class groups benefit the most from these transfers. Regarding the expected impact on deprivation, the figure was a 2.7 percentage point fall for lone parents and a 1.4 percentage point fall for those in households with a person with a disability. Regarding social class, the unemployed (4 percentage point fall) the lowest social class (1 percentage point fall) and the middle social class group (1 percentage point fall) saw the greatest decrease in deprivation.

Introduction

The Department of Social Protection is responsible for monitoring poverty trends and patterns in order to contribute to the development of social inclusion policies. This report examines the association between three broad types of cash and non-cash transfers and their association with deprivation. The analysis examines access to transfers and simulates the impact of transfers by considering the relationship between household income and deprivation, with and without the transfers.

Data and definitions

The report draws on the 2017 data from the CSO's Statistics on Income and Living Conditions (SILC). This survey contains detailed information about the social risk and social class status of the household. The data also contains administrative and detailed information of the household's income and the benefits and transfers that the household receives in the previous year. We also use data from the Primary Care Reimbursement Service (PCRS), and the ESRI's Simulating Welfare Income Tax Childcare and Health (SWITCH) model to assign a cash value to medical, GP cards, and childcare related allowances. We consider the following transfers throughout the report.

- Housing supplements are payments tied with larger housing costs, they consist of rent supplement, rent allowance, and mortgage interest supplement[3].
- Housing benefits are smaller payments tied to specific expenses (TV license, electricity or gas allowance). SILC data also considers additional payments in this measure including fuel allowance, telephone support allowance, and the water conservation grant[4].
- Medical Cards give means-tested households access to medical services, prescription medicines and hospital care for free. GP visit cards are similar in that they cover the cost of GP visits, but not the costs of medicines and other medical services.
- The Early Childhood Care and Education (ECCE) programme provides early childhood care and education for children of pre-school age. Children can start ECCE when they are 2 years and 8 months of age and continue until they

[3] Housing Assistance Payments are not included in our report, as this data was unavailable in SILC's 2017 wave.
[4] The Water Conservation Grant is a once off payment. If received, it is recorded in the reference year as part of a wider measure of housing benefits recorded by SILC statistics (variable HY074 in the data).

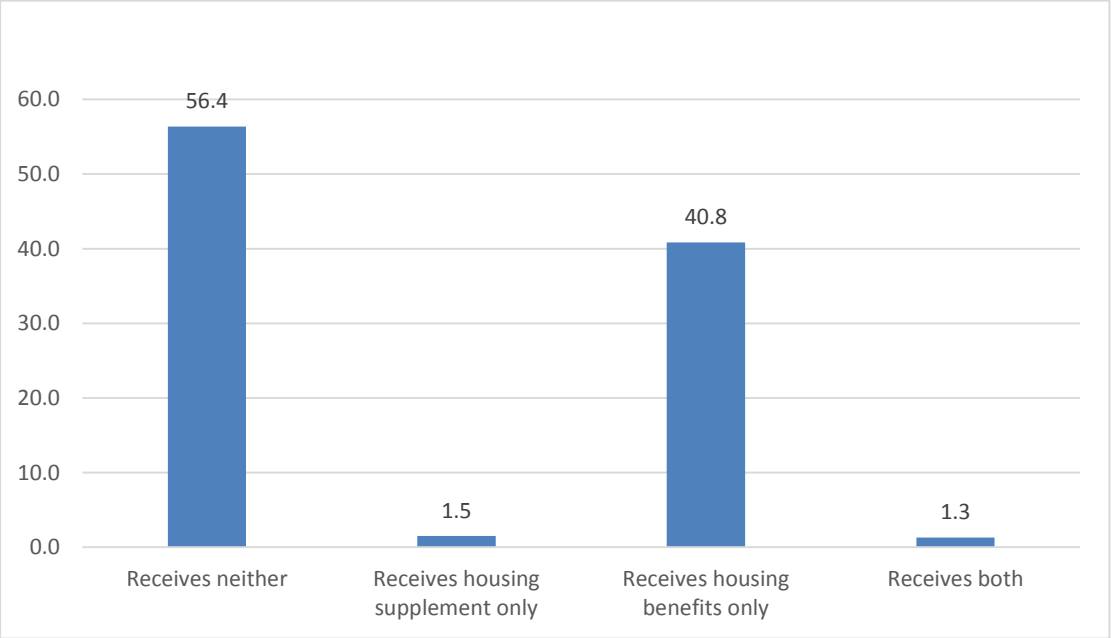
transfer to primary school. The scheme covers the cost of formal childcare in playschools and day-care services. Participating centres and playschools provide a pre-school service free of charge to all children within the qualifying age range. The service is for a set number of hours over a set period of weeks.

- The Community Childcare Subvention (CCS), and Community Childcare Subvention Plus (CCSPlus) programmes which assisted 27,000+ in 2016/2017, and 38,000+ in 2017/2018, help disadvantaged families and those in training and education cover the cost of childcare. The Community Childcare Subvention Universal (CCSU) programme is comparable to both the CCS and CCSPlus. The least common programme is the Training and Employment Childcare programme (TEC), where just 6,000+ recipients were registered between 2016 and 2017, and 4,000+ between 2017 and 2018. Here too, childcare costs were partially covered by the state for participating providers.

Section 1: Transfers tied to housing

Figure 1 shows that a substantial portion of the population relies on housing benefits, but only a fraction received housing supplements or both housing benefits and housing supplements.

Figure 1: Percentage of households receiving transfers tied to housing



Source: CSO Statistics on Income and Living Conditions, 2017

Box 1: Social risk and social class

Social risk groups: Most people, meet their material needs through the market – usually through their own work or that of their families. Social risk groups are made up of people who face barriers to labour market participation. The barriers may be linked to the challenge of combining work and sole-caring responsibilities (lone parents), illness or personal capacity (e.g. people with a disability), or to differences in norms by life-course stage (children are expected to be in full-time education; and older people are expected to retire from work).

The groups examined here are:

- Lone parents and their children
- Working-age adults with a disability and their children
- Other adults (age 30-65) and their children

- Older people (aged 66 and over).

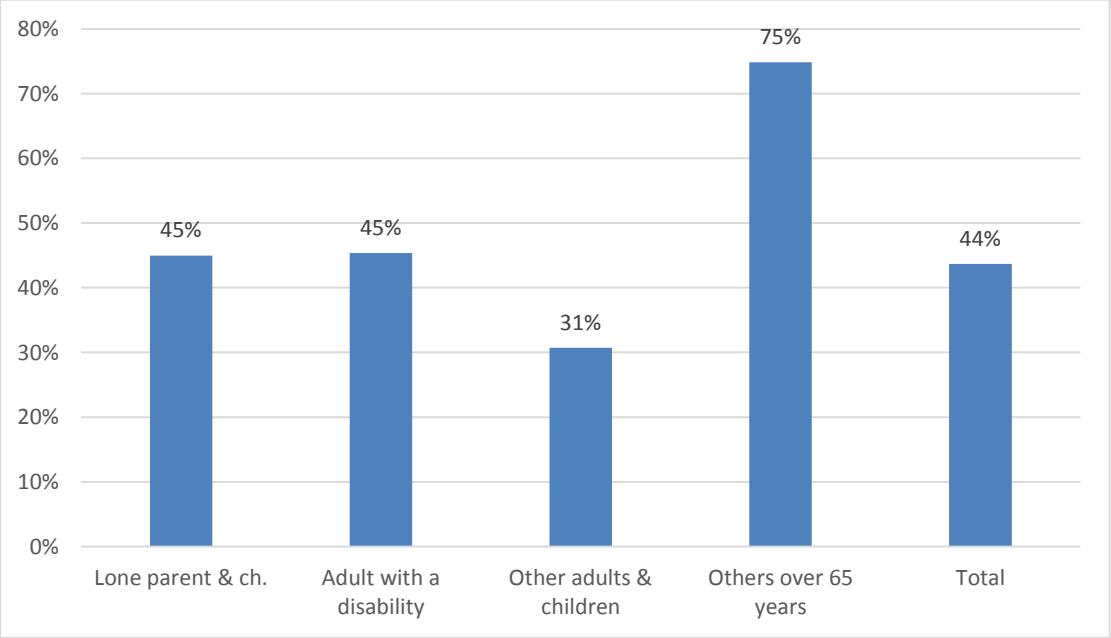
Social Classes: Social classes can be understood as groups with differing levels of power in the market, either because they own assets, or have marketable skills or because they hold positions of trust in an organisation. Social class patterns are not discussed directly in this Research Briefing, but social class is controlled in some of the analyses. The classes distinguished in the analysis are:

- High social class (professional/managerial)
- Middle social class (technical, white collar occupations)
- Lowest social class (semi-skilled/un-skilled manuals).
- Unemployed social class (those unemployed and who have "never worked")

Receipt of housing transfers by social risk group

We find that adults over 65 are the most likely to receive housing transfers, most likely in the form of the Housing Benefits package[5]. However, lone parents and adults with a disability are more likely to receive the transfers when compared to working age adults.

Figure 2: Receipt of housing transfers by Social Risk



Source: CSO Statistics on Income and Living Conditions, 2017

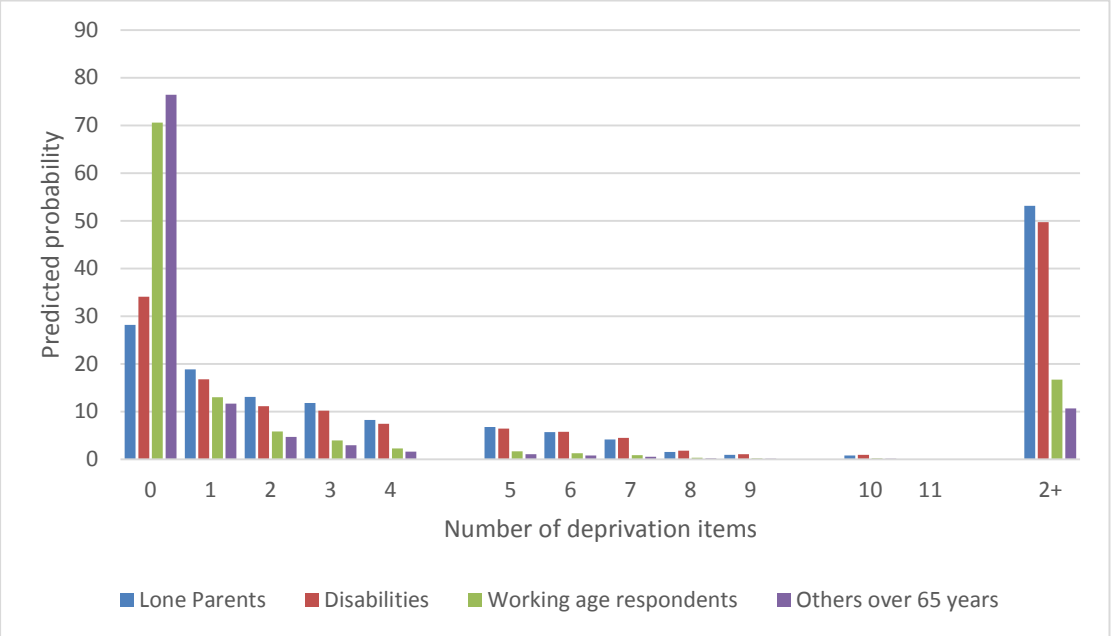
[5] We cannot test this explicitly due to CSO limits on small samples in the data.

Deprivation levels with and without housing transfers, by social risk group

Figure 3 shows the predicted probability of experiencing deprivation by social risk groups, controlling for social class, characteristics of the household and their equivalised household income. Thinking of the binary measure, shown at the far right on the chart (citing two or more deprivation items), we show that lone parents and households with a person with a disability had the highest rates of deprivation, and that older adults had the lowest rates of deprivation.

Considering deprivation with and without transfers (Figure 4), we note that the impact of transfers is greatest among lone parents (5.7 percentage point fall in deprivation) and households with a person with a disability (3.2 percentage point fall in deprivation). Our findings suggest that the most vulnerable groups have the most access to housing transfers, and that these transfers in turn have a strong association with lower risks of deprivation.

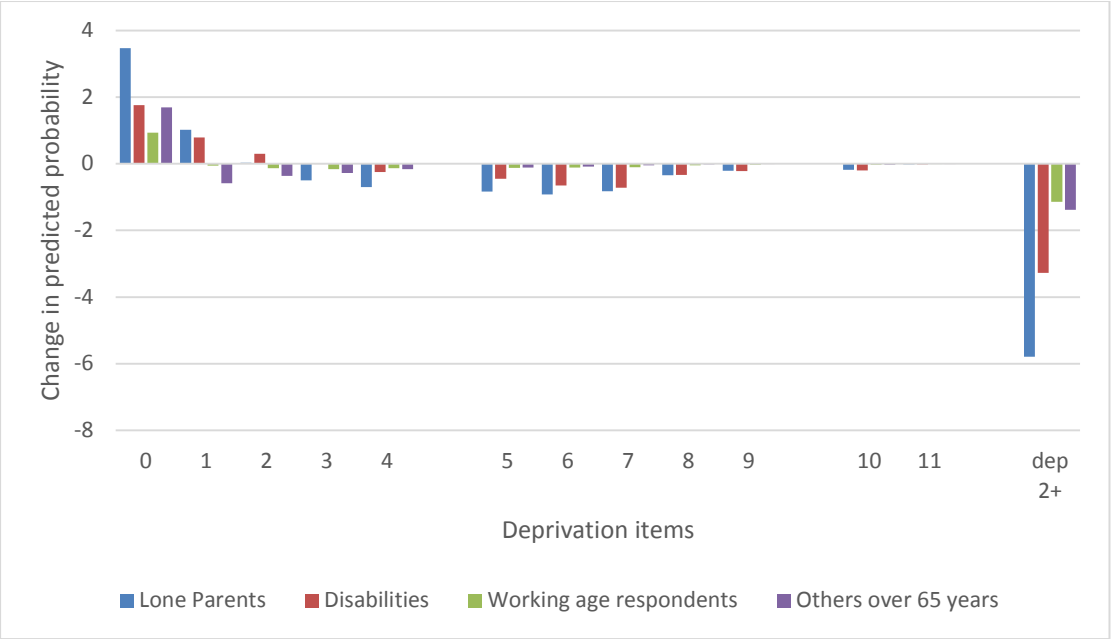
Figure 3: Predicted probability of deprivation by social risk



Source: CSO's Statistics on Income and Living Conditions, 2017

Note: The chart contains predicted probabilities of deprivation. The model controls for social risk, social class, characteristics of the head of the household, and equivalised household income

Figure 4: Change in deprivation after housing transfers are considered

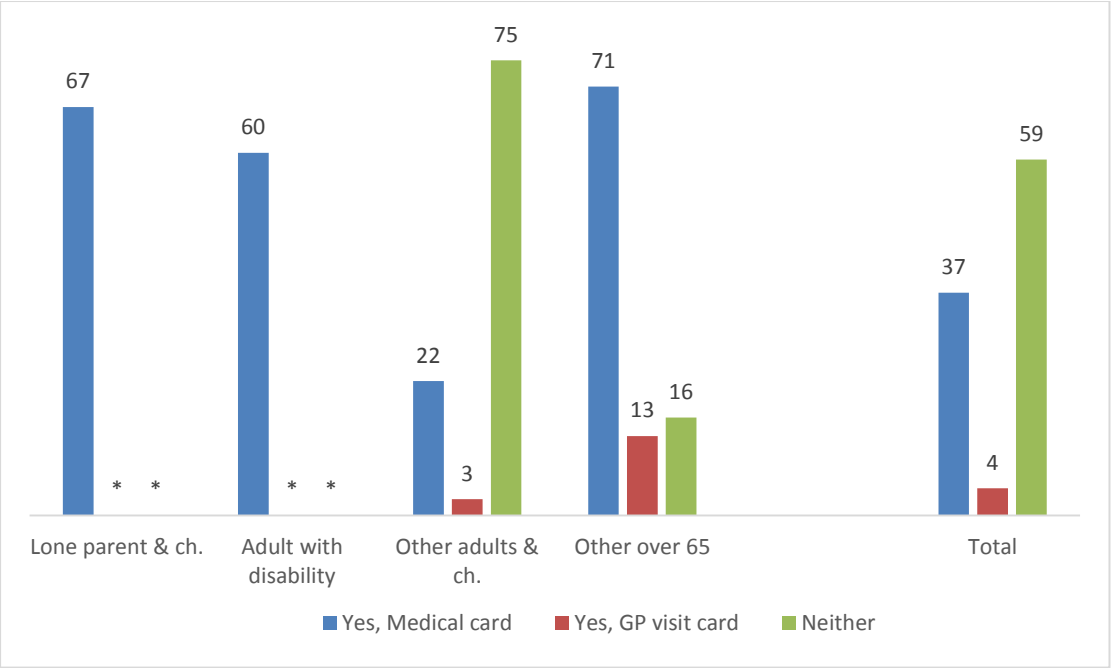


Source: CSO's Statistics on Income and Living Conditions, 2017

Section 2: Medical cards and GP visit cards

We note that 31 per cent of the overall sample holds a medical card or a GP visit card. However, medical cards are most often held by those in the vulnerable social risk groups. Most lone parents (67 per cent), adults with a disability (60 per cent), and older adults (71 per cent) were in receipt of a medical card. Working age adults were less likely to receive the card although 22 per cent of these respondents had access (Figure 5). The level of receipt of a GP visit card is more modest overall (4 per cent) and across groups; the lowest being among the working age adults (3 per cent) and the highest among older adults (13 per cent).

Figure 5: Percentage of persons aged 16 and over in receipt of a medical card or GP visit card by social risk group



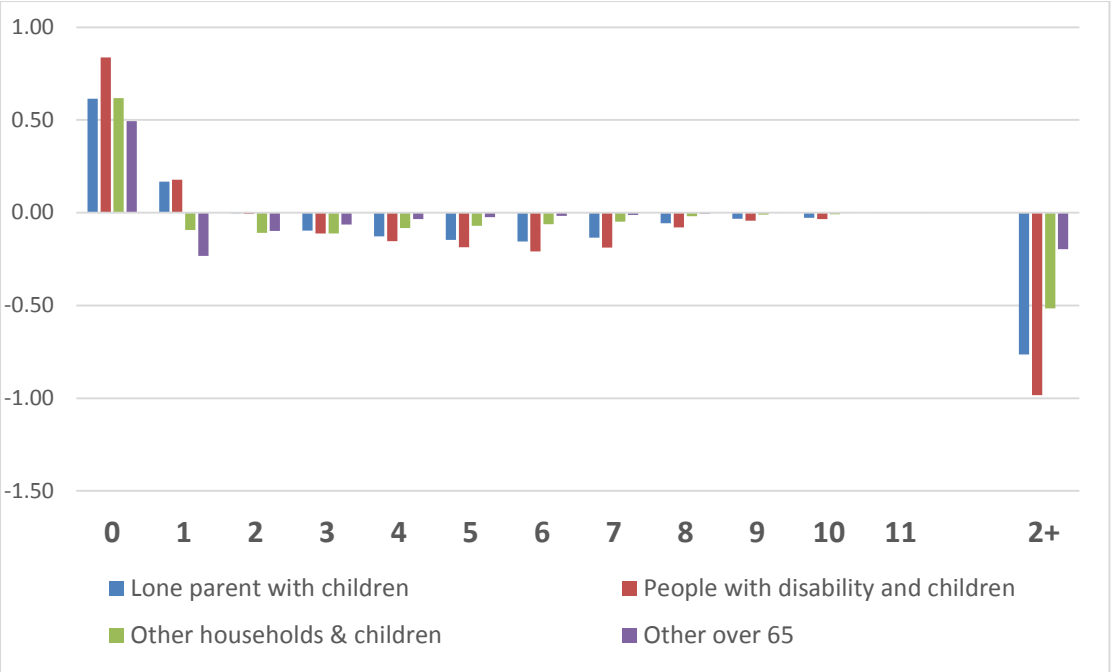
Source: SILC 2017. Authors' calculations.

Note: CSO rules prevent us from reporting on categories with few observations. These are marked with a star [*] symbol.

Deprivation levels with and without Medical and GP cards, by social risk group

As previously, we can simulate the household level of deprivation before and after the monetary value of the card, to show their association with deprivation (Figure 6). Households with a person with a disability experienced the sharpest reduction in deprivation after accounting for the value of the cards (1 percentage point fall), followed by lone parents (0.7 percentage point fall). The remaining groups were less affected by the transfer. Overall, the impact of these transfers is lower than the impact of housing transfers, most likely because the value of medical and GP cards is smaller than the value of housing transfers.

Figure 6: Change in predicted probabilities of deprivation for medical card or GP visit card holders by social risk groups

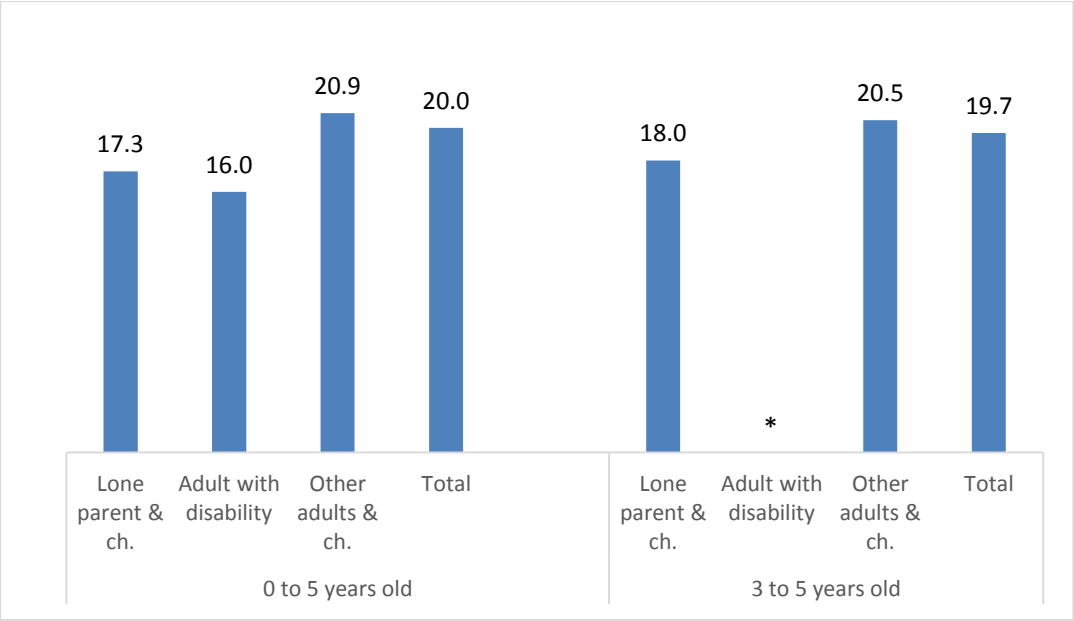


Source: SILC 2017. Authors' calculations.

Section 3: Childcare

We find that social risk groups with children differ little in terms of formal childcare use, however, the number of hours per week of childcare differs significantly by social risk. Figure 7 considers this difference for children aged 0-5 and more specifically, children aged 3-5. In general, lone parents and households with a person with a disability use less formal childcare when compared to other working age adults with children. This difference is far smaller in households with children aged 3-5 who are more likely to qualify for the schemes considered throughout the report.

Figure 7: Mean weekly hours in formal childcare by children's age and by social risk group, SILC 2017

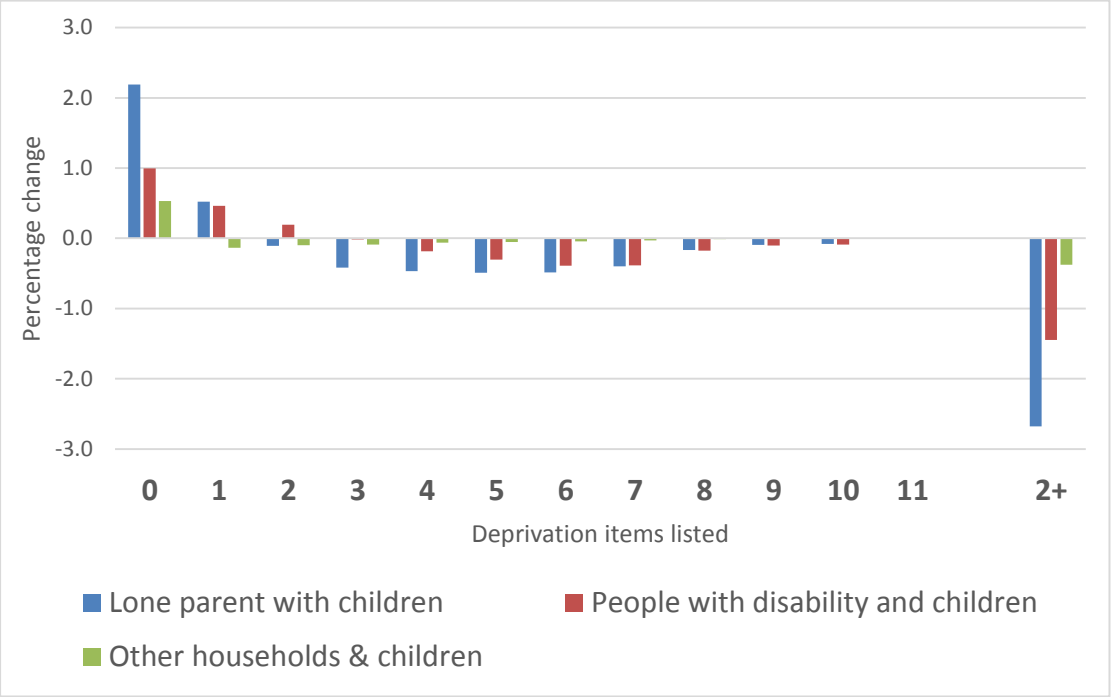


Source: SILC 2017. Authors' calculations.

Note: The sample size for children aged 3 to 5 in families with a person with a disability is too small to be reported.

As before, we can assign these transfers a cash value using data from the ESRI's SWITCH model. Once we have these values we can consider the rate of deprivation in the home with and without childcare related transfers. Figure 9 lists the effects of our simulation, we find that lone parents benefitted the most from transfers (2 percentage points fall in deprivation), as did households with a person with a disability (1.4 percentage point fall in deprivation). These groups are also the most likely to cite deprivation overall (Figure 3, above).

Figure 9: Change in predicted probabilities of deprivation by social risk groups

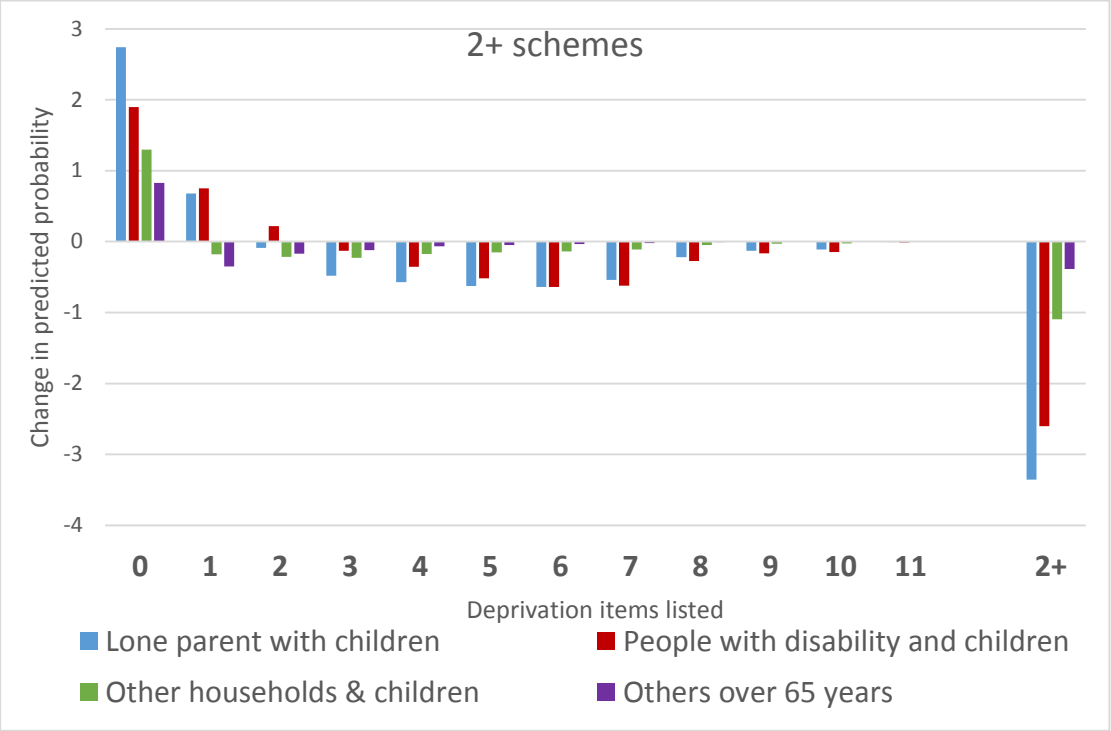


Source: SILC 2017. Authors' calculations.

Section 4: Total effect of transfers

In the final section of the report we consider the impact of the three transfer types together. Keeping the deprivation rates from figure 3 in mind, we find that those who receive multiple transfers benefit the most in terms of a lower association with deprivation. We also find that lone parents (3 percentage points fall) and households with a person with a disability (2.6 percentage points fall) have the most to gain from transfers. These results are summarised in Figure 10.

Figure 10: Change in predicted probabilities of deprivation by social risk groups for households receiving two or more transfers



Source: SILC 2017. Authors' calculations.

Note: Results focus only on those receiving two or more transfer types.

Section 5: Policy Implications

The purpose of the report was to consider the distribution of cash and non-cash transfers across social risk and social class groups, and to estimate their association with deprivation. The analysis provides general lessons for policy.

1. The transfers examined here had the expected impact in reducing deprivation, so they have a role to play in reducing social exclusion. Although transfer programmes are expensive, they reduce deprivation and help facilitate the achievement of a standard of living in line with social norms, especially for lone parents and the unemployed.
2. Those receiving benefits were generally those most in need – the vulnerable social risk groups and social classes. Thus means tested transfers reach those who need help. However, more universal transfers should not be overlooked, as they have an important impact on vulnerable groups. For example, while many childcare transfers are open to most parents of young children, it is lone parents and the unemployed who see the greatest return on these transfers in terms of a reduction in predicted deprivation.
3. The impact of the different schemes differed between social risk groups: housing transfers were particularly important for lone parents and households with a person with a disability; medical card were particularly important for people with disabilities; childcare benefits were particularly important for lone parents.
4. The social risk groups benefitting most from the schemes in the simulations remain those most deprived (lone parents and households where an adult has a disability). While transfers limit the deprivation faced by these groups, they are on average more likely to face deprivation than the remaining groups, even after transfers are considered. Therefore, the effectiveness of these transfers should be compared to the effectiveness of some alternative policy strategies.

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