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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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ASCC	After-School Child Care Scheme
CCS	Community Childcare Subvention
CCSPlus	Community Childcare Subvention Plus
CCSU	Community Childcare Subvention Universal
CEC	Community Employment Childcare (programme)
CETS	Childcare Education and Training Support
CSO	Central Statistics Office
ECCE	Early Childhood Care and Education
ECS	Early Childhood Scheme
FET	Further Education and Training
HAP	Housing Assistance Payment
SILC	Survey on Income and Living Conditions
SWITCH	Simulating Welfare Income Tax Childcare and Health
TEC	Training and Employment Childcare

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Minister's foreword

Each year the Central Statistics Office publishes data from the annual Survey on Income and Living Conditions which provides important information on the levels of poverty and deprivation in Ireland. This allows us to monitor our progress in reducing these levels and to assess whether we are bringing about real change for people who are living in poverty and/or experiencing deprivation and social exclusion.

This report takes us a step further by focusing on three types of supports, housing, childcare and primary health services, and examining the impact they have on deprivation in Ireland. It examines whether those who most need these supports are receiving them and looks not just at social class groups, but also at social risk groups.

At a time where Ireland is facing significant social and economic challenges as a result of the Covid-19 pandemic and its related restrictions, this research provides useful insight into the impact of these supports, not just individually but also cumulatively. It is a valuable addition to the existing research on this subject and will help inform the implementation of the Roadmap for Social Inclusion 2020-2025, the national strategy for poverty reduction and improved social inclusion in Ireland.

I would like to thank the research team in the ESRI for their detailed and thoughtful analysis in producing this study: Bertrand Maître, Ivan Privalko and Dorothy Watson. I also want to acknowledge the contribution of the Social Inclusion Division in the Department of Social Protection which managed the study through to its publication.

Joe O'Brien, T.D.

Minister of State with
responsibility for Social Inclusion

Réamhrá ón Aire

Gach bliain, foilsíonn an Phríomh-Oifig Staidrimh sonraí ón Suirbhé ar Dhálaí Ioncaim agus Maireachtála, ar suirbhé bliantúil é a chuireann eolas tábhachtach ar fáil faoi leibhéil bhochtaineachta agus díothachta in Éirinn. Cuireann sé ar ár gcumas monatóireacht a dhéanamh ar dhul chun cinn maidir leis na leibhéil sin a laghdú agus measúnú a dhéanamh ar cibé acu an bhfuil fíorathrú á bhaint amach againn ar mhaithe le daoine atá beo bocht agus/nó daoine a dtéann díothacht agus eisiamh sóisialta i bhfeidhm orthu.

Téann an tuarascáil seo níos faide ach díriú isteach ar thrí chineál tacaíochtaí, is iad sin tithíocht, cúram leanaí agus seirbhísí cúraim phríomhúil, agus scrúdú a dhéanamh ar an tionchar a bhíonn acu ar dhíothacht in Éirinn. Déanann sé scrúdú ar cibé acu an bhfaigheann siad siúd is mó a dteastaíonn na tacaíochtaí sin uathu na tacaíochtaí sin. Ní hamháin go mbreathnaítear ar ghrúpaí de réir aicme shóisialta ach breathnaítear ar ghrúpaí riosca shóisialta freisin.

Tráth a bhfuil dúshláin shuntasach shóisialta agus eacnamaíochta roimh Éirinn mar gheall ar an bpaindéim Covid-19 agus na srianta lena mbaineann, cuireann an taighde seo léargas úsáideach ar fáil ar thionchar na dtacaíochtaí sin, ní hamháin astu féin ach i dteannta a chéile freisin. Cuireann sé go mór leis an taighde atá ann faoin ábhar sin agus tacóidh sé le heolas a dhéanamh don Treochlár um an Ionchuimsiú Sóisialta 2020-2025 a chur i bhfeidhm, arb é sin an straitéis náisiúnta maidir le laghdú bochtaineachta agus cuimsiú sóisialta feabhsaithe in Éirinn.

Ba mhaith liom buíochas a ghabháil leis an bhfoireann taighde san Institiúid Taighde Eacnamaíochta agus Sóisialta as an anailís mhionsonraithe mhachnamhach a rinne siad agus an staidéar sin á chur le chéile acu: Bertrand Maître, Ivan Privalko agus Dorothy Watson. Ba mhaith liom freisin aitheantas a thabhairt don obair a rinne an Rannóg um Chuimsiú Sóisialta sa Roinn Coimirce Sóisialaí, a bhainistigh an staidéar go dtí an foilseachán.

Joe O'Brien, T.D.
Aire Stáit atá freagrach as Cuimsiú Sóisialta

Executive summary

This report explores the association between three specific types of social transfer, and deprivation – the inability to afford basic goods and services. We are interested in both cash and non-cash transfers that are tied to specific areas of need; these are housing, childcare, and medical care. The study has three aims. First, we explore the coverage of these social transfers, asking if those who need transfers are most likely to receive them. Second, we consider the difference in deprivation between recipients and non-recipients. Third, we explore rates of deprivation among recipients before and after accounting for transfers, and whether this association is different for social risk and social class groups. Our main research question asks: what is the association between transfers and deprivation for social risk and social class groups? While other authors typically focus on the relationship between transfers and income poverty, which is defined using a monetary value, we consider a broader outcome, namely the household's ability to achieve a basic standard of living.

When measuring the association between transfers and deprivation, we assign a monetary value for non-cash transfers ('in-kind' transfers) like medical cards and childcare services. We do not need to do this for tied cash transfers like Rent Supplement, or more specific transfers with obvious cash values, like Housing Benefits (which contain a package of services like the free TV-licence scheme). However, where transfers are in-kind, we first estimate their possible cash value. We use several sources to estimate their worth, including data from the Primary Care Reimbursement Service and ESRI's SWITCH model (Simulating Welfare Income Tax Childcare and Health). Specifically, we estimate the effects of childcare supports and childcare schemes, which provide crucial resources to young families, especially unemployed families. We also assign a monetary value to medical and GP cards, which do not take the form of a cash transfer but provide an important resource to families.

Governments intervene to limit poverty and deprivation but must increasingly achieve 'more with less'. An important consideration is whether those who

receive the transfers are the neediest and whether the transfers improve their lives. Despite their importance, there is little research on the link between transfers and deprivation.

Key findings: Housing transfers

The Irish housing market experienced substantial change in the last twenty years, with home ownership rates declining and rates of private rented accommodation rising. Despite the decline in home ownership rates, the supply of social housing has not increased, resulting in an increasing reliance on the private rental sector for the provision of accommodation to families and individuals. This was accompanied by a change in housing transfers.

We find that the housing transfers that we consider in our report have declined in recent years, although we note that more recent programmes, such as Housing Assistance Payments (HAP), have increased. Our data, which refers to 2017, does not consider this scheme.[1] However, even before the introduction of HAP payments (which were launched in 2014 and became nationally available in 2017), the total cost and the number of those receiving housing transfers which we consider in our report has been in decline (Figure 2.4 and Figure 2.5). Part of this effect may be explained by the economic recovery that took place during that time. Importantly, we note that the average housing transfer has increased in value since 2012, which likely reflects the rising cost of housing, but may also reflect a difference in the composition of households seeking the payment.

Using data from the Survey on Income and Living Conditions, we find that a substantial portion of the population receive housing transfers of some kind (roughly 44 per cent). However, most of these respondents receive **Housing Benefits**, which are transfers designed to help with heating, electricity, and

[1] The survey was conducted in 2017 but the income reference period is the 12 months prior to the date of the household interview. The 2017 wave of SILC did not include questions about HAP. These appeared in the 2018 wave.

other minor costs. A far smaller portion of the population, (roughly three per cent), receive **Housing Supplements**,[2] which are designed to help cover the costs of rent or mortgage interest payments (Figure 2.7). There are sharp differences in the value of housing benefits and housing supplements, with supplements being higher on average but less common (Figure 2.8). A small portion of respondents (1.3 per cent) receive both a Housing Supplement and a Housing Benefit; the value of their transfers is typically higher than the other groups.

We find that respondents over the age of 65 had the greatest access to Housing Transfers (**Housing Supplements** or **Housing Benefits**[3]). Although we are not able to split housing transfer types by social risk and social class groups due to small numbers, we find that housing transfers more broadly were more common among older respondents. This finding likely reflects the transfers and benefits that are tied to retirement. Working age adults ("Other adults" in the figures) were the least likely to receive housing transfers (Figure 2.9). Among those receiving transfers, however, we note large differences in their value. The mean value of transfers was highest for lone parents and those with a disability, possibly reflecting their greater likelihood of receiving Housing Supplement instead of Housing Benefits.

Regarding social class, a clearer picture emerges. The unemployed or "never worked" social class and lower social class groups were the most likely to receive transfers when compared to the other groups (Figure 2.11). The value of transfers was also highest for these groups when compared to middle and higher social class groups (Figure 2.12). We suspect this is due to such groups qualifying for wider benefits, such as Rent Supplement.[4] However, due to data limitations we cannot explore this directly. Finally, we find that deprivation is higher among those receiving housing transfers, even

[2] The Mortgage Interest Supplement scheme has been discontinued but existed when data was collected. This scheme is discussed in Chapter 2.
[3] Due to CSO limitations we cannot distinguish between housing benefits and housing supplements by social risk groups, although a minority of the sample receive housing supplements.
[4] This is partly due to the eligibility requirements for rent supplement.

within social risk (Figure 2.13) and social class groups (Figure 2.14). This suggests that those experiencing deprivation are the most likely to receive housing transfers.

Finally, we use a simulation technique to estimate the association between transfers and deprivation. We find that housing transfers have a positive effect, in that they are associated with a decreased predicted probability of deprivation (Figure 2.16). More importantly, we find that the impact of housing transfers is greatest for lone parents and adults with a disability in terms of social risk (Figure 2.18) and unemployed and lower occupational groups in terms of social class (Figure 2.20). In both instances, vulnerable groups are most likely to benefit from housing transfers. Specifically, our simulation shows that lone parents saw an almost six percentage point decrease in their chance of deprivation after the value of transfers were considered, where working age adults ("Other adults" in the graph) saw a less than one percentage point decrease after the same transfers were considered. Further, those in the unemployed or "never worked" social class saw an almost six percentage point decline in their deprivation rate after the value of transfers were considered, while those in the highest social class group saw a less than one percentage point decrease after the same transfers were considered.

Key findings: Medical care

Regarding Ireland's health-related transfers, we focus on two specific schemes, medical cards and GP visit cards. The former covers the cost of GP visits and prescribed medications, while the latter covers GP visits only. The latter was recently expanded to include children under the age of six and people over the age of 70. For other groups, the distribution of medical cards did not change much over the period studied (Figure 3.1). We find that vulnerable social risk groups are particularly likely to receive a medical card (Figure 3.8), when compared to working age adults ("Other adults" in the figures), the majority of whom do not receive either a medical card or a GP visit card. Focusing on children under the age of 16, the pattern becomes even stronger, with the majority of those in vulnerable social risk groups

holding a medical card and the majority of those in the reference category (Other adults with children) without either card (Figure 3.9).
We also find a similar pattern across social class groups. Lower social class groups and unemployed class groups are unique in that most of these respondents hold a medical card, while in higher and middle social class groups most respondents do not have access to medical cards (Figure 3.10). This also confirms the previous findings that vulnerable groups are the most likely to receive the card. As before, the relationship is particularly strong when we focus on children under the age of 16.

As with housing transfers, we find that medical cards are more common among those who are income poor, when compared to respondents who are not income poor. We also find that the majority of those in deprivation hold a medical card, while a majority of those who are not deprived have no access to either a medical card or a GP visit card. Lastly, we note that most respondents who are consistently poor hold a medical card, compared to those who are not consistently poor, where the majority holds neither card (Figure 3.12).

Once again, we find that these tied transfers have a positive effect in that they lower the predicted probability of deprivation. However, we find that this effect does not differ strongly by social risk (Figure 3.15) or social class (Figure 3.17) groups. We note that unemployed respondents and respondents with a disability see a stronger effect when deprivation is split into a binary variable (‘deprived’ and ‘not deprived’). For example, our simulation shows that adults with a disability report a one percentage point decrease in their predicted probability of deprivation, after we account for the value of transfers, while the decline is far smaller for working aged adults without a disability (less than 0.25 percentage points). In terms of social class, those who have never worked report a one percentage point fall in their predicted probability of deprivation after considering the value of transfers tied to health, while those in the highest social class see a far smaller effect (less than 0.5 percentage points).

Key findings: Childcare transfers and services

Childcare transfers are particularly important in Ireland since formal childcare services are not strictly universal. We summarise the main available childcare schemes and services, noting the supports designed with social risk and social class groups in mind. CSO figures show that children under the age of 18 are the most likely to experience deprivation when compared with other age groups (Figure 4.1). However, within age groups, younger children (aged 0-5) are the least likely to experience deprivation when compared to households with older children (Figure 4.2).

Results suggest that childcare use is lowest among deprived households when compared to non-deprived households. However, when we restrict our analysis to households with children aged 3-5, we find higher rates of childcare participation and less inequality between deprivation groups (Figure 4.3). This result could stem from the government childcare schemes which target children aged 3-5. We also find that households reporting deprivation cite fewer hours of childcare when compared to households who are not deprived (Figure 4.4).

We find minor differences in the use of childcare between social risk groups (Figure 4.5) but wider differences in the quantity of childcare that users cite (Figure 4.6). Working age adults with children cite the most hours, while adults with a disability and lone parents cite the least number of hours. Likewise, we find a similar difference in terms of social class groups, with higher social class groups citing more care, and middle and lower social class groups citing less care (Figure 4.8).

Our simulation results show that childcare subsidies are associated with lower deprivation. We find that lone parents have the most to gain from these subsidies, while other working age adults have the least to gain (Figure 4.10). Considering the value of transfers, lone parents saw a fall in predicted probability of deprivation of almost three percentage points. We also find that, in social class terms, unemployed households have the most to gain from childcare subsidies than the other social class groups (Figure

4.12). This group also saw a fall in the predicted probability of deprivation of four percentage points.

Key findings: Cumulative effects of transfers

Finally, we consider the cumulative effects of these three sets of tied transfers. We note that most respondents receive at least one transfer but this average masks large differences between social risk and social class groups. For example, across social risk groups, most lone parents receive two or more sets of transfers (48 per cent), while a significant portion of respondents with a disability (40 per cent) and older respondents (70 per cent) receive one set of transfers. Regarding social class groups, we also find that the highest social class respondents are the least likely to receive two or more sets of transfers and that 39 per cent receive none of the transfers. This distribution differs for middle, lowest, and unemployed social class groups who are most likely to use just one set of transfers.

We then considered the difference in deprivation between those who receive no tied transfers, those who receive one set of transfers, and those who receive two sets of transfers. Respondents who receive transfers cite higher levels of deprivation, with respondents who receive multiple transfers citing the highest rates. However, this difference can be explained by social risk, social class, and the financial wellbeing of the household.

Finally, our simulations find an association between tied transfers and lower rates of deprivation, with vulnerable groups benefitting the most from transfers and the greatest effect seen where the respondent relies on more than one set of transfers. Lone parents who receive two or more transfers saw an over three percentage point fall in their chances of deprivation, after we considered the value of transfers. In comparison, working age adults (“Other adults” in the figures) who received two or more transfers saw a less than one percentage point fall in their chance of deprivation.

Chapter 1

Introduction

1.1 Introduction

Social transfers give crucial supports to vulnerable families, providing access to important services (like medical care or childcare options), without which they would face greater risk of social exclusion. This study compares the distribution of specific transfers tied to housing, health, and childcare, and the association between these and deprivation in Ireland (2017). Specifically, we will estimate the social risk and social class differences in access to transfers and their association with deprivation. Deprivation is the inability to afford basic goods and services, like new clothes, a warm coat and replacement of furniture (Whelan and Maitre, 2006). This measure is different to income poverty, which is traditionally used in analyses of transfers.

Studies of transfers typically look at the impact on cash transfers on poverty (Savage et al., 2019; Watson and Maitre, 2013) but recipients of such transfers are often entitled to a range of additional, non-cash transfers, services, and supports, designed to limit the experience of poverty and deprivation. In this study we will explore the association between these transfers and the deprivation of vulnerable groups in Ireland.

This project has three aims. First, we will explore the coverage of transfers, considering these overall and how they differ by social risk and social class groups. Second, we will consider differences in deprivation between transfer recipients and non-recipients. Third, we consider households' chances of deprivation with and without the transfers, using a simulation. Throughout the report we focus on three specific tied transfers: **housing**, which take the form of Rent Supplement and Mortgage Interest Scheme Supplements, while others are non-cash housing benefits tied to energy, television, and heating; **healthcare**, which take the form of medical cards and GP visit cards; **childcare,** which consider the imputed cost of universal non-cash childcare support. In a concluding chapter, we will consider the impact of **all three** transfers together.

Social transfers are designed to reduce income poverty and deprivation.

Governments across Europe, regardless of welfare regime or ideological stance, commit some portion of their annual budget to these (Notten, 2016). However, countries differ in their generosity and their preference for transfer types, focusing on some combination of means-tested and universal, cash and non-cash transfers. While most researchers explore the impact of income transfers on poverty, they less often consider non-cash or in-kind transfers (Russell and Nolan, 2000; Savage et al., 2019). Further, authors often use income poverty as an outcome, rather than measures of material deprivation. However, those who explore the impact of transfers on deprivation routinely find a negative association between the two (Notten, 2015, 2016; Nelson, 2012; Saunders and Wong, 2011). Our work builds on these contributions but also revisits previous research, which explored the link between social transfers and income poverty in Ireland (Watson and Maitre, 2013). In this report we dig deeper, looking at the association between the listed transfers and material deprivation.

1.2 Framing social transfers, recipients and their effects

This section outlines the theoretical framework between social transfers and consumption; more specifically it outlines the association between market income, transfers, and deprivation. In an economy there are households whose market incomes are below average. In many of these, financing basic costs is difficult. This difficulty (income poverty) leads to consumption difficulties (material deprivation). While income poverty is calculated using a household's income relative to a benchmark (commonly 60% of median household disposable income), material deprivation is an objective measure of what a household can and cannot afford, using measures of what is generally considered "a customary life" (Nelson 2012; Watson and Maitre, 2013; Whelan et al, 1996). Notten (2015) suggests income poverty is "*a monetary, indirect, resource-based indicator*", while material deprivation is "*an adverse material outcome resulting from a lack of financial means and is thus a non-monetary, direct, outcome-based indicator*".

In order to limit the impact of low market income on poverty and deprivation, the welfare state supplements household income directly (by cash transfers)

or indirectly (by offering non-cash or in-kind transfers such as supplemented medical cards) (Barr, 2012; Sen, 1997). The question for state actors is therefore who should qualify for these transfers and whether or not these transfers are effective (Atkinson, 1998). Gaps between market income and necessities lead to deprivation, as a result transfers would ideally bridge this gap. Throughout this report, we will focus on the association between transfers and material deprivation. While income poverty was a commonly studied indicator across Europe, it became apparent that income poverty failed to capture several differences in living standards (Nelson, 2012) as well as the effects of economic cycle in periods of economic growth and recession. Examining the link between transfers and measures of deprivation is a way to address some of the shortcomings of a focus solely on income poverty.

1.3 Social transfers, income and non-cash benefits

Alleviating poverty is a goal for all national welfare states. This is achieved through diverse combinations of service provision, income transfers, and benefits. Generally, income transfers and benefits are designed to guard against economic shocks, to provide redistribution over the life course, and to consider different needs between social groups at different life stages and with changing economic circumstances (Atkinson, 1995).

Broadly speaking, country poverty rates fall with increased social spending (Notten, 2015). Due to pressure from recession and subsequent austerity, welfare states have had to achieve more with less (Watson and Maitre, 2013) and transfers and benefits have become subject to scrutiny for their effectiveness and efficiency (Notten 2015; LeFebvre, 2007; Caminada and Goudswaard, 2010; Esping Andersen and Myles, 2009). In the following, we summarise the main impacts of these transfers below, focusing first on income poverty and then on deprivation.

1.3.1 Social transfers and income poverty

Regarding who receives transfers, Notten (2015) finds that most income transfers go to the lowest income quintile, and that households in upper

quintiles rarely receive transfers. Notten (2015) also shows wide differences between six European countries (Germany, France, Ireland, the Netherlands, Sweden, and the UK) in the share of respondents receiving transfers and the types of transfers received (housing, family, or social assistance). Ireland has a particularly high share of households receiving any kind of transfer (70%), when compared to the UK (39%) and Sweden (33%). This is especially true for Ireland's transfers tied to housing (30%), which are far higher than those in Germany (0.43%) and Sweden (9.5%). This difference is likely related to country differences in the provision of services (like social housing) versus country differences in the use of transfers (like housing related benefits for use in the private market). Notten (2016) also finds broad country differences in the average value of income transfers between six European countries,[5] with recipients in the UK (€5,796) and Ireland (€5,130) receiving higher amounts than Germany (€3,789) or the Netherlands (€3,664). In short, Ireland's transfers cover a significant portion of the population, and the average transfer is more generous in Ireland when compared to other European countries. Callan et al. (2018a) also note that Ireland's income transfers played an important role in limiting the potential increase in inequality following Ireland's 2008 recession. After the economic downturn, more people became dependent on welfare support, which in turn limited inequality increases through the tax-benefit system.

Regarding the effects of transfers, several authors find a negative association between transfers and income poverty. Notten and Guio (2016) show a basic negative association between income transfers and post-transfer levels of income poverty risk. There is also evidence that certain transfers are more effective than others in this regard. Miežienė and Krutulienė (2019) find that transfers designed to limit social exclusion and transfers that target spending on children and the family have the greatest impact on poverty reduction, compared to other transfer types. Using Irish SILC data, Watson and Maitre (2013) consider the impact of transfers on the

[5] Figures are nominal, not PPP adjusted.

poverty gap (the difference between market income and the poverty threshold). They find that transfers covered 84 per cent of the gap in 2004 and 88 per cent of the gap in 2011. This effect also had group differences, ranging from 84 per cent for working-age adults to 95 per cent for retirement age adults (2011), again suggesting that vulnerable households benefit most from transfers. The effect was also observed for children, with the pre-transfer poverty gap reduced by 87 per cent after transfers.

There is also evidence that transfer types are effective across a range of countries. Chzhen and Bradshaw (2012) report that transfers reduce income poverty in a sample of lone parent families from several European countries. This effect remains even when controlling for GDP per capita differences between countries, which reduce but do not eliminate the effects of transfers. Chzhen and Bradshaw (2012) also find significant differences in who experiences poverty and the importance of household composition when thinking about transfers and poverty. They claim lone fathers are less likely to experience income poverty than lone mothers, and that younger householders are more likely to be in poverty when compared to older heads of household. However, it is not clear whether there are group differences in the effect of income transfers on poverty; for example, whether income transfers for lone mothers are more effective than income transfers for lone fathers in alleviating income poverty (Chzhen and Bradshaw, 2012).

1.3.2 Social transfers and deprivation

A key group of authors also consider deprivation as an outcome. Starting with the general link between transfers and deprivation, the highest quintile of deprivation is the most likely to receive income transfers, across a range of European countries (Notten 2016).

Income transfers also reduce the likelihood of experiencing deprivation (Notten and Guio, 2016; Notten, 2015, 2016), but this link is less straightforward than the relationship between income transfers and income poverty, because measures of poverty and transfers rely on a €1-to-€1 relationship. Thus, Notten (2016) highlights that deprivation may be further affected by debt or wealth, access to non-financial resources, and the

general needs of the household (childcare, elder care, and family size). These measures cannot be assigned a euro value but may affect a household's ability to consume certain essential goods.

Regarding country differences, there is a negative relationship between country levels of social assistance and country levels of deprivation (Nelson, 2012). There are also country differences in the importance of individual level predictors when estimating deprivation, with low-assistance countries showing the strongest link between individual level factors and deprivation. In this way, among countries with low support, individual characteristics are a better predictor of deprivation than they are in countries with high support. Here too Chzhen and Bradshaw (2012) find that social transfer generosity[6] limits the respondent's likelihood of experiencing deprivation, although country GDP levels may be a stronger predictor of this outcome. Overall, deprivation levels differ by country, and generosity of transfers may explain some of these differences.

Regarding group differences, household composition is again cited as an important factor. Deprivation is highest among single respondents, lone parents, unemployed respondents or those with only a primary education (Nelson, 2012). Elsewhere, Chzhen and Bradshaw (2012) report that lone parent mothers are more likely to experience deprivation when compared to lone parent fathers, and that larger lone parent families have a greater likelihood of experiencing deprivation, when compared to smaller families. Regarding group differences in the effects of transfers on deprivation, Saunders and Wong (2011) report that respondents with a disability, lone parents, and the unemployed see small deprivation-reducing effects after transfers, while older respondents see greater effects.

In short, material deprivation differs between social risk groups and between countries. Further, income transfers are associated with lower rates of

[6] "*Social transfers include all contributory and non-contributory individual and family level cash benefits including unemployment benefits and disability benefits, housing allowances and family/child related allowances, but not including old age and survivors benefits which are treated as original (before transfers) income in this analysis.*" Chzen and Bradshaw (2012, p.494)

deprivation. Generally, there is little written about links between transfers and deprivation, thus the purpose of this report is to contribute knowledge to this area.

1.3.3 Non-cash transfers

In the poverty literature, there is a large body of research on the role of cash transfers to alleviate poverty but much less so on non-cash benefits and the motivations for such policy. Currie and Gahvari (2008) provide a detailed account of many different theoretical explanations for non-cash benefits as part of government social welfare policies. According to the authors, there are two main justification for non-cash benefits; paternalistic and egalitarian viewpoints. In paternalistic approaches, societies provide non-cash benefits to recipients (who may prefer cash) as a way of controlling aid and welfare. In egalitarian approaches, non-cash benefits are the result of a wider desire to help individuals secure basic rights to goods and services like adequate food, access to medical services, education or housing. As a result these are provided directly via non-cash benefit. As the two approaches show, non-cash transfers may not be a universal solution to deprivation, and may rely on the wider system of welfare in a given society.

Nonetheless, non-cash transfers may have important effects on income poverty and deprivation, in that they provide specific resources (like medical cards) rather than cash transfers. In this way, they are particularly important in alleviating deprivation. Those receiving cash transfers are often entitled to many non-cash transfers such free heating, electricity, television, and other forms of assistance like access to social housing. The literature differs in terms of how to add a cash value to services such as the medical card and childcare. In the next few paragraphs we consider non-cash transfers and their valuation.

Non-cash transfers help households at the bottom of the income distribution to cover the most basic costs of housing, medical, and childcare services. Russell and Nolan (2001) estimate that 61 per cent of medical card spending goes to households in the bottom 30 per cent of the income distribution. The

authors also argue that the elderly have the greatest access to medical cards, while the working poor, those who are unemployed, and those with large families have less access to medical cards. Despite this, imputing a monetary value to the schemes is not straightforward, although authors have been able to value certain non-cash transfers (Russell and Nolan, 2000; Callan and Keane, 2009; Callan et al., 2018b).

There are two issues with assigning a value to non-cash benefits. The first is that recipients of in-kind transfers may be worse off than similar recipients who do not receive the transfer. For example, Callan and Keane (2009) suggest the biggest consumers of health services are not those with more "total resources" but rather those with the biggest demand for health services (possibly due to illness or a disability). Thus, assigning a cash value to consumers of several healthcare procedures means they cannot be considered "better off" or "less deprived" when compared to similar people who consume fewer health services. A second issue is the gap between qualifying for transfers and uptake of services, Callan et al., (2018b) found that despite entitlements to medical and GP visit cards, there are gaps in their take-up; suggesting that entitled non-recipients may not necessarily need such transfers or benefit from them.

Non-cash transfers are often found to have the biggest impact on families with children and the elderly, and the lowest impact on single households and young families without children (Saunders et al., 1992). Speaking on the importance of education, and health related transfers, they write:

> "*the impact of noncash income is best viewed within a life cycle context. Education accrues to families with school age children, while health care benefits – though received by all – are disproportionately high for the elderly, particularly the very old. The inclusion of noncash income thus has the largest impact on the final incomes, and hence average living standards and poverty rates, of families with children and the elderly.*" (Saunders et al., 1992, p.33)

Researchers differ in their approach to estimating the value of a service, especially one that is provided free or at a reduced fee. Some take an

accounting approach, where the cost of the services provision is attached to the service itself. A second approach (subjective and more difficult) is to ask people to value access to the service themselves, although this leads to different estimates, depending on respondent characteristics, circumstances, and preferences (Smeeding, 1982). The most common approach is the risk-related approach, which is based on cost of service per capita. Rather than applying the same average value to everyone irrespective of some of their characteristics, they receive a value corresponding to the average usage by their gender and age group. This method has been used in Ireland for the valuation of medical card (Savage et al., 2016; Russell and Nolan, 2001), as well as internationally (Saunders et al.,1992; Donaldson et al., 2002).

1.4 Data and Measurement

We draw on Ireland's Survey of Income and Living Conditions (SILC). We use the 2017 wave of data, which records individual and household composition measures as well as income, and transfer receipt in the areas of housing, medical cards, and childcare.[7]

Importantly, the 2017 survey does not consider receipt of Housing Assistance Payments (discussed in detail in Chapter 2). This scheme was launched in 2014 and became nationally available in 2017. It is a scheme that pays a proportion of private market rent directly to the landlord on the tenant's behalf. The scheme has become an important part of Ireland's housing provision policy, outlined in Rebuilding Ireland.[8] However, data on the scheme does not feature in SILC 2017.

The purpose of Ireland's SILC is to provide individual level and household level statistics on income, living standards, poverty, deprivation, and inequality (CSO, 2017, p.87). We are particularly interested in transfers tied to housing, childcare, and medical services, and the social risk and social

[7] SILC 2017 was the most recent SILC wave available at the time of the data analysis for this report.
[8] Rebuilding Ireland: Action plan for housing and homelessness (2016). Available at: https://rebuildingireland.ie/

class differences in these measures. We are also interested in how these measures impact deprivation, and the social risk and social class differences in who experiences deprivation.

A major strength of the survey is that cash and some non-cash benefit figures do not rely on the respondent's recall and are instead gathered from administrative sources using their Personal Public Service number.[9] In this way the data can capture the exact size and scope of benefits and allowances. Another significant strength of the survey is that it contains many of the important controls mentioned in the review summary above. Using SILC, we can control for many of the measures noted above, like family size and household composition, as well as the main characteristics of the head of the household. These measures are important predictors of deprivation.

1.4.1 Housing transfers, medical cards, and childcare subsidies

Using the SILC, we outline and define housing, medical, and childcare transfers. These three transfer types were chosen because of their significance in terms of number of recipients and because of data availability. First, starting with housing transfers, Ireland's SILC considers two measures of Total Housing Allowances which are imputed using a respondent's PPS number. These transfers are the only ones related to housing which are available to us in SILC. Other transfers exist, as mentioned above, however we focus only on housing transfers as they appear in SILC 2017. The first is made up of **housing supplements**, Rent Allowance, Rent Supplement, Mortgage Interest Supplement, Exceptional Needs Payments, and Heat Supplement (measured together). In order to simplify our analysis, we focus only on households who receive Rent Allowance, Rent Supplement, and Mortgage Interest Supplement; in short, we ignore transfers tied to

[9] Childcare support and medical card/GP visit card values are estimated separately, as described in corresponding chapters below.

Exceptional Needs Payments and Heat Supplements.[10] The second is made up of **housing benefits** including Free TV license, Energy Allowance, Fuel Allowance, Telephone Support Allowance,[11] and a Water Conservation Grant (measured together). Using these measures, we can discern between four groups of households:

- Those not in receipt of any housing transfers.
- Those in receipt of Housing Supplements only.
- Those in receipt of Housing Benefits only.
- Those in receipt of Housing Supplements and Housing Benefits.

Due to CSO publication guidelines on cell size we sometimes collapse these categories into a simplified measure capturing those who receive and those who do not receive any type of housing transfer. This simplified measure masks significant differences in access and total benefit received. However, it is the best measure available to us. Beyond who receives benefits, we also consider the total amount received in these four categories (with the reference category, those not in receipt of any housing allowance, always set to 0).

Second, Ireland's SILC considers whether adults hold a medical card, a GP visit card or neither. The survey also captures whether children under the age of 12 in the household hold a medical card, a GP visit card, or neither. We impute a value to these cards using data from the Primary Care Reimbursement Service annual statistics and from the SWITCH database.[12] In this way we can compare the following groups:

- Households receiving neither card.
- Households receiving a medical card.
- Households receiving a GP card.

Finally, the SILC dataset contains information about the presence and age of

[10] We ignored these transfers as their monetary value is small relative to wider housing transfers.
[11] This scheme no longer exists.
[12] SWITCH is the ESRI's tax benefit model based on the CSO SILC data. The model can simulate the effect of changes to the tax and welfare system on household income.

children in the household and the number of weekly hours spent by each child (up to the age of 12) in different forms of childcare (none, formal childcare,[13] relatives or family). Using subsidies information from the Department of Children, Equality, Disability, Integration and Youth (DCEDIY) and simulation from the SWITCH model, we allocate the value of a childcare transfer to the income of a household. This value is the same as the subsidies provided by DCEDIY to the childcare providers, except we assume that this value is paid to the household. We develop this process further in the childcare chapter.

1.4.2 Identifying vulnerable groups – Social class groups

Social classes are groups that share a common set of resources, and a common level of access to life chances (Goldthorpe and Jackson 2007; Friedman et al., 2015). Class differences in resources include difference in capital, social capital, skills, and organisation-specific knowledge. Class differences in life chances include employment, promotion, and other economic opportunities, such as working in a protected occupation. Class categories capture not only a person's current situation but also their ability to maintain their status despite shocks like illness, job loss, and early retirement (Friedman et al., 2015).

We define social class groups using the occupation-based European Socioeconomic Classification (ESeC), which draws on the work of John Goldthorpe and Robert Erikson (1992). Our focus is the social class position of the head of the household (the person responding to the household questionnaire, identified as the main person responsible for housing costs). We apply their social class value to the household. Because of the small sizes of some social class groups and to comply with CSO statistical rules, we aggregate and simplify these groups into just four categories:

- High social class – defined as managerial and professional

[13] Formal childcare is defined as childcare provided by a waged employee in a formal setting, it does not include private childminders.

occupational positions (ESeC classes 1 and 2).

- Middle social class, including other technical and white-collar occupations, the self-employed and farmers (ESeC classes 3, 4 and 5).
- Lowest social class – including skilled and semiskilled manual and routine non-manual occupations (ESeC classes 6 to 9).
- Unemployed or those who have never worked. These respondents are the most limited in terms of resources in that they have limited access to the market (ESeC code 10).

1.4.3 Identifying vulnerable groups – Social risk groups

Social risk groups are distinguished on the basis of non-class characteristics that result in differences in their risk of poverty and deprivation (Watson et al., 2016). Lone parents, older adults, children, the unemployed, and people with a disability are limited in their access to employment and the extent to which they can participate in labour market. Social risk groups are different to social class groups in that they offer additional explanations for the risk of poverty or exclusion (Watson et al., 2016). Drawing on earlier work which examined the evolution of income poverty and deprivation over the life cycle, Watson et al. (2016) frame social risk groups as those who differ in their risk of poverty due to non-class, personal, or family factors that restrict their capacity to meet their need through the market. This report focuses on three drivers of social risk:

- Life course stage: Children and people older than working age are vulnerable to social exclusion and deprivation because of reduced (or no) access to employment in their own right.
- Personal resources: Illness or disability potentially limits a person's work capacity. Further, illness and recovery involves additional costs in treatment, medication, and aids (Cullinan, Gannon and O'Shea 2013). Disability may also be penalised in the labour market through discrimination or unaccommodating facilities.
- Non-work caring responsibilities: responsibility for childcare or

others who have an illness or infirmity limits a person's capacity to engage in employment.

Respondents who are at risk of deprivation and income poverty are the most likely to benefit from cash and non-cash transfers alike. Households that are particularly prone to poverty, despite their social class, are those with children, those with older adults, and those where someone has a disability (NESC, 2005). Elsewhere, studies have found that lone parents are at risk of social deprivation and poverty (Watson et al., 2016). The remaining group, that of working age adults who are neither lone parents, nor someone with a disability or living with an adult with a disability, have a lower risk of poverty and deprivation. As a result, we consider them the reference social risk category to which we compare the remaining groups. Our social risk groups are therefore:

- Lone parents and their children.
- Individuals (including children) in households where at least one working-age member has a disability (which may be the respondent).
- Individuals aged over 65.
- Working age adults who are not lone parents, and who do not have a disability, and their children (the reference category).

We consider social class and social risk groups as both important in determining deprivation and the need for non-cash benefits. These two concepts, although aimed at capturing the socioeconomic resources that individuals and households have, only partially overlap. In fact, while social class captures differences in market power, social risk captures barriers to accessing the market in the first place. Both are important predictors of differences in life chances.

1.4.4 Deprivation and income poverty

Within SILC, income is measured at the household level over the twelve months preceding the interview. All income sources of all household members are included. As well as weekly social welfare payments, less

frequent payments are also included (such as Child Benefit, which is paid monthly, and payments such as Back to School Clothing and Footwear Allowance) along with the cash value of near-cash benefits (e.g. free electricity, gas and TV licence). In constructing the indicator of at-risk-of-poverty, we take disposable income – the level of household income after tax and social transfers such as pension or unemployment benefits. The measurement of at-risk-of-poverty also takes account of household size and composition by using an equivalised scale. This involves an adjustment to income so that we can compare incomes of households that differ in size. The Irish national equivalised scale allows a weight of 1 for the first adult in a household, 0.66 for each subsequent adult (over the age of 14) and 0.33 for each child. Equivalised income is a household's disposable income divided by the household equivalisation scale. A household is at-risk-of-poverty if its equivalised income is below 60 per cent of the median equivalised income.

Deprivation is defined as the ability to afford a list of basic goods and services (Whelan and Maitre, 2007). They are:

- Two pairs of strong shoes
- A warm waterproof overcoat
- Buy new (not second-hand) clothes
- Eat meal with meat, chicken, fish (or vegetarian equivalent) every second day
- Have a roast joint or its equivalent once a week
- Had to go without heating during the last year through lack of money
- Keep the home adequately warm
- Buy presents for family or friends at least once a year
- Replace any worn out furniture
- Have family or friends for a drink or meal once a month
- Have a morning, afternoon or evening out in the last fortnight for entertainment

We consider people who are unable to afford two or more of the listed items to be experiencing basic deprivation. This is the basis for calculating the

deprivation rate.[14]

1.5 Estimating the relationship between transfers and deprivation

The relationship between low income households and the experience of deprivation is well established (Calandrino, 2003; Whelan and Maître, 2006), though the overlap between income poverty and material deprivation is not perfect (Whelan and Maître, 2006). To illustrate the relationship between income and deprivation, results from SILC 2017 (CSO, 2018) show, for example, that 44 per cent and 39 per cent respectively of the two bottom-income deciles are deprived (lacking at least two items) while it is three per cent and less than two per cent for those in the ninth and top income decile. The aim of the modelling exercise in the first part of the report is to establish a formal relationship between income and deprivation while taking account of other characteristics that would be associated with income, such as the person's level of education or the household size.

We use static simulation to estimate the association between transfers and deprivation as proposed by Notten and Guio (2016). That is, we treat SILC's measure of deprivation as a categorical and ordinal measure, as have other authors (Notten and Guio, 2016, forthcoming). We treat each value of deprivation as a category and so estimate the likelihood of moving to a higher value of deprivation for each control (Freese and Long, 2006; Rabe-Hesketh and Skrondal, 2008). Several types of regressions can be used when using a count dependent variable. We follow the Notten and Guio (forthcoming) approach by comparing five types of regressions in order to identify the model that fits the data best and that we will use for the rest of the analysis.

We include a summary table of several regression models in the appendix. We chose to estimate the association between transfers and deprivation

[14] Background notes are available here: https://www.cso.ie/en/releasesandpublications/ep/p-silc/surveyonincomeandlivingconditionssilc2017/backgroundnotes/

using ordinal logistic regression, since these models produced the lowest values for both the Akaike Information Criterion (AIC) and Bayesian Information Criterion (BIC). Notten and Guio (forthcoming) use the same approach for the same reason.

The regressions used for the comparisons are a Poisson regression, a Negative binomial regression, a Zero-inflated regression, a Generalized ordered logit regression, and an Ordered logit regression. We compare these with an Ordinary least squares regression (OLS). For each of these regressions, the dependant variable is the count number of deprivation items ranging from 0 to 11; we include several control variables, such as individual and household characteristics that are likely to be associated with material deprivation.

Once we estimate the basic group differences in deprivation, we use post estimation techniques to consider the predicted probability of citing each deprivation category. Using this model, we then capture the difference in deprivation with and without transfers, by first estimating the predicted probability of being deprived, controlling for gross household income. When estimated, we then add the value of transfers into the measure of household income, and again estimate the predicted probability of being deprived. The difference between these two predictions is the association between transfers and deprivation. We present the most basic model in the section below. We consider the impact of transfers using this model in each subsequent chapter.

1.6 Estimating deprivation and group differences in deprivation

In order to simulate the impact of transfers on deprivation, we use a basic model to consider the chance of deprivation and the group differences in this chance. Specifically, we consider three models which estimate the likelihood of experiencing higher deprivation. The first models consider the social risk and social class groups. The second adds the characteristics of the head of the household. The final set considers household income, our key measure

for simulating the effects of transfers in later chapters, and the characteristics of the household. Using a model that considers only the impact of income on deprivation would give a biased estimate because there are several other factors which impact deprivation such as social risk and social class membership, even when measures of income are held constant. We will use the coefficients in Model 3 as the main predictors of deprivation with and without transfers. Before we consider this, however, we will note the impact of the proposed measures.

TABLE 1.1: ORDINAL LOGISTIC REGRESSION ESTIMATING DEPRIVATION

	Model 1	Model 2	Model 3
	Deprivation	Deprivation	Deprivation
VARIABLES			
Ref: Older adults			
Lone parents	6.09***	4.24***	1.61
Disability	5.19***	2.98***	1.89**
Working age adults	1.60***	1.25	0.88
Ref: High & lower professional			
Inter/tech/self-employed	1.77***	1.45**	1.08
Lower service/unskilled manual	2.89***	2.01***	1.44*
Unemployed/never worked	5.31***	2.42**	1.38
Ref: Head of household male			
Head of household female		1.26*	1.47**
Age of head of household		0.99*	1.01
Ref: Head of household non-Irish			
Head of household Irish		0.85	0.57**
Ref: Head of household working			
Head of household unemployed		3.50***	2.30***
Head of household in education		1.84	1.31
Head of household in home duties		1.71**	1.11
Head of household retired		0.94	0.9
Head of household ill/disabled		4.16***	2.88***
Head of household not yet at work		2.28*	0.83
Ref: Head of hh has tertiary degree			
Head of hh has primary education		1.79***	1.49*
Head of hh has secondary education		1.36*	1.33*
Equivalised household income			0.39***
Ref: 2 adult household			
1 adult household			1.17
3 or more adult household			0.97

1 adult with children <18			1.33
2 adults with children <18			1.19
Other households with children <18			1.38
Number of children <18			1.08
Number of adults 18-65			0.96
Number of adults 65+			0.62*
Rented accommodation			1.98***
/cut1	6.86***	4.18***	0.00***
/cut2	15.67***	10.00***	0.00***
/cut3	26.90***	17.65***	0.00***
/cut4	46.36***	31.10***	0.01***
/cut5	74.06***	50.43***	0.01***
/cut6	122.78***	84.84***	0.01***
/cut7	231.09***	162.19***	0.03**
/cut8	544.97***	388.07***	0.07*
/cut9	1,082.30***	775.03***	0.13
/cut10	2,305.76***	1,653.85***	0.28
/cut11	31,925.03***	22,935.27***	3.94
Observations	12,251	12,251	12,251

The first set of estimates (Model 1) considers differences in social risk and social class in the likelihood of experiencing higher rates of deprivation. Starting with social risk, we note wide differences between groups: lone parents, working age adults, and respondents with a disability have a significantly higher chance of experiencing deprivation when compared to older adults (those aged over 65). Differences also emerge for social class, with intermediate, lower, and unemployed classes having greater chances of higher deprivation when compared to the highest social class group (High occupations and lower professionals). These effects are predictable, with vulnerable groups citing a greater chance of experiencing deprivation.

We can explain part of this difference by considering the characteristics of the head of the household. We do this in Model 2, noting that the gender,

age, and nationality of the head of the households explain part of the effects of social risk and social class. The economic status and educational attainment of the head of the household also closes some of the gaps between social risk and social class groups. With these factors in mind, we now see than lone parents are now four times more likely than older respondents to cite higher levels of deprivation, and respondents with a disability are three times more likely to cite higher deprivation when compared to respondents over 65.

Regarding social class groups, the middle social class group is now 1.4 times more likely to cite greater deprivation when compared to the highest social class group. The lowest social class group is two times more likely to cite greater deprivation when compared to the highest social class. Finally, the unemployed group are 2.4 time more likely to cite deprivation. Although the characteristics of the household explain some of these differences, social risk and social class groups still have an impact on deprivation, even when we consider these factors.

Lastly, we consider the impact of equivalised household income and general household composition. With these measures added to the model, social risk and social class differences are now minor. For social risk, the only significant difference is that between older adults and respondents with a disability. For social class, the only difference is between the highest social class and the lowest social class. Importantly, equivalised household income has a strong and negative effect on the likelihood of citing higher levels of deprivation (0.39 decrease in odds for every unit increase in equivalised household income).

All statistical models can present advantages and limits. One issue in the model specification that could affect our results is based on the assumption in ordinal logistic regression (“assumption of proportional odds”) that the effects of the independent variables are proportional across the different thresholds. So, taking the income variable as one of our independent variables, we assume that there is indeed a consistent effect of income across the different deprivation threshold. However, Guio et al. (2017) found

that the item composition of deprivation varies across deprivation levels, which could suggest that within the relationship between income level and deprivation items can vary. Some items can be regarded as “less severe” (going out with friends for example), while others are more basic items (being able to afford food/clothes). Guio et al. (2017: 35) found that at the lowest level of deprivation we tend to find “*less severe*” items. Another issue is that the measure of deprivation is not perfect as the level of deprivation can be underestimated as people adjust their preferences (Hallerod, 2006) or because of a weaker relationship between income and deprivation like for self-employment income, as shown by Whelan, Layte and Maître (2004). All these issues could affect substantially the coefficients in the regression models.

In the next chapter we deal with the transfers tied to housing costs. Chapter 3 considers medical and GP visit cards, Chapter 4 considers childcare, and Chapter 5 examines the cumulative effects of transfers. Chapter 6 concludes and offers policy recommendations.

Chapter 2

Housing support

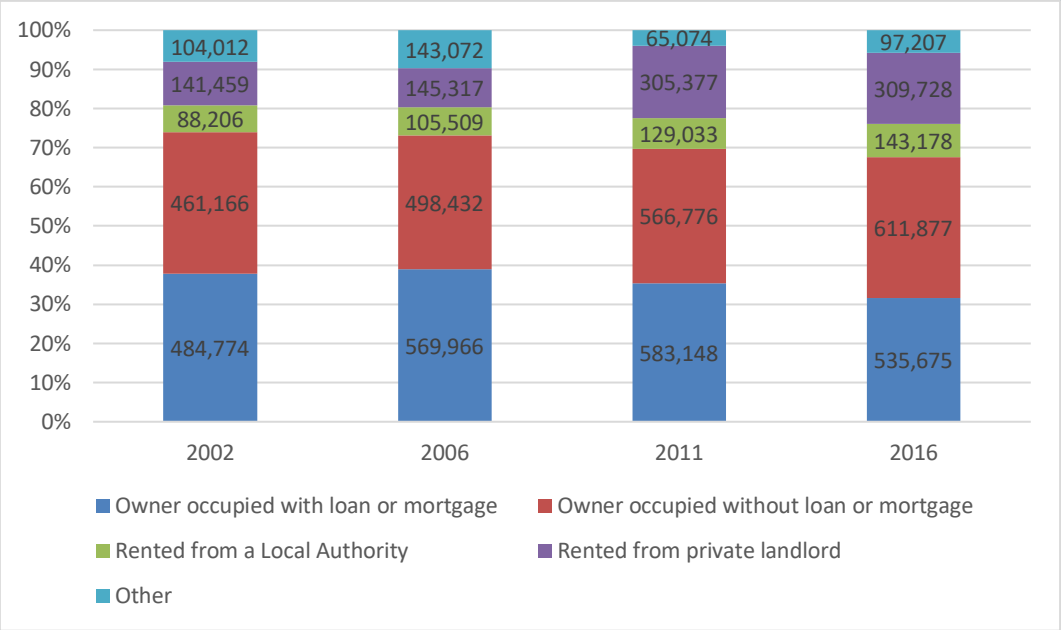
This chapter considers the distribution of housing transfers and the association between transfers and deprivation. Housing transfers are a key form of specific assistance, tackling one of the most important costs for individuals and families. These transfers take the form of **housing supplements**, covering the cost of rent or mortgage interest, and **housing benefits**, covering the cost of heating, electricity and other utilities. We ask two main questions throughout this chapter. Who receives which transfers? What is the association between receiving (and not receiving) transfers and deprivation after the characteristics of recipients are controlled for?

Although important, we do not consider the role of public housing. Public housing likely has a significant impact on deprivation given that it is provided to tenants at a differential rate (Fahey, 1999). Neither do we consider users of the Housing Assistance Payment scheme, which does not feature in our dataset but which has become an important policy instrument for housing provision in Ireland. Despite these two omissions, we can capture the distribution of housing supplements and housing benefits, and their association with deprivation.

2.1 Housing over time

The cost and nature of housing has changed since 2002. Previous studies of non-cash benefits focused on imputed rents for homeowners (Callan and Keane, 2009). In this approach, authors focused on the imputed rent gained from home ownership. However, Ireland's share of owner occupation declined from 74 per cent in 2002 to 68 per cent in 2016. During that time rental properties have grown in importance. Further, the costs associated with housing, especially housing in the rental sector, have also changed. These changes prompted the government to create new forms of support for those renting their homes in the public and private housing sector.

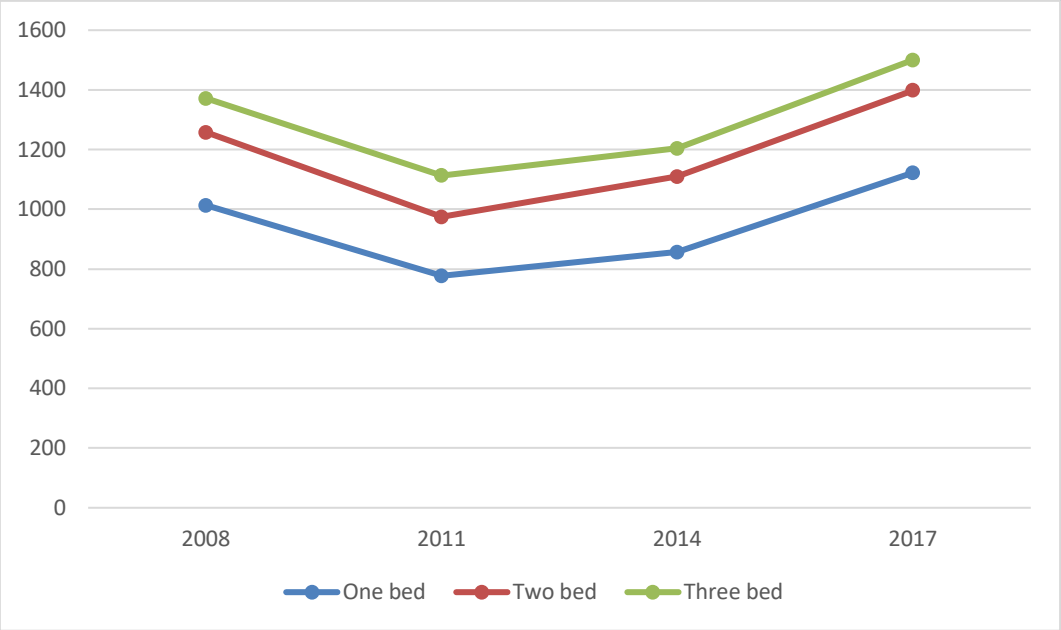
FIGURE 2.1: NATURE OF IRELAND'S HOUSING TENURE OVER TIME (2002-2016)



Source: Statbank Census data 2002-2016 for entire state
Note: Complicated forms of tenure, like rental from voluntary housing bodies and purchase of social housing units are marked "Other".

Figure 2.1 shows the pace of change in the composition of Ireland's tenure types. Both the 2002 Census and the 2006 Census record a similar distribution of tenure types. However, the 2011 and 2016 Censuses record a sudden growth in the share of private rented accommodation, moving from 10 per cent of all homes in 2006 to 19 per cent of all homes in 2011. During this time, the share of homes owned with a mortgage declined slightly from 39 per cent in 2006 to 35 per cent in 2011 and 36 per cent in 2016. In short, the composition of the housing market has changed since 2006, where rates of ownership have fallen, while rates of renting have increased. Housing related benefits, as a result, must consider this change in the composition of tenure types.

FIGURE 2.2: AVERAGE MONTHLY RENT OF A TENANCY IN CO. DUBLIN (2008-2017)



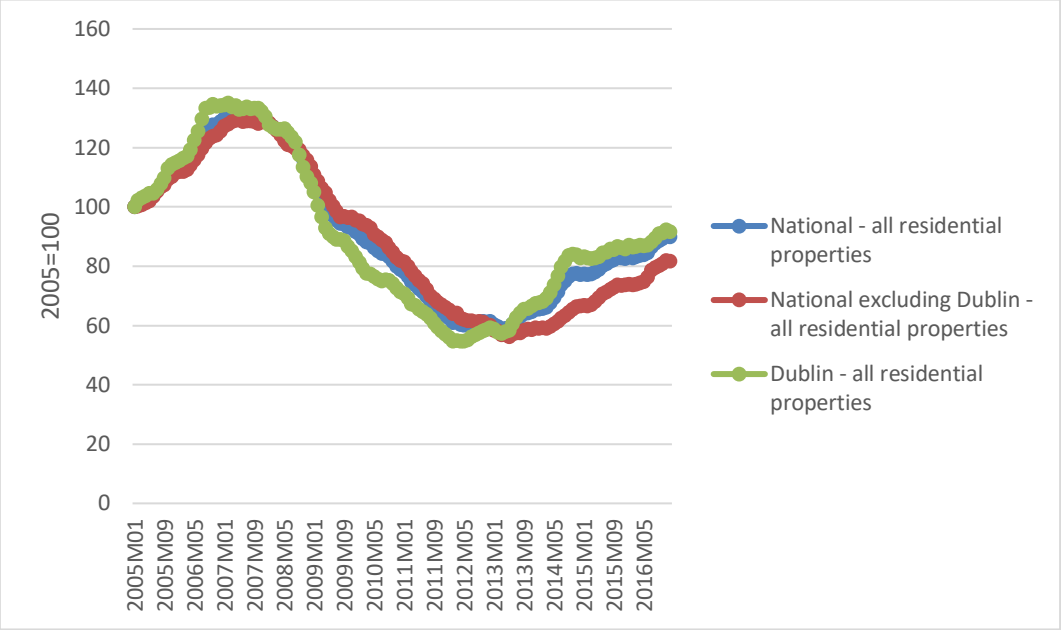
Source: RTB Average Monthly Rent Report by Property Type, Location, Number of Bedrooms and Year

Note: For illustrative purposes we show only results for Dublin, although the pattern of rent increases emerges in other counties.

Note: Prices are nominal.

While the composition of the housing market has changed, the cost associated with the rental market has also changed. Figure 2.2 shows that in 2017 the average cost of renting in Dublin has surpassed 2008 levels. This pressure is likely acute for families with children, where there is a requirement for larger accommodation but without the corresponding increase in earners that exist in all-adult households.

FIGURE 2.3: HOUSING PRICE INDEX (2008-2017)



Source: CSO Statbank figures

Homeowners may also rely on income transfers tied to housing. Figure 2.3 shows that home ownership costs, measured as the price of property, have also changed since 2012. The cost of homeownership, in Dublin and nationally, experienced a peak in 2007 and a trough in 2012. Since then, the cost of housing has risen steadily and is approaching 2005 levels, especially in County Dublin. This suggests that non-cash benefits for homeowners will also be important, especially for those who bought homes near the peak of the distribution, who may now be struggling with such costs.

While this assistance took the form of the Mortgage Interest Scheme, there are two important points of note regarding the scheme. First, new applications to the scheme closed in January 2014, and payments were ended in December 2017. In short, the scheme no longer exists. However, we will use data from 2017 in our analysis, which captures beneficiaries of this scheme, and so we can make conclusions about the scheme. Second, this scheme strictly applied to interest payments only and did not apply to the principal payments of mortgages.

2.2 Housing benefits, allowance, and assistance over time

Vulnerable households like those of people aged over 65, and households at risk of poverty and deprivation may be eligible for transfers which offset rental or mortgage interest costs, these take the form of **housing supplements**. They may also be eligible for assistance with heating, fuel, electricity, TV costs, and telephone costs. These take the form of **housing benefits**.[15] Some of these schemes are currently discontinued.[16] However, they were in existence when the data was collected and so can help understand the association between transfers and deprivation. Before looking at trends in transfers, we briefly describe the schemes tied to the cost of rent. We do this in Table 2.0 below.

[15]The package is designed for those aged 70 or over, regardless of whether they receive a State pension. The package is not means tested. DSP Note: it is also available to people under 70 years of age, subject to certain conditions

[16]The Mortgage Interest Payment scheme and Telephone Support Allowance scheme no longer exist.

TABLE 2.0: DESCRIPTION OF RENT SUPPLEMENT AND HOUSING ASSISTANCE PAYMENTS

Name	Description
Rent Supplement (RS)	The scheme was first introduced in 1977, and provides financial support to existing private sector tenants with a short-term difficulty in affording rent. The tenant must have been living in the rented accommodation (or social private homeless accommodation) for at least six months of the last year; have been able to afford the rent at the beginning of the tenancy and have difficulty affording it now due to a substantial change in circumstances (e.g. unemployment). Administered by the Department of Social Protection, RS is typically paid to people in receipt of a social protection payment and those in full-time employment are not eligible. RS tenancies constituted approximately 18 per cent of socially supported housing in 2016. This scheme is on-going although new applicants are encouraged to consider HAP[17].
Housing Assistance Payments (HAP)	This scheme was introduced to gradually replace long-term RS recipients. Dwellings are provided through the private sector, the tenant must be assessed as being in housing need, the rent (which is subject to limits depending on the area) is paid directly to the landlord by the Local Authority and the tenant pays the relevant 'differential rent' to the LA. HAP tenants may take up full-time employment while retaining the support. RS recipients who are assessed as being in long-term 'housing need' must be transferred to the HAP on a phased basis. Tenants source their own accommodation and once approved for HAP are expected to remain for at least two years.

Source: Details taken from Watson and Corrigan (2019); Details of other housing support schemes are outlined in Appendix Table A.2

With these supports in mind, we consider the main patterns of Housing Supplements (tied to costs like rent) and Housing Benefits (tied to costs like

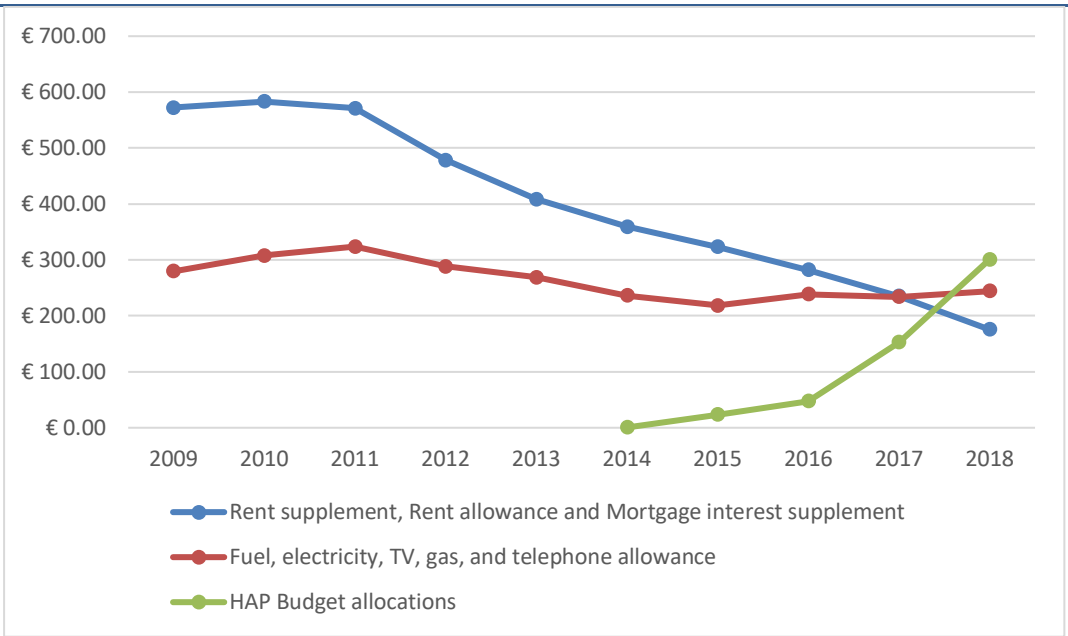
[17] According to figures from the Department of Housing, Local Government and Heritage , 3,185 recipients transferred from Rent Supplement to Housing Assistance Payments in 2017. https://data.gov.ie/dataset/hap-scheme-2014-2018

heating) over the last ten years. Figure 2.4 lists the DSP's total spending on two sets of schemes. The first covers Rent Supplement, Rent Allowance, and Mortgage Interest Supplement. Rent Supplement, mentioned above, is designed for low income households living in the private sector. The scheme is still operational. Rental Allowance is payable to tenants "*of certain dwellings affected by the decontrol of rents on 26th July 1982*". This scheme is designed with a unique group of tenants in mind, those affected by rent control legislation passed in July 1982. Mortgage Interest supplement, as mentioned above, provided short term income support to those unable to make mortgage interest payments. The scheme only applied to respondents' family homes and did not cover payments on the mortgage's principle. It ended in 2018.

From the figure below, the total cost of these schemes gradually declined from 2011. Part of this decline can be explained by the gradual introduction of the Housing Assistance Payment scheme (outlined in Table 2.0) which was designed to gradually replace Rent Supplement, although both schemes are in existence at the time of writing.

For reference only, we include Budget allocation figures for the HAP scheme. It is important to note that this data is taken from a different source to the other schemes and so may not be comparable. As data on HAP spending was not available in the Statistical Information on Social Welfare Services Annual Report (2018), these details were instead taken from (Kilkenny, 2019).

FIGURE 2.4: TOTAL COSTS OF SOCIAL ASSISTANCE IN MILLIONS, BY SOURCE OVER TIME (2009-2018)

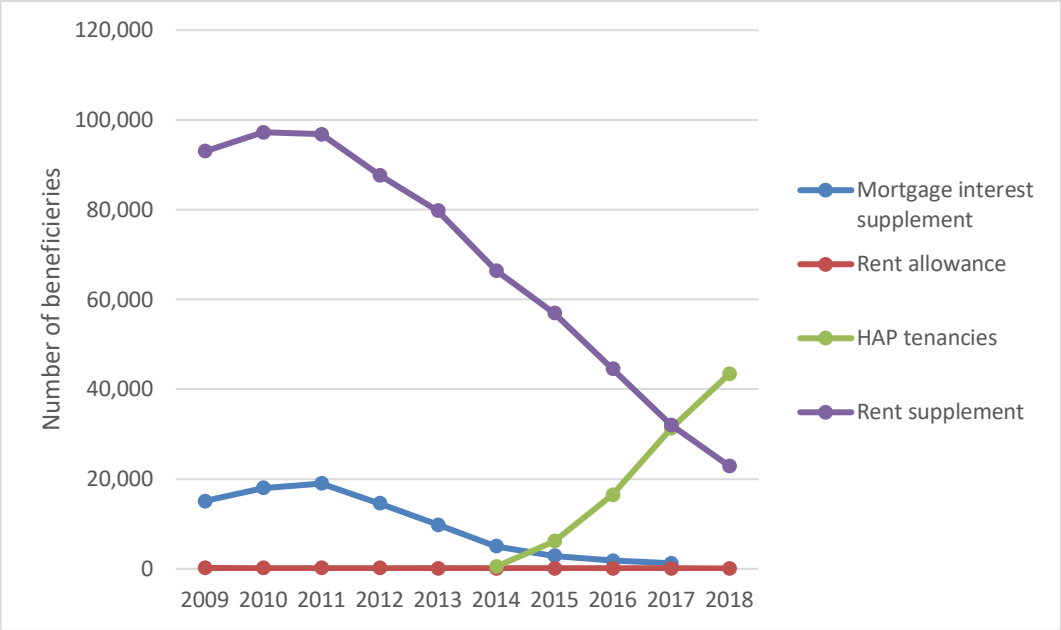


Source: All data but HAP is sourced from Statistical Information on Social Welfare Services: Annual report 2018. HAP data taken from Kilkenny (2019)

The second set of payments (Housing Allowance) cover expenses tied to heating, electricity, TV, and telephone related costs. Some of these payments apply universally to a specific population (retired respondents or those over the age of 65), while others apply to households on low incomes. The total costs tied to these payments appear steady since 2015 after a decline (2011-2015). Thinking of trends in general, there is a decline in government transfers tied to housing costs, at least in terms of the transfers considered here.

We now consider the number of recipients of different types of Housing Supplement.

FIGURE 2.5: TOTAL NUMBER OF SCHEME BENEFICIARIES, FOCUSING ONLY ON HOUSING COST SCHEMES, OVER TIME (2009-2018).

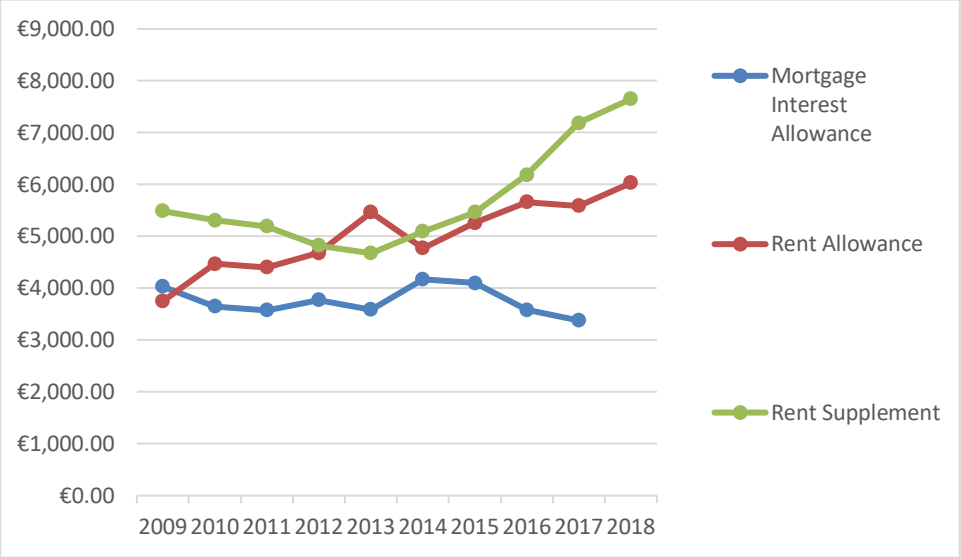


Source: All data but HAP is sourced from Statistical Information on Social Welfare Services: Annual report 2018. HAP data taken from Kilkenny (2019)

Beyond total spending, Figure 2.5 shows that the total number of beneficiaries for Rent Supplements, Rent Allowance, and Mortgage Interest Supplements has fallen gradually since 2011. Most beneficiaries receive payments through the Rent Supplement scheme. The number of recipients has fallen since 2012, partly because of economic recovery and partly because of the Housing Assistance Payments scheme (see Table 2.0 above) which launched in 2014 and became nationally available in 2017. The Mortgage Interest Supplement scheme closed to new applicants in January 2014 and ended in December 2017. However, even before then the number of beneficiaries had begun to fall, possibly due to Ireland's economic recovery from 2012. Since the Rent Allowance scheme (discussed above) is tied to a specific group of tenants, the scheme's beneficiaries are in double digits and declining every year. Thus, this scheme is focused on specific beneficiaries and cannot be expanded to the wider population.

For reference, we include figures on HAP recipients from Kilkenny (2019). While these figures may not be directly comparable, they suggest that the HAP scheme is growing in terms of users.

FIGURE 2.6: AVERAGE ANNUAL PAYMENT PER BENEFICIARY (2009-2018)



Source: Statistical Information on Social Welfare Services: Annual report 2018. Authors' calculation, constant prices

Note: The Mortgage Interest Allowance scheme ended in 2017.

Although the number of beneficiaries had declined since 2011, the average value given to a beneficiary appears to have risen since 2014 (Figure 2.6). This is especially true with the most popular benefit, Rent Supplement. This increase likely reflects the increased cost of housing, especially in the south-eastern part of the country. The figures above are a rough estimate of average payments but could also reflect differences in the composition of beneficiaries, rather than any changes in maximum entitlements. For example, on Rent Supplement, more single parent households may have become reliant on the scheme during the years considered, which would change the costs associated with the "average tenant", without noting a change in overall housing costs.

2.2.1 A note on the Housing Assistance Payment scheme

Part of the decline in funding for housing transfer can be explained by the launch of the HAP scheme, noted above. Statistics on the scheme do not feature in the Statistical Information on Social Welfare Services Annual Report, and so we briefly summarise the available data published by Kilkenny (2019) in Table 2.1.

Kilkenny (2019) shows that exchequer funding for the HAP scheme grew quickly from €0.5m in 2015 to €423m in 2019, which is on par with Rent Supplement spending for 2013 (Figure 2.4). Official outturn for the HAP scheme over the five years of implementation amounted to €503m. The scheme also saw an increase in tenancies from just 485 in 2014 to 43,443 in 2018. This figure is on par with recipients of Rent Supplement in 2016 (Figure 2.5). This quick growth suggests that a significant portion of the decline in Rent Supplement can be explained by the growth of the HAP scheme. Future work should consider the impact of HAP on deprivation, which we were not able to do this here.

TABLE 2.1: SUMMARY OF HOUSING ASSISTANCE PAYMENTS SCHEME (2014-2018)

Year	2014	2015	2016	2017	2018
Budget REV allocations in millions of €	€0.5	€23.2	€47.7	€152.7	€301
Out-turn (Appropriation Account) in millions of €	€0.4	€15.6	€57.7	€152.7	€276.6
Tenancies	485	6,165	16,493	31,228	43,443

2.3 Housing Transfers and the Survey of Income and Living Conditions

We now turn to housing-related transfers as they appear in the SILC dataset. We consider group differences in coverage, and the average amount received by social risk and social class groups. We also consider the average levels of deprivation for those receiving and those not receiving transfers, and their respective differences by social risk and social class. We first compare summary data as documented by the Department of Social Protection annual statistical report for 2018 to data in the SILC (Table 2.2.). Using survey weights, we find that roughly 50,000 people benefit from transfers related to housing, costing a total of €227 million, although this is

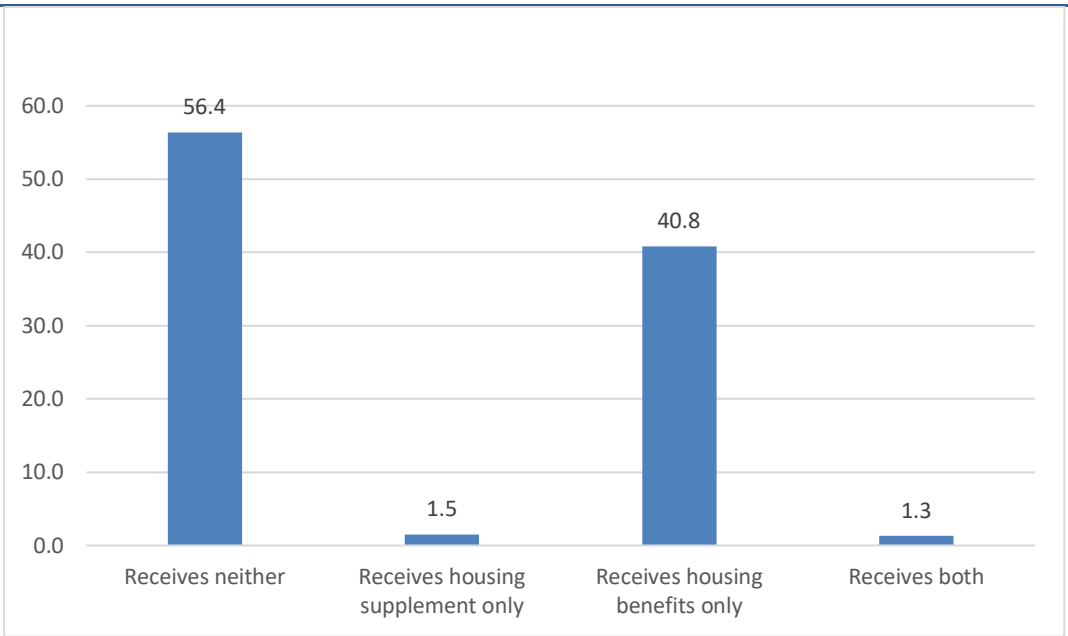
an estimate in the sample. Table 2.2 suggests that the SILC dataset may be overestimating the total number of recipients on one hand but underestimating the total cost of the transfers. However, generally the SILC data reflects the data reported by the DSP well.

TABLE 2.2: CUMULATIVE COST OF RENT SUPPLEMENT, RENT ALLOWANCE, AND MORTGAGE SUPPLEMENT

Source	Department of Social Protection 2016	Department of Employment Affairs and Social Protection 2017	Ireland Survey on Income and Living Conditions 2017 (weighted)
Beneficiaries	46,436	33,399	50,058
Total	€282.32 million	€ 235.21 million	€ 227.88 million

We consider four key groups: those who receive housing supplements only, those who receive housing benefits only, and those who receive both housing supplements and housing benefits. In order to compare this group to a meaningful reference, we consider households who receive none of these transfers as the fourth group.

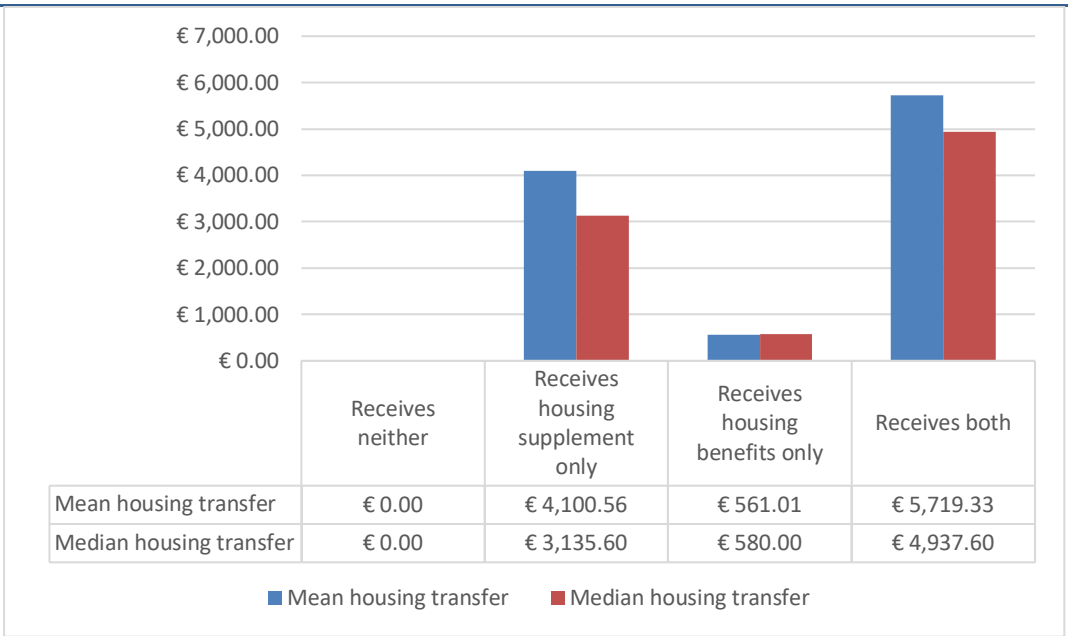
FIGURE 2.7: PERCENTAGE OF HOUSEHOLDS RECEIVING TRANSFERS TIED TO HOUSING.



Source: SILC 2017. Authors' Calculations
Note: Household level data, answered by head of household.
Note: SILC 2017 does not contain data on beneficiaries of HAP or those beneficiaries who have transferred from RS to HAP.

Most households (56 per cent) do not receive any transfers tied to housing though they may receive other benefits or transfers. Just over one per cent of households receive only housing supplements such as assistance with rental payments or mortgage interest and do not receive transfers tied to electricity, TV, and heating. Just over 40 per cent of households receive housing benefits tied to electricity, TV, and heating without receiving supplements tied to larger housing costs. Many of these benefits are standard benefits tied to age, hence their higher coverage. Finally, just over one per cent of the sample receives both housing benefits and housing supplements.

FIGURE 2.8: AVERAGE ANNUAL HOUSING TRANSFER BY TYPE OF TRANSFER.



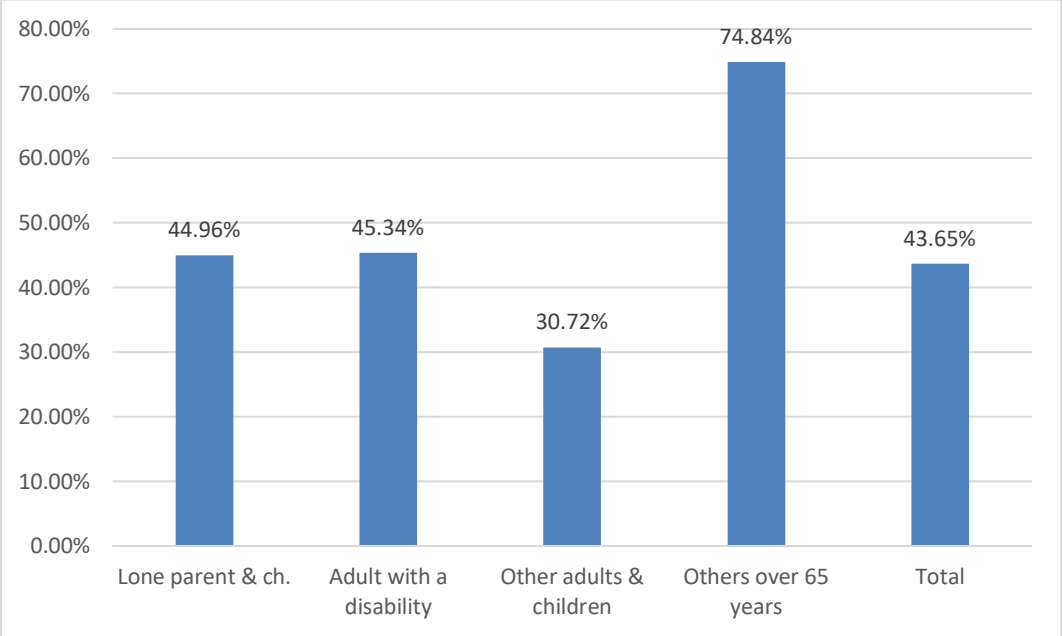
	Receives neither	Receives housing supplement only	Receives housing benefits only	Receives both
Mean housing transfer	€ 0.00	€ 4,100.56	€ 561.01	€ 5,719.33
Median housing transfer	€ 0.00	€ 3,135.60	€ 580.00	€ 4,937.60

Source: SILC 2017. Authors' Calculations
Note: Household level data, answered by head of household.
Note: SILC 2017 does not contain data on beneficiaries of HAP or those beneficiaries who have transferred from RS to HAP.

Figure 2.9 lists the mean and median sum received by each recipient type. Respondents who receive only housing supplements receive an average payment of €4,100+, or a median payment of €3,100+ for the entire year. Respondents who receive housing benefits only, receive an average payment of €560+, or a median payment of €580 for the entire year, which is substantially lower when compared to respondents who receive transfers tied to rental or mortgage interest costs. Respondents who received both housing supplements and housing benefits receive an average transfer of €5,700+, or a median payment of €4,900+ for the entire year.

Those receiving housing supplements, and both housing supplements and housing benefits, are a minority. However, their annual housing transfers are significantly higher than the transfers receive by respondents in receipt of housing benefits only. We now turn to the social risk differences in access to these payments. These are listed in Figure 2.9.

FIGURE 2.9: RECEIPT OF HOUSING TRANSFERS BY SOCIAL RISK.

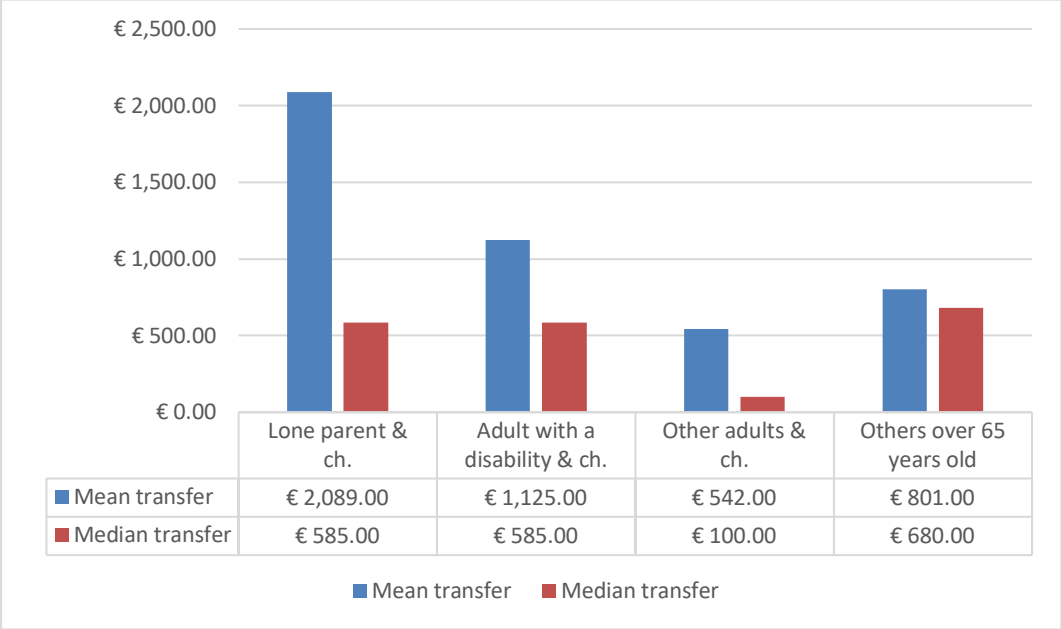


Source: SILC 2017. Authors' calculations
Note: Household level data, answered by head of household.
Note: SILC 2017 does not contain data on beneficiaries of HAP or those beneficiaries who have transferred from RS to HAP.

Due to CSO limitations on cell size, we cannot explore social risk differences in the type of housing transfer received (as featured in Figure 2.1 for example). However, we can split social risk groups by whether they receive any housing transfer and the average value in such transfer (Figure 2.9).

The most obvious finding is that older respondents are the most likely to receive a housing transfer in some form (respondents over 70 are entitled to the scheme, as outlined in the appendix of programme entitlements). This reflects the benefits and entitlements tied to retirement and old age, mentioned earlier. The remaining groups are less likely to receive a housing transfer when compared to older adults. Among lone parent households, 45 per cent receive a housing transfer. Among households with a person with a disability, 45 per cent of households receive a housing transfer. In working age households ("other adults", in the figures), where there are no lone parents or people with a disability, 31 per cent of households receive a housing transfer of some type.

FIGURE 2.10: AVERAGE ANNUAL TRANSFER BY SOCIAL RISK.



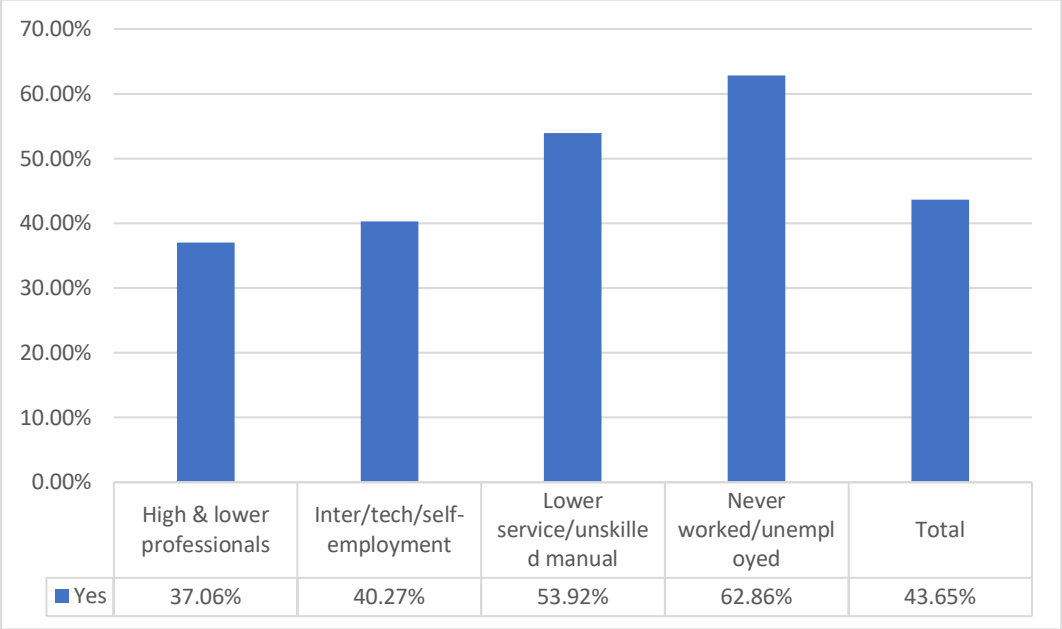
	Lone parent & ch.	Adult with a disability & ch.	Other adults & ch.	Others over 65 years old
Mean transfer	€ 2,089.00	€ 1,125.00	€ 542.00	€ 801.00
Median transfer	€ 585.00	€ 585.00	€ 100.00	€ 680.00

Source: SILC 2017. Authors' calculations
Note: Household level data, answered by head of household.
Note: SILC 2017 does not contain data on beneficiaries of HAP or those beneficiaries who have transferred from RS to HAP.

Lone parent households and households with a person with a disability receive higher mean housing transfers than other working-age households. Also, older households receive less on average than the two main social risk groups but more than the reference of other working-age households. We also note that in each group, there is a wide gap between the mean and the median, suggesting extreme values, most likely due to the high but rare instances of Rent Supplement. This discrepancy does not exist for older households suggesting these households receive more uniform payments (less Rent Supplement).

Thinking only of households who receive transfers, we see that lone parents receive an average payment of €2,000+ per year, or a median of just €580+ per year. We also see that households with a person with a disability receive an average payment of €1,100+ per year, or a median payment on €585 per year. Other working-age households receive an average payment of €542, or a median payment of €100. Finally, older households receive an average payment of €800+ or a median payment of €680 for the entire year. We turn to social class in Figure 2.11.

FIGURE 2.11: ACCESS TO TRANSFERS BY SOCIAL CLASS (2017)



Source: SILC 2017. Authors' calculations
Note: Household level data, answered by head of household.
Note: SILC 2017 does not contain data on beneficiaries of HAP or those beneficiaries who have transferred from RS to HAP.

Respondents in the highest social class have the lowest access to housing transfers, although roughly 37 per cent of them receive such a transfer. The middle classes have more access to housing transfers (40 per cent); however, most do not receive housing transfers. Those in the lowest social class grouping have more access to housing transfers and most are entitled to some form of housing transfers. The group of unemployed or those who have never worked are the most likely to receive housing transfers (62 per cent). As before, the most vulnerable social groups are also most likely to receive housing transfers.

FIGURE 2.12: AVERAGE ANNUAL TRANSFER BY SOCIAL CLASS (2017)

	High & lower professionals	Inter/tech/self-employment	Lower service/unskilled manual	Never worked/unemployed
Mean transfer	€ 609.00	€ 665.00	€ 1,077.00	€ 1,524.00
Median transfer	€ 100.00	€ 349.00	€ 580.00	€ 702.00

Source: SILC 2017. Authors' calculations
Note: Household level data, answered by head of household.
Note: SILC 2017 does not contain data on beneficiaries of HAP or those beneficiaries who have transferred from RS to HAP.

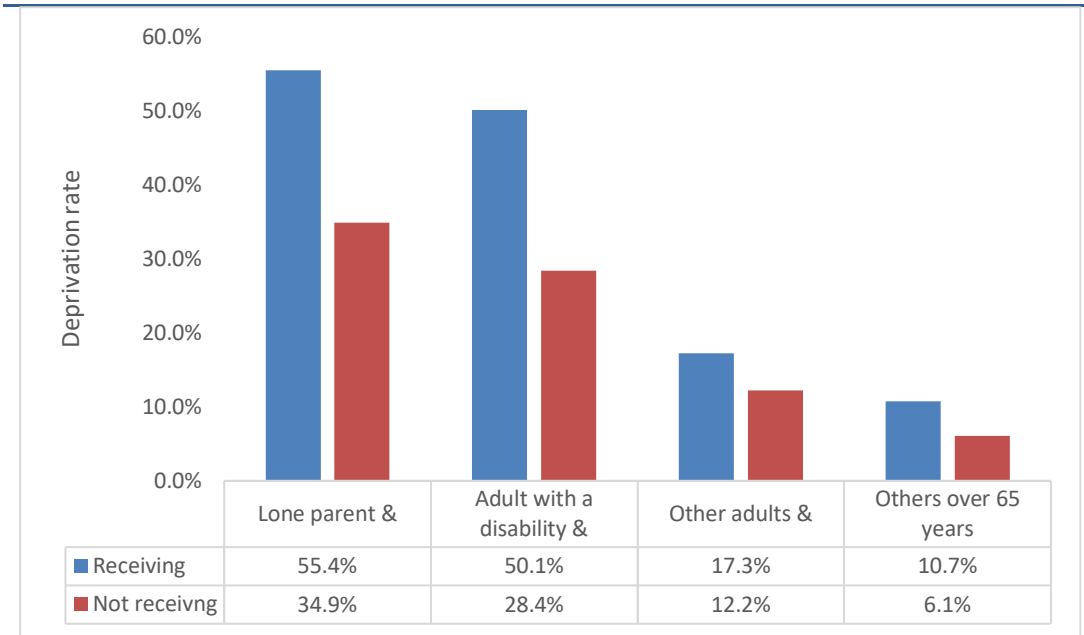
Thinking of group differences in transfer amount, members from the higher social class, who also receive a transfer, receive an average payment of €609, or a median payment of €100. Members from middle class groupings, who also receive a housing transfer, get an average payment of €665, or a median payment of €350. Members from the lowest social class grouping typically receive an average payment of €1,000+, or a median payment of €580. Finally, the unemployed or those who have never worked receive an average payment of €1,500+, or a median payment of €700+.

Payments appear to increase steadily depending on the social class of members. As before, the sharp difference between mean and median payments suggests that there are higher values in the data for each class group. Again, this likely stems from the fact that housing benefits and housing allowances are conflated into one measure.

Lastly, we compare the deprivation rate between those who receive housing transfers and those who do not receive them. We can further split these groups by social risk and social class categories. We note that households

qualify for housing transfers for several reasons which go beyond their social risk and social class. Thus, a lone parent household which does not qualify for a housing transfer may be an affluent household without significant housing costs (Callan and Keane, 2009). In the same way, lone-parent households who receive income transfers may also report a greater rate of deprivation than a lone-parent household that is not in need of social transfers, for reasons other than their status. However, given what we know about social risk groups, we would expect a greater rate of deprivation in such homes when compared to homes with other working-age adults who are not lone parents and who do not have a disability.

FIGURE 2.13: DEPRIVATION RATE BY HOUSING TRANSFER RECEIPT AND SOCIAL RISK (2017)



	Lone parent &	Adult with a disability &	Other adults &	Others over 65 years
Receiving	55.4%	50.1%	17.3%	10.7%
Not receivng	34.9%	28.4%	12.2%	6.1%

Source: SILC 2017. Authors' calculations
Note: Household level data, answered by head of household. The deprivation rate is the proportion of the group who experience enforced lack of 2 or more deprivation items.
Note: SILC 2017 does not contain data on beneficiaries of HAP or those beneficiaries who have transferred from RS to HAP.

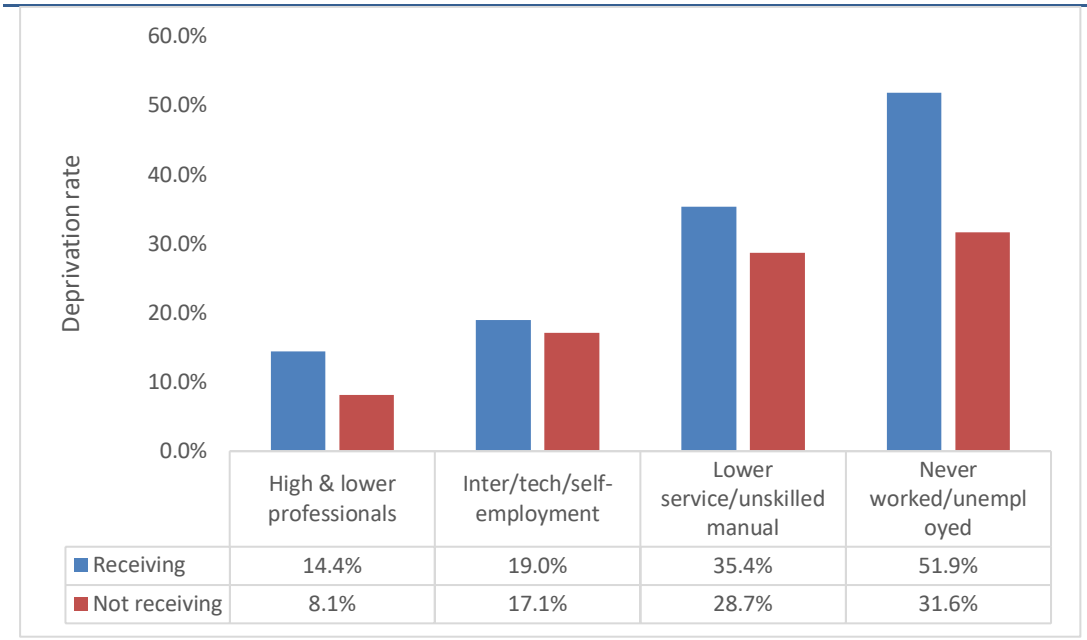
There are three general patterns in Figure 2.13. First and most importantly, recipients of social housing transfers in each social risk group report higher deprivation than those who are not in receipt of housing transfers. The difference is largest for lone parents who receive (54 per cent) and do not receive transfers (35 per cent), and households with a person with a

disability where respondents receive (50 per cent) and do not receive transfers (28 per cent). However, even considering other working-age households, those receiving transfers are more likely to cite deprivation (17 per cent) than households not in receipt of transfers (12 per cent), although the absolute rates for both groups are small.

The second point is that social risk groups, such as lone parents and households with a person with a disability, have far higher levels of deprivation than other working age households, regardless of whether they receive transfers. In short, households in vulnerable social risk groups have higher absolute deprivation, than any other groups.

Finally, households with older adults are the least likely to experience deprivation, and even households who receive housing transfers are often better off than households not in receipt of transfers. It is important to note that social-risk group membership cannot fully explain the need for social transfers tied to housing. Therefore, those receiving transfers obtain them because of eligibility criteria which go beyond social risk and social class. If they were not in receipt of such benefits, their rates may be higher still. As before, we can substitute social risk for social class, in trying to understand the relationship between transfers and deprivation.

FIGURE 2.14: DEPRIVATION BY HOUSING TRANSFER RECEIPT AND SOCIAL CLASS



	High & lower professionals	Inter/tech/self-employment	Lower service/unskilled manual	Never worked/unemployed
Receiving	14.4%	19.0%	35.4%	51.9%
Not receiving	8.1%	17.1%	28.7%	31.6%

Source: SILC 2017. Authors' calculations
Note: Household level data, answered by head of household. The deprivation rate is the proportion of the group who experience enforced lack of 2 or more deprivation items
Note: SILC 2017 does not contain data on beneficiaries of HAP or those beneficiaries who have transferred from RS to HAP.

Recipients of housing transfers report higher deprivation across all social classes. This gap is especially high among those in the unemployed or never worked group, where those receiving housing transfers report higher deprivation (52 per cent) than those not receiving transfers (32 per cent). The difference emerges again for the lowest social class groups who receive (35 per cent) and do not receive (29 percent) transfers. This difference is less pronounced among middle class groups who receive (19 per cent) and do not receive (17 per cent) transfers.

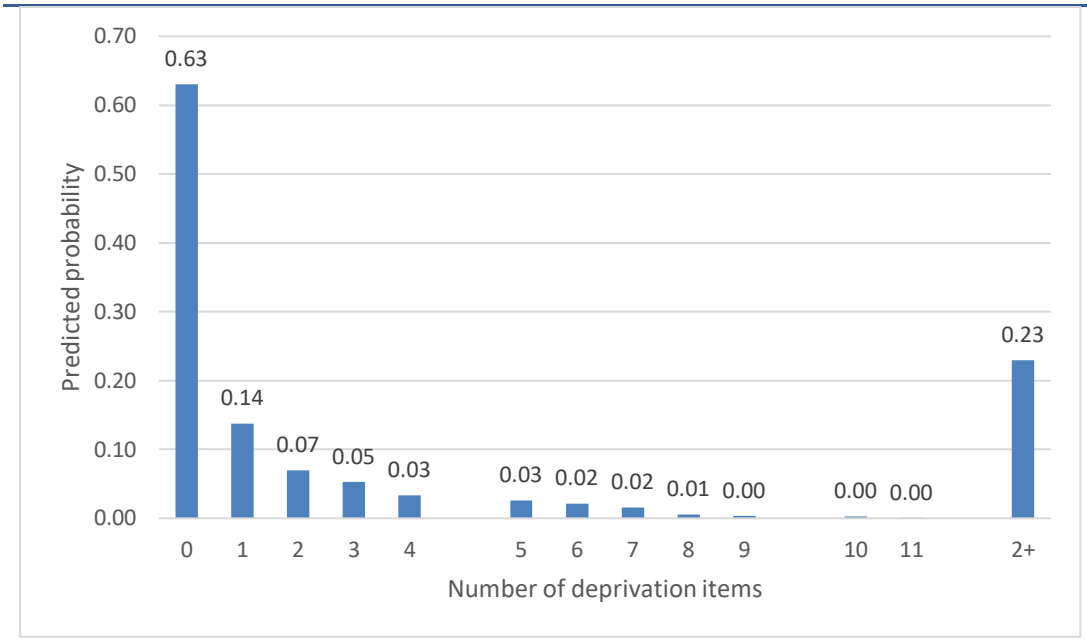
Regardless of transfer receipt, members in the unemployed or never worked social class group are the most likely to report deprivation when compared to all other groups. Unlike social risk groups however, it appears that the most stable group (Highest social class) is largely unaffected by whether they receive housing transfers. As mentioned previously, higher rates of deprivation among respondents who receive housing transfers likely reflects the greater need for transfers among these respondents as well as the

accuracy in social policy of targeting the population most in need of housing support.

2.4 Deprivation levels with and without housing transfers

In this section we will simulate the effects of housing transfers by predicting levels of deprivation with and without such transfers. Throughout, we will focus on the models discussed in the previous chapter. We re-estimate this model but subtract the value of housing transfers from households' "log equivalised household income". We then calculate the households' predicted level of deprivation. In the second step, we add the value of housing transfers back into the equivalised household income measure and again calculate the households' predicted probability of deprivation. We subtract the difference of these two predicted probabilities and present the results. Before considering the effect of the transfer, we first show the absolute rate of deprivation in Figure 2.15.

FIGURE 2.15: PREDICTED PROBABILITY OF EXPERIENCING EACH LEVEL OF DEPRIVATION (%).

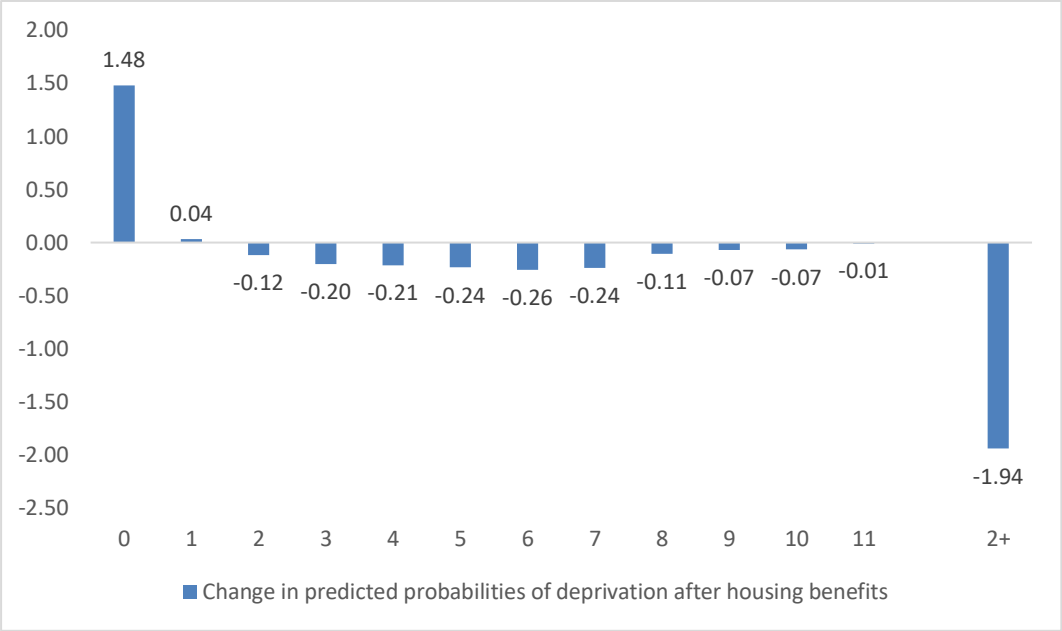


Source: SILC 2017. Authors' Calculations

Note: The chart contains predicted probabilities taken from model 3 in Table 1.1. The model controls for social risk, social class, characteristics of the head of the household and equivalised household income. Household income contains all forms of income except the value of housing transfers.

Most respondents do not report any deprivation (63 per cent), a smaller portion cite just one item out of 11 (14 per cent). For the overall population, absolute levels of deprivation are significant. We now turn to the effect of housing transfers for those who receive them.

FIGURE 2.16: CHANGE IN DEPRIVATION AFTER HOUSING TRANSFERS ARE INCLUDED INTO TOTAL HOUSEHOLD INCOME.



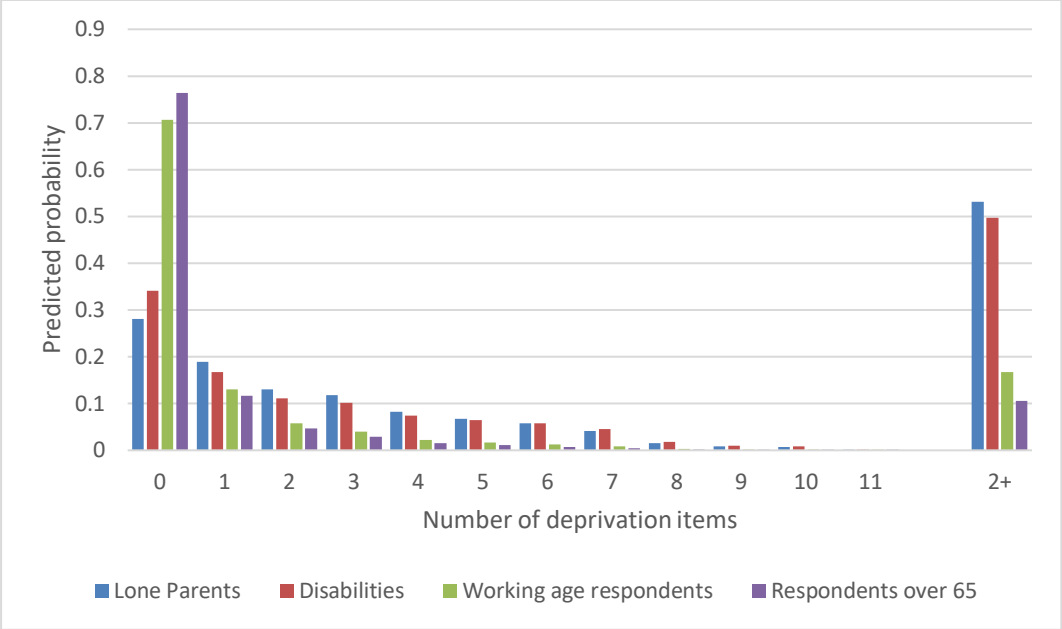
Source: SILC 2017. Authors' calculations
Note: The chart contains predicted probabilities taken from model 3. The model controls for social risk, social class, characteristics of the head of the household and equivalised household income.

Figure 2.16 captures the difference in deprivation after housing transfers are added to the model. The results are minor, but they suggest that housing transfers increase the odds of experiencing no deprivation by 1.48 percentage points. If we consider the binary definition of deprivation (two or more items) we see that transfers lower the predicted probability of citing deprivation by almost 2 per cent. These differences are drawn from respondents in the middle of the deprivation distribution, which sees a decline after the transfers are included. The results, however, focus on people overall, whereas it is likely that social risk and social class differences exist in the association between transfers and deprivation.

2.4.1 Social risk differences in deprivation and transfers

We now consider specific social risk groups and their experience with deprivation and transfers. Firstly, we note the absolute rates of deprivation, after controlling for the measures outlined in Model 3 in Table 1.1.

FIGURE 2.17: PREDICTED PROBABILITY OF EXPERIENCING EACH LEVEL OF DEPRIVATION BY SOCIAL RISK.

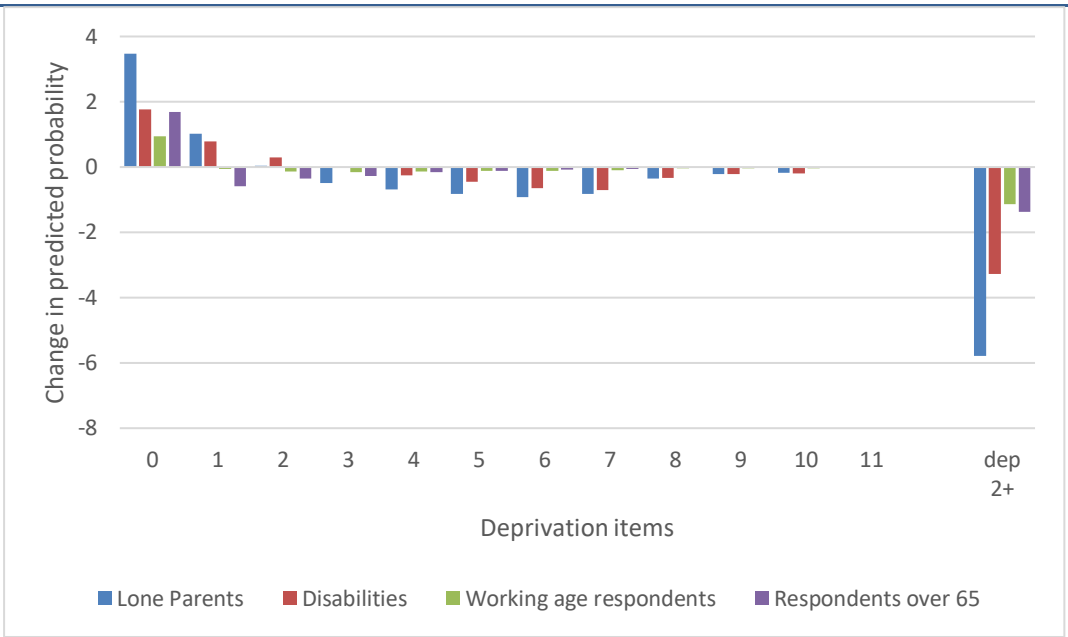


Source: SILC 2017. Authors' calculations
Note: The chart contains predicted probabilities taken from model 3. The model controls for social risk, social class, characteristics of the head of the household and equivalised household income.

Figure 2.17 shows that deprivation (instances where a household cannot afford two or more items on the list of deprivation items) was the least common among adults over 65 years of age (Over 65) and other working age adults (Other adults). Regarding Other adults, our model predicts that they have an over 70 per cent chance of citing no deprivation items (not having a morning, afternoon or evening out once a fortnight, or not having a meal with meat, chicken, fish (or vegetarian equivalent) every second day, etc.). Adults over 65 also have an over 70 per cent chance of citing no deprivation items. Lone parents and people in households where someone has a disability have lower predicted probabilities of having no deprivation

and higher predicted probabilities of citing multiple deprivation counts (over 50 per cent). Most other working-age adults and older adults have either no deprivation or lack just one deprivation item. Most lone parents and people in households with a person with a disability lack two or more items of deprivation. We now consider the effects of housing transfers on deprivation.

FIGURE 2.18: CHANGE IN DEPRIVATION AFTER HOUSING TRANSFERS BY SOCIAL RISK.



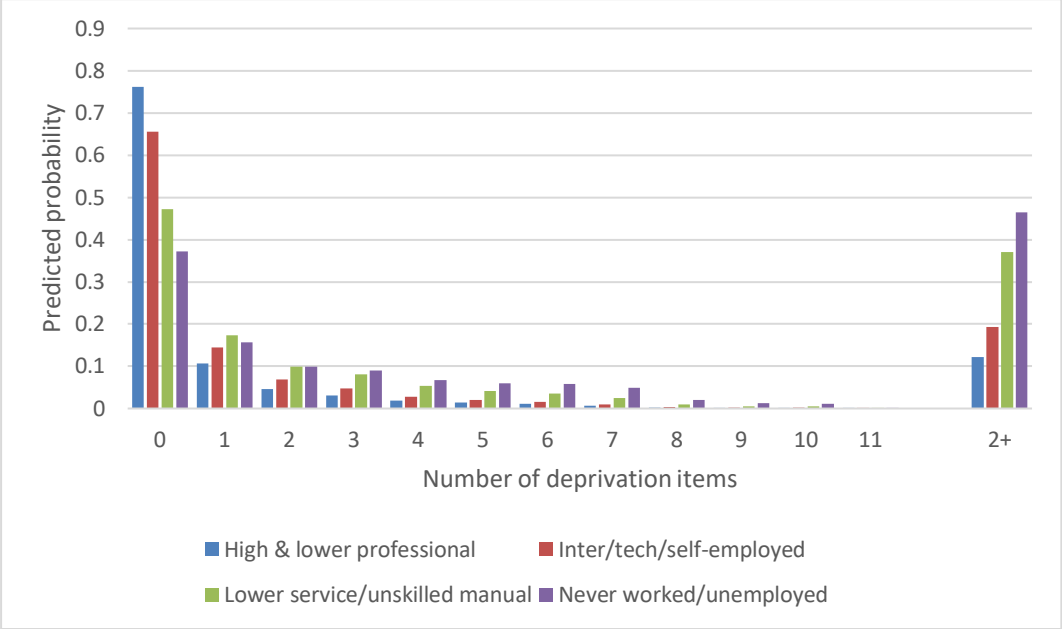
Source: SILC 2017. Authors' calculations
Note: The chart contains predicted probabilities taken from model 3. The model controls for social risk, social class, characteristics of the head of the household and equivalised household income.

Thinking of the binary outcome, the greatest change in deprivation occurs for lone parents (-5 percentage points in the chance of lacking two deprivation items) and those with a disability (-3 percentage points in the chances of lacking two deprivation items). A lesser effect is found among working-age adults and adults over 65. Some of these results reflect the low levels of absolute deprivation noted earlier. For example, other working-age adults are unlikely to be deprived in absolute terms (Figure 2.17), and therefore housing transfers (if any received) likely have a lower impact when compared to lone parents, who have higher rates of absolute deprivation.

2.4.2 Social class differences in deprivation and transfers

We now turn to social class differences in absolute deprivation and their experience with housing transfers. As before, we first consider the absolute rates of deprivation, after controlling for the measures discussed in the previous chapter.

FIGURE 2.19: PREDICTED PROBABILITY OF EXPERIENCING EACH LEVEL OF DEPRIVATION BY SOCIAL CLASS

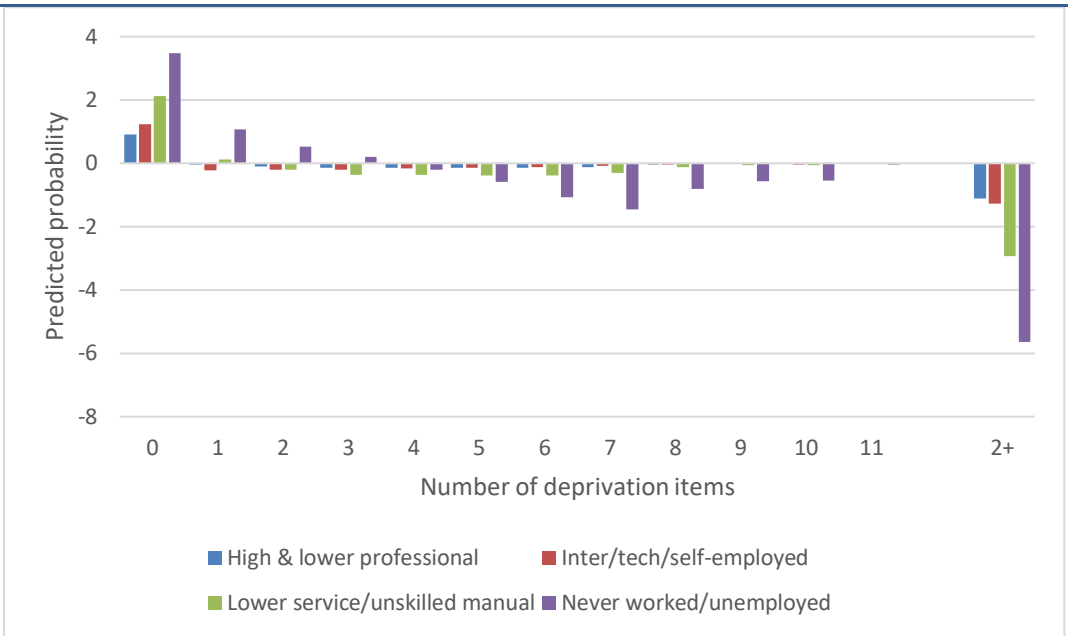


Source: SILC 2017. Authors' calculations
Note: The chart contains predicted probabilities taken from model 3. The model controls for social risk, social class, characteristics of the head of the household and equivalised household income.

There is a strong difference between the highest social class and each subsequent class (Figure 2.19). The probability of listing deprivation gradually increases across social classes. Those in the unemployed/never worked class, for example, have a less than 40 per cent chance of listing no deprivation items, while those in the highest social class group have a predicted probability of over 70 per cent of listing no deprivation items. Further, those in the lower group and the unemployed/never worked social class group are the most likely to cite additional items of deprivation. We now turn to the effects that housing transfers have on deprivation for these

groups (Figure 2.20).

FIGURE 2.20: CHANGE IN DEPRIVATION AFTER HOUSING TRANSFERS BY SOCIAL CLASS.



Source: SILC 2017. Authors' calculations
Note: The chart contains predicted probabilities taken from model 3. The model controls for social risk, social class, characteristics of the head of the household and equivalised household income.

The graph is now the inverse of the predicted probability of deprivation. The effect of housing transfers is most pronounced among the unemployed/never worked group who see more than a three-percentage point increase in their chances of reporting no deprivation items. The intermediate group also sees some return to housing transfers, as does the highest social class, although these are far smaller effects. Housing transfers for the unemployed/never worked group also increase their chances of lacking just one or two items of deprivation, rather than several.

The effects of transfers are on par with simulations carried out by Notten (2019), who considered Ireland overall but did not split these effects by social risk and social class groups. We also note that the effect of transfers is positive in that they lower deprivation levels, and that vulnerable social risk groups like lone parents, those living in households where a person has a disability, and those over the age of 65 benefit the most from housing

transfers. In terms of class, we note that vulnerable social classes, such as the unemployed and the lowest social class, benefit the most from housing transfers, compared to other social classes.

2.5 Summary

This chapter explored the importance of housing transfers and simulated their effects on deprivation. Ireland has experienced a compositional change in its housing market, with a growing reliance on private rental, and a fall in home ownership. Within the housing market there has been an increase in cost, most notably the cost of rent, but also in the cost of home ownership. This change has led to pressure on families, especially those of vulnerable social risk and social class groups. Support and transfers tied to housing costs have declined in recent years, especially in terms of support tied explicitly to rental and mortgage interest costs, although we note more recent schemes such as Housing Assistance Payments have emerged to fill the gap in the private rental sector. Although our data captures household who may have received HAP, we are not able to explicitly isolate households who receive this payment.

With these changes in mind, we explored the prevalence and effect of housing transfers in the Irish SILC data. We found that most recipients of housing transfers received relatively small benefits that were tied to energy and other housing costs. Few recipients received support tied to the more substantial rent or mortgage interest costs, and fewer still received both types of support. The average level of transfers differed greatly, depending on the type of support received. Due to CSO data limitations we were not able to explore these differences by social risk and social class, instead we opted to consider all housing supports together as one category.

Older recipients are the most likely to receive housing transfers with over 70 per cent of this group receiving some type of housing support. Part of this effect stems from the automatic entitlement to housing supports tied to retirement and old age pensions, such as various fuel allowances and television licence fees. Other working-age adults were the least reliant on

housing transfers, just over 30 per cent of them collected some form of transfer. People living in households with a person with a disability and lone parents sat at the national average, just over 44 per cent of them received housing transfers of some kind. Regarding the average transfer, lone parents received the highest average payments (over €2,000 for the year), most likely because they were reliant on transfers to fund housing in the private rental market. People living in households with a person with a disability (over €1,000 for the year) and older people (over €800 for the year) received less on average, possibly because they were less reliant on transfers tied to explicit housing costs and more reliant on energy transfers such as heating and electricity. Other working-age adults received the lowest amounts on average, just over €100 for the year. The results change when we consider the median transfer, with groups receiving largely uniform payments of just over €500 for the entire year.

Regarding social class, we found that the highest social class groups relied little on transfers (37 per cent), but that subsequent groups were gradually more reliant, from middle social class (40 per cent), to the lowest social class (53 per cent), to the unemployed/never worked (62 per cent). These groups became progressively more likely to receive housing benefits, most likely due to limited resources. The average transfer was also lowest among the highest social class group (€609 for the year) and became progressively higher for each subsequent group, from the middle social class (€665 for the year), to the lowest social class (€1,000 for the year), and the unemployed/never worked (€1,500 for the year).

We noted that deprivation was highest among those receiving housing transfers. Thus, deprived households have a greater chance of receiving transfers compared to those who are not deprived. We also found that levels of deprivation among older and other working age groups were lower than lone parents and people living in households with a person with a disability regardless of whether they received housing transfers or not. We reported a similar finding among social class groups, with each group reporting higher deprivation if they received housing transfers. Further lowest social class and unemployed/never worked groups contained higher levels of deprivation

than the Highest and Middle social class groups regardless of whether they received housing transfers or not.

Lastly, we simulated the effects of housing transfers on deprivation. Transfers reduce deprivation and furthermore, vulnerable groups, such as lone parents and people living with a person with a disability, report the highest benefit from housing transfers when compared to other working-age adults. Respondents who are unemployed/never worked or those who are in the lowest social class category also benefit most from transfers.

Chapter 3

Medical support

3.1 Primary care reimbursement service and general medical services

In Ireland, the Health and Service Executive (HSE) is responsible for the provision of public health resources through hospitals, health care centres, community centres, and social care services. Access to health services, including GP visits, relies on payment. However, access to medical services (such as GP visits, drugs and surgery) may be provided free of charge through the General Medical Services (GMS) scheme. Card holders are exempt from certain payments described below.

Eligibility for medical cards is means tested based on income, with some applicants eligible due to poor health conditions. Eligibility for GP visit cards is also means tested, however, respondents aged 70 and above are automatically eligible and drawn into the scheme, as well as children aged under six. These beneficiaries do not have to pay fees to see a GP but do have to pay for other medical services or medicines. In 2017, an estimated 43.8 per cent of the population was covered under the GMS scheme, either via a medical card (33.6 per cent) or a GP visit card (10.2 per cent). For people not meeting the means test for a medical card or a GP visit card, they might still be eligible if such refusal has for consequence that they (or their dependents) have “undue hardship” or it is “unduly burdensome” to get GP services from their own resources.[18] The medical card covers a wide range of medical services such as free GP, public out-patient and in-patient services, prescribed drugs and medicines, dental, optical, aural services and maternity services. GP visit card covers GP visits but it does not cover hospital charges and prescribed drugs (unless covered by the Drug Payment Scheme).

3.1.1 Medical card

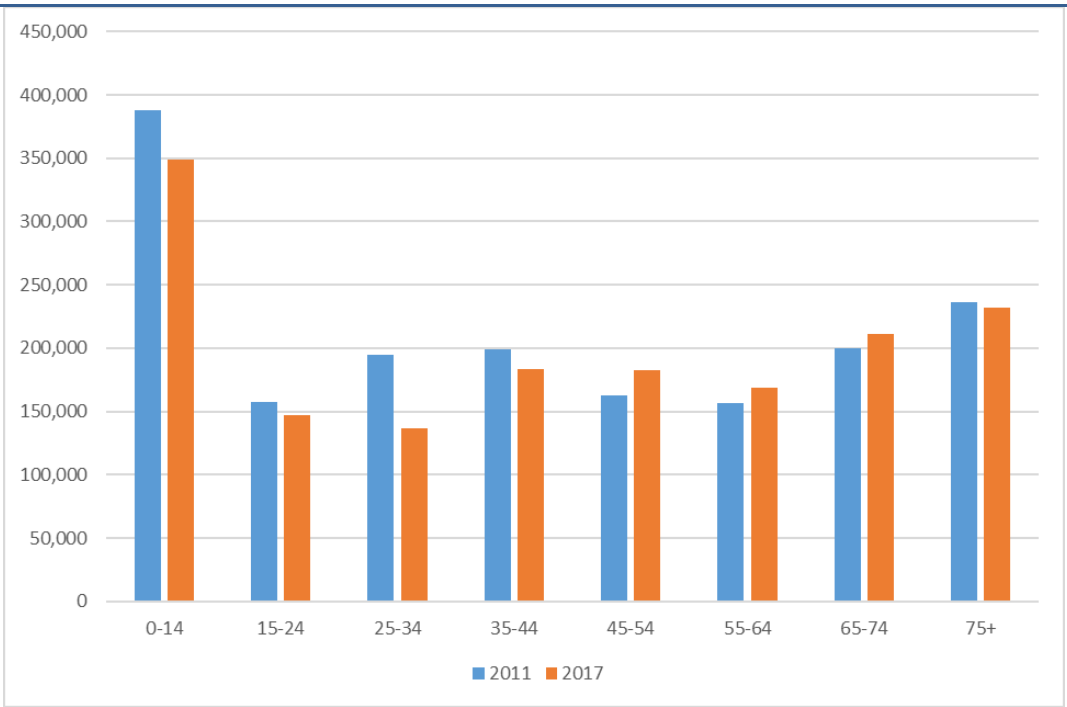
The Primary Care Reimbursement Service (PCRS) is responsible for payments to medical professionals who provide free or reduced-cost medical

[18] The assessment of hardship looks at the applicant and their family’s ability to meet basic costs such as decent housing, provision of heating, food and clothing.

services to the public. The PCRS provides annual statistics about the number of people in receipt of medical cards by gender and age; we list these in Figure 3.1 and Figure 3.2. We show two time-periods in the figures to highlight the change in age composition of recipients over time.

Figure 3.1 shows the absolute number of people in receipt of medical cards, while Figure 3.2 expresses these recipients as a percentage of the age group. Medical cards are least common among respondents aged 15-24. They are most common among respondents aged 65 and over but also among those aged 0-14. Comparing the two time-periods outlined below, the overall number of people in receipt of a medical card fell from just over 1,694,000 in 2011 to almost 1,610,000 in 2017. The number of recipients has been relatively stable between time points. The largest fall took place for the 25-34 and 0-14 age groups. There has been no corresponding increase in medical card holders among older groups.

FIGURE 3.1: NUMBER OF PEOPLE IN RECEIPT OF MEDICAL CARD BY AGE GROUP, (2011-2017)



Source: HSE statistics. Authors' Calculations

Splitting the CSO population estimates by age, we show the rate of medical

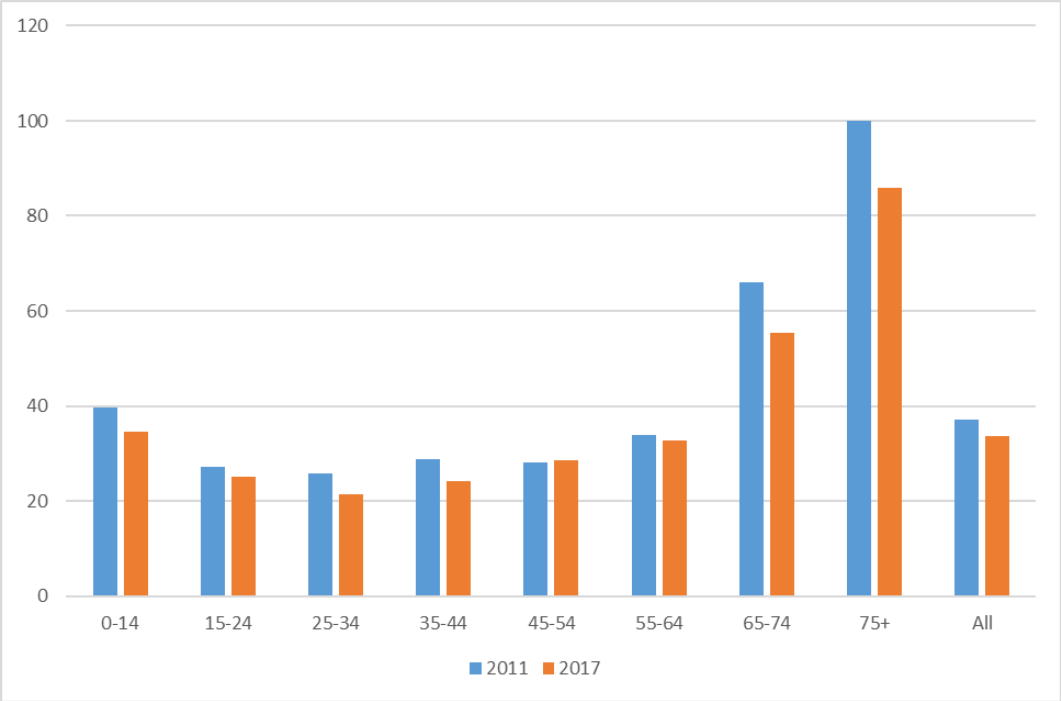
card use for each age group. There was a reduction in the percentage of people eligible for a medical card going from 37 per cent in 2011 to 34 per cent in 2017 overall.[19] Generally, the age distribution of medical cards has a U-shape with younger and older people being more likely to qualify for the cards, compared to working-age adults. However, there are also substantial differences between younger and older respondents, with lower levels of receipt among the young.

Looking at the medical card rate, we see there was a minor reduction between time points for almost all people, except those aged 45-54. One possible explanation could be the relative reduction of people satisfying the means test criteria, as household income increased during the recovery and fewer people were in receipt of welfare benefits with entitlements to a medical card. This reduction was more pronounced for the two older age groups than for the younger age groups. Among older people (aged 75+), medical card receipt fell 14 percentage points between 2011 and 2017.

The fall in receipt of medical card among the 75+ group is due to people not satisfying the means test for medical card and to a change over time in the income limits for the means test. The initial income limits to qualify for a medical card for people aged 70+ in 2011 were a gross weekly income of €700 for a single person and €1,400 for a couple. These limits were reduced to €600 and €1,200 respectively with the Budget 2013 and to €500 and €900 with the Budget 2014 up to 2019. As a consequence there has been an increase in the percentage of receipt of GP visit card among this age group as can be seen in Figure 3.4.

[19] CSO and the HSE use different age group classification for the younger population, the best possible aggregation was to group all children under the age of 14. The classification is identical between the two data sources for all the other age groups.

FIGURE 3.2: PERCENTAGE OF ELIGIBLE PERSONS IN RECEIPT OF MEDICAL CARD BY AGE GROUP (2011-2017)



Source: HSE Statistics
Note: Authors' calculations based on CSO population estimates from databank and HSE.

3.1.2 GP visit card

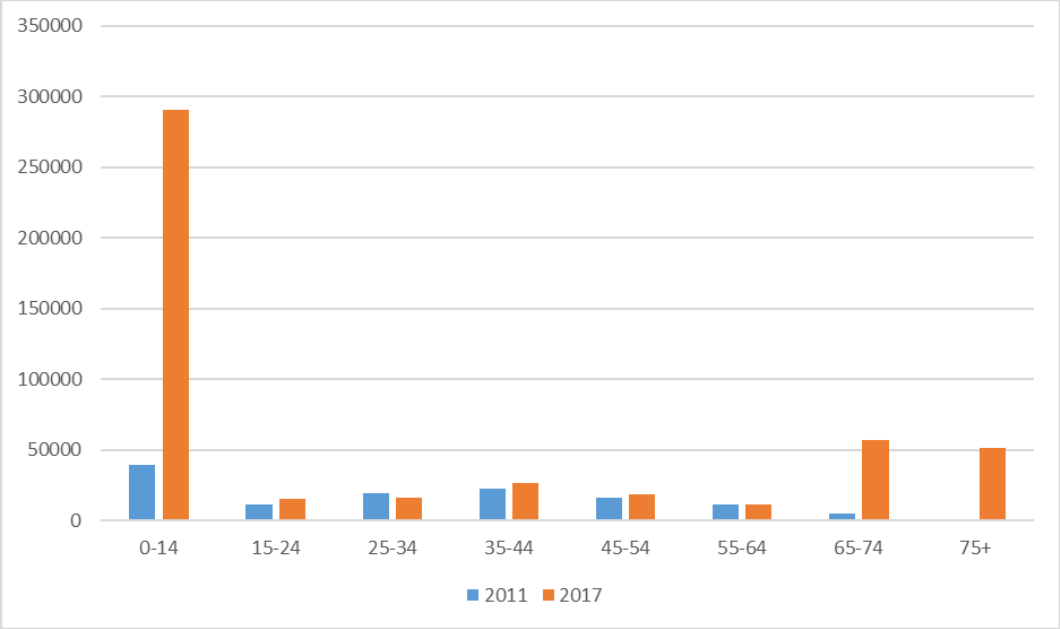
The PCRS also holds annual statistics on the number of persons in receipt of GP visit cards. Figure 3.3 lists these figures, split by age and year, as before.

There is a sharp difference between years of data collection. In 2011, few GP cards were issued and people aged 70 and over did not hold them.[20] The age group most likely to receive a GP card in both years was working-age adults (35-44). In 2017, GP cards were most prevalent among children aged 14 and under (250,000+ cards), older people had the least amount of access to GP cards, especially those aged 55 to 64 (11,300+ cards). People aged 70 and over also became eligible for the cards. Comparing GP cards and medical cards across all age groups, we found that there are far fewer

[20] They either did not qualify for a GP card or qualified for a medical card.

people in receipt of a GP visit card than a medical card. The sharp rise in older and younger GP visit card users stemmed from a reform by the Department of Health, which gave GP visit cards to all children aged under six and to all people aged 70+ regardless of income, starting from August 2015. The increase in GP visit card among those aged 70+ was also due to an increase in the number of people not satisfying the means test for a medical card (see medical card section above for further details)

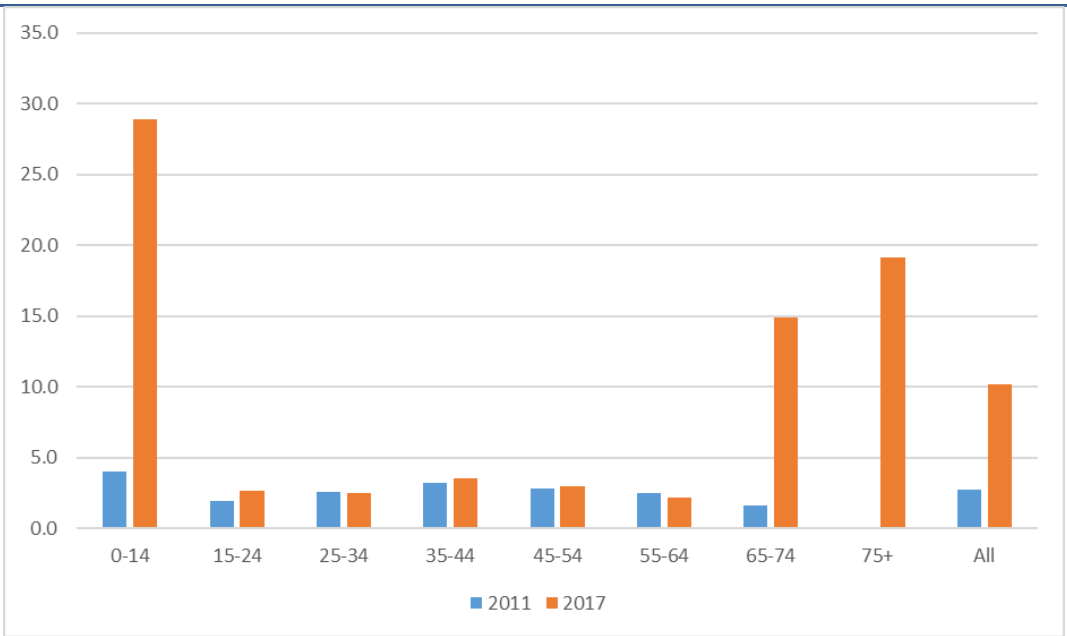
FIGURE 3.3: NUMBER OF ELIGIBLE PERSONS IN RECEIPT OF GP CARD BY AGE GROUP, 2011-2017



Source: HSE Statistics

Figure 3.4 considers the likelihood of holding a GP card by age group, as before. It shows that GP visit cards were generally uncommon in 2011 (3 per cent), but quickly became more widespread (10 per cent) by 2017. However, the main driver of this change is the distribution of GP cards to children (aged 0 to 14) and older adults (aged 70 and over). Looking at the rate of card holders to non-card holders, the change between 2011 and 2017 was extremely minor for all other groups.

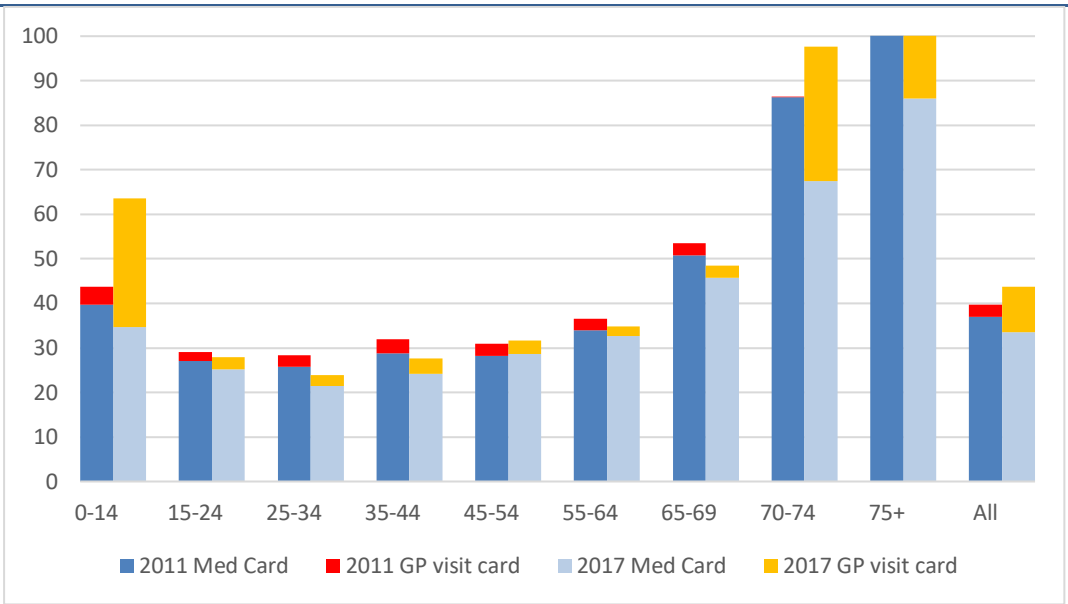
FIGURE 3.4: PERCENTAGE OF ELIGIBLE PERSONS IN RECEIPT OF GP VISIT CARD BY AGE GROUP (2011-2017)



Source: HSE Statistics
Note: Author calculations based on CSO population estimates from databank and HSE.

Finally, in Figure 3.5 we report the total extent of coverage of the medical card and GP visit card drawn from the results presented in Figure 3.4 and Figure 3.2. The overall distribution of access to the medical card and GP visit card takes the form of a U-shape across age groups. Combining both cards, the level of coverage for the population goes from a total of 23 per cent in 2017 for the age group 25-34 to a high of 100 per cent in both years for people aged 75 and over. As seen in the previous charts, by far the access to the medical card is the dominant form of medical cover but less so in 2017 for the age group 0-14 and 70-74.

FIGURE 3.5: PERCENTAGE OF ELIGIBLE PERSONS IN RECEIPT OF MEDICAL CARD AND GP VISIT CARD BY AGE GROUP, (2011-2017)



Source: HSE Statistics
Note: Author calculations based on CSO population estimates from databank and HSE.

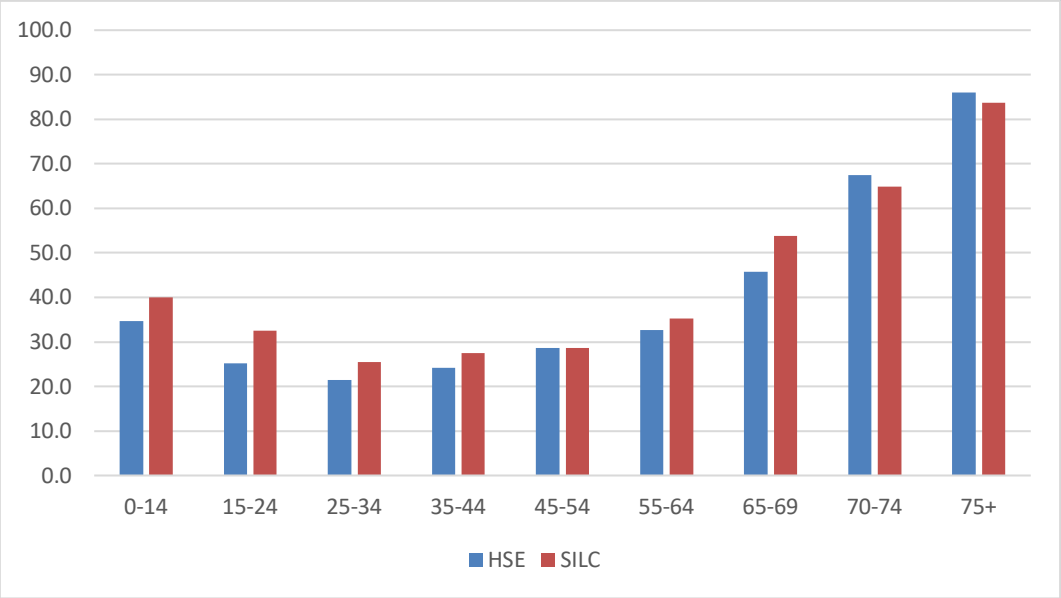
3.1.3 Cost of medical cards and GP visit cards

The PCRS also provides annual statistics on the total cost of medical services provided to the public. Two of its largest components are the costs of prescribed drugs and costs tied to medical card and GP card holders. In 2017 the total GMS expenditure on medical card holders and primary care schemes was €2.75 billion. The largest expenditure was for the payment to pharmacists for €989 million, followed by €552 million in payments to GPs for services provided to medical card and GP visit card holders.

3.1.4 Comparing HSE and SILC data

In this section we compare data from the Irish SILC to HSE statistics. Specifically, we look at the percentage of medical card and GP visit card holders across age groups in both datasets. Figure 3.6 shows a similar U-shaped pattern in the relationship between medical cards and age. Although there is a slight overestimation in the SILC data for those under the age of 70, both sets of statistics are quite similar, suggesting they capture a similar trend or distribution.

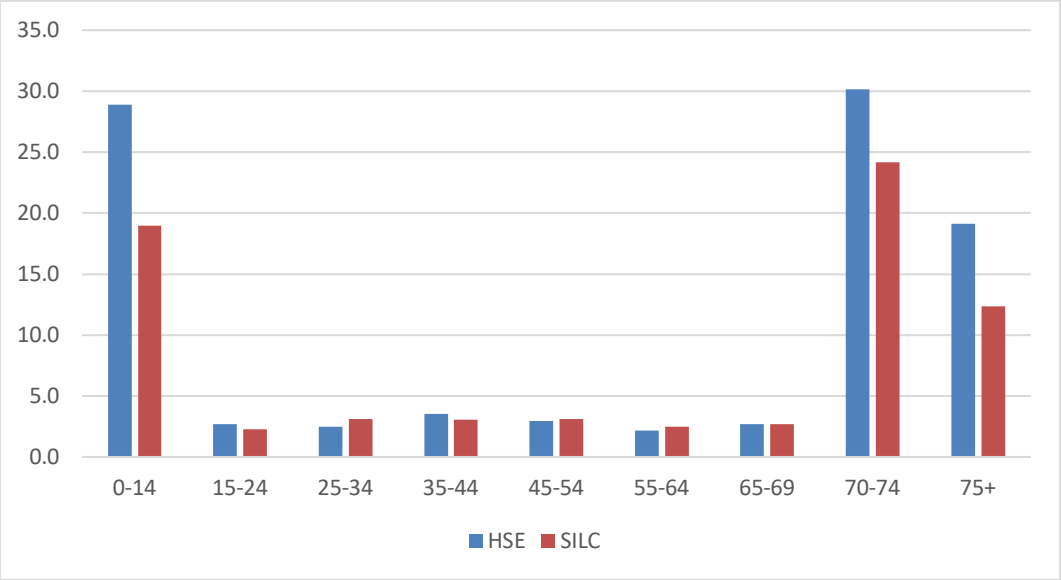
FIGURE 3.6: PERCENTAGE OF PERSONS IN RECEIPT OF MEDICAL CARD BY AGE GROUP, HSE AND SILC 2017



Source: HSE Statistics & SILC 2017

Figure 3.7 recreates this plot with the GP visit cards in mind. It shows that despite the exception of younger and older age groups, the percentage of recipients of a GP visit card within age groups is almost identical. However, at both extremes the SILC data tends to underestimate the percentage of recipients compared to the HSE data. This is especially true among younger recipients. These differences could to be related to the fact that while members from both age groups (up to the age of six for the 0-14 group) are entitled to the GP visit card (unless they have a medical card), respondents do not report holding the GP visit card (on behalf of children under six) or for themselves. Moreover, as noted in Chapter 2, some of the differences between the HSE data and SILC could be due to some sampling errors.

FIGURE 3.7: PERCENTAGE OF PERSONS IN RECEIPT OF GP VISIT CARD BY AGE GROUP, HSE AND SILC 2017



Source: HSE Statistics and SILC 2017

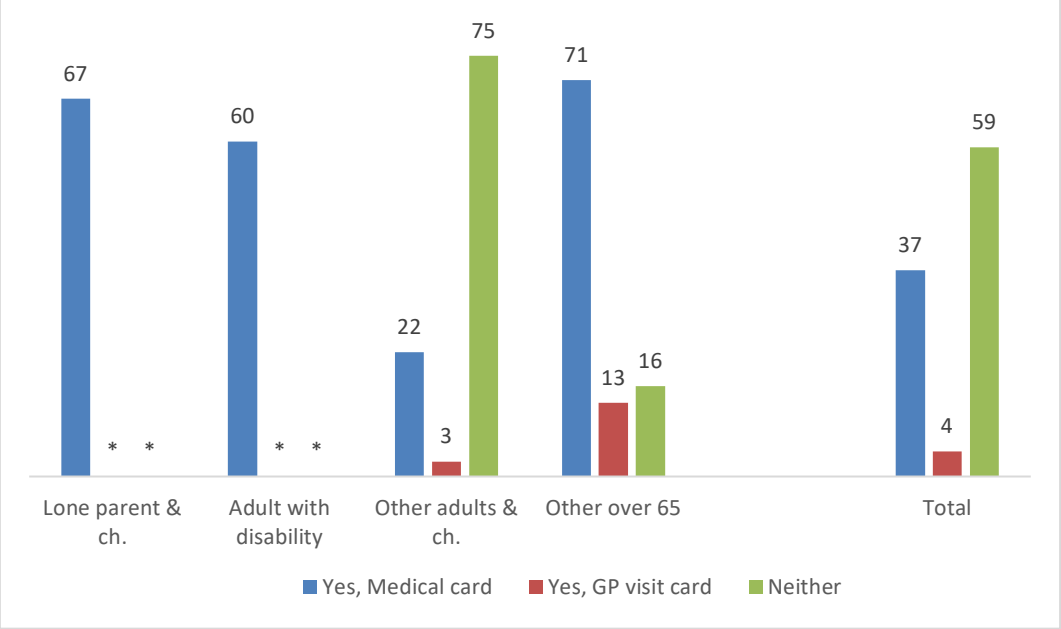
3.2 Medical and GP visit cards across social risk groups

We now turn to the SILC dataset to learn more about who receives and uses these transfers. We are especially interested in social risk differences regarding access to these cards. Social risk-groups are particularly important because they are limited in the extent to which they can engage with the labour market (Privalko et al., 2019). Access to medical and GP visit cards is means-tested with the applicants' income and economic status in mind. However, it is universal for those above a specific age in retirement and is sometimes granted to other groups (like those with certain disabilities) because of discretionary evaluations of an applicant's circumstances. For example, the most vulnerable groups of the population are more likely to receive these transfers, even when means-tested benchmarks such as income thresholds are not met.

Figure 3.8 shows the distribution of medical cards overall and by social risk group. There are two important patterns in this figure. First, most respondents overall have neither a medical card nor a GP visit card (59 per

cent). Just 37 per cent have a medical card and just four per cent have a GP visit card, which is the least common health-related transfer. Second, among vulnerable social risk groups (lone parents, adults with a disability, and adults aged 65 and over) respondents with a medical card are more common than respondents who either have a GP visit card or neither card. This is not the case among other working age adults (Other adults), where it is more common to have neither benefit.

FIGURE 3.8: PERCENTAGE OF PERSONS AGED 16 AND OVER IN RECEIPT OF MEDICAL CARD OR GP VISIT CARD BY SOCIAL RISK AND GROUPS



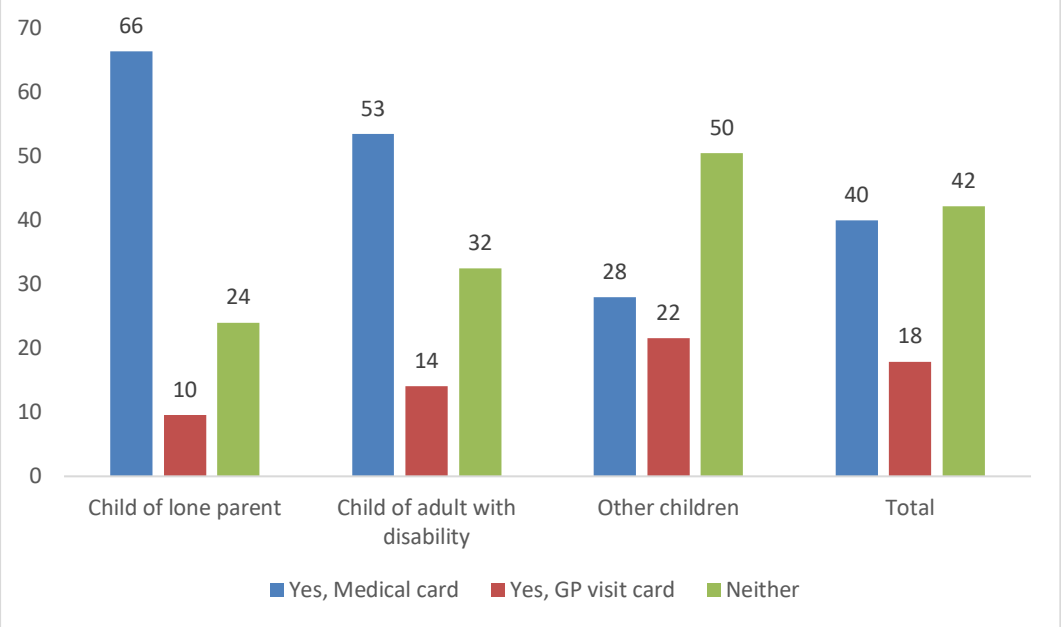
Source: SILC 2017. Authors' calculations
Note: * indicates the cell size was too small to report the statistic (CSO guidelines).

Focusing only on children aged less than 16, a slightly different pattern emerges (Figure 3.9).[21] Again, there are two noteworthy results. First, over half of children under 16 have either a medical card or a GP visit card. Second, as before, children in lone-parent households and households with a disability are more likely to receive a medical card than they are to receive neither card. However, children from households with other working-age

[21] During the interviews, respondents were asked if children up to the age of 16 were covered by a medical card or GP visit card.

adults (other children) are more likely to not be in receipt of a card compared to receiving a medical card or a GP card.

FIGURE 3.9: PERCENTAGE OF CHILDREN AGED LESS THAN 16 IN RECEIPT OF MEDICAL CARD OR GP VISIT CARD BY SOCIAL RISK GROUPS



Source: SILC 2017. Authors' calculations
Note: * indicates the cell size was too small to report the statistic (CSO guidelines).

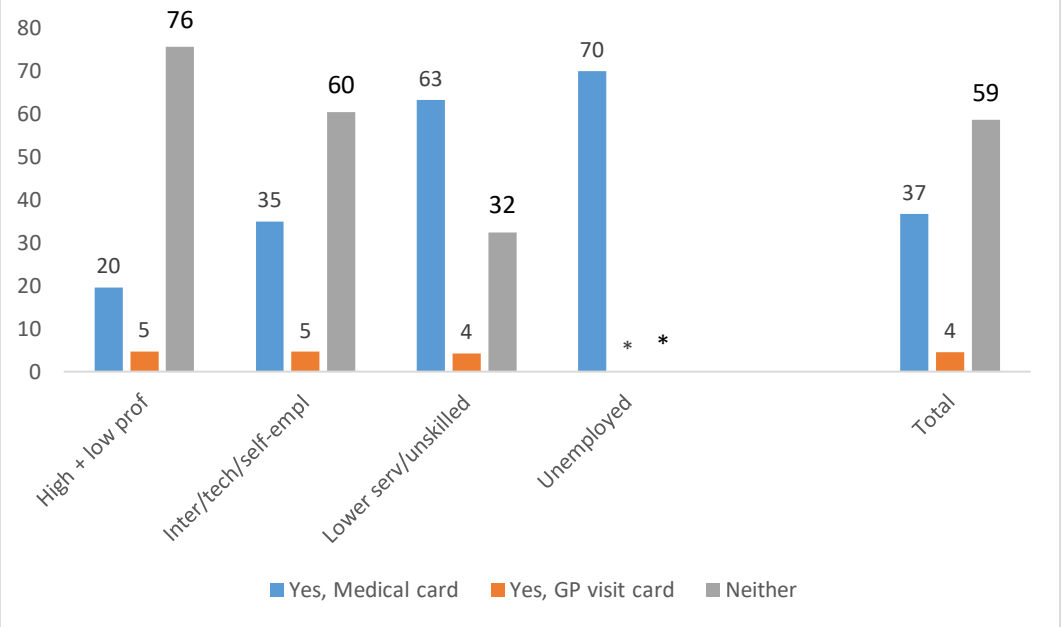
3.3 Medical and GP visit cards across social class groups

We can also consider the differences above in terms of social class, using the categories discussed in Chapter 1. As before, we are particularly interested in differences between social class groups in terms of who gets access to transfers and who does not. Again, it is important to note that social class does not fully explain access to medical and GP visit cards, but we expect some correlation between disadvantaged class categories and access to the transfer.

Figure 3.10 shows a clear and gradient pattern between social class and access to medical cards or GP visit cards. First, the highest and intermediate social class groups are unique in that respondents in these groups are more

likely not to receive either card, than to receive a medical card or a GP visit card. Second, the lowest social class group and the unemployed are unique in that most respondents in this group receive a medical card. Those who do not receive a card are in the minority. Third, the level of receipt of medical card increases gradually from 20 per cent, for higher and lower professional, to reach 63 per cent, for the lower or unskilled manual classes, and a high of 70 per cent for the unemployed class or those who have never worked.

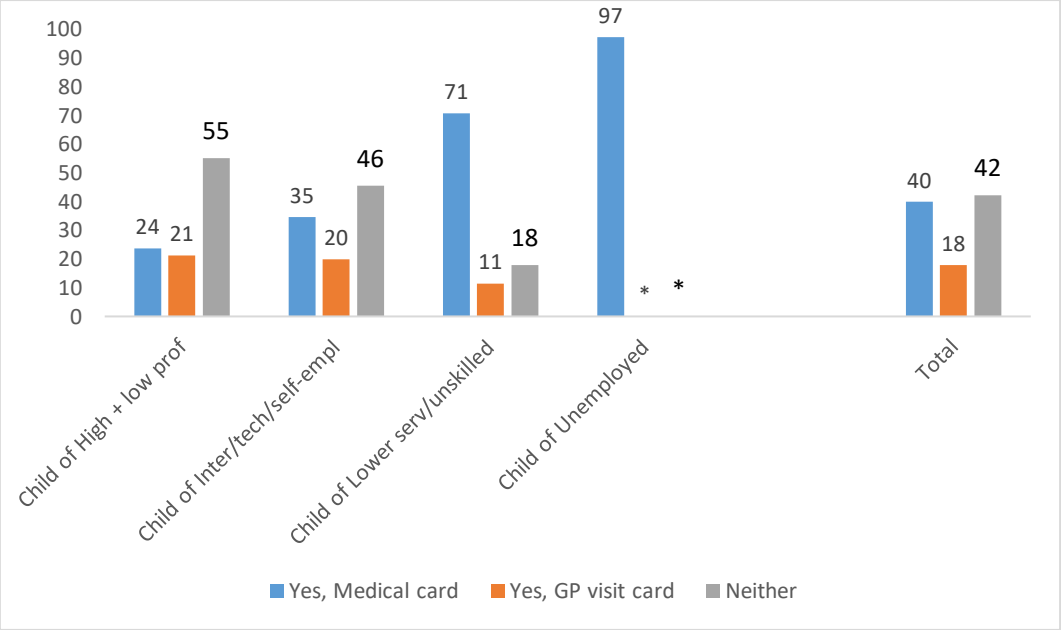
FIGURE 3.10: PERCENTAGE OF PERSONS AGED 16 AND OVER IN RECEIPT OF MEDICAL CARD OR GP VISIT CARD BY SOCIAL CLASS GROUPS



Source: SILC 2017. Authors' calculations
Note: * indicates the cell size was too small to report the statistic (CSO guidelines).

As before, we turn our attention only to children aged 16 and under. The class differences in access to medical and GP visit cards remains largely the same, although the differences between classes are somewhat more extreme. Seventy-one per cent of children from the lower-class groups and 97 per cent of children from unemployed class groups receive a medical card. The universal delivery of a GP visit card for children under the age of six explains the higher level of receipt of this cover across all social class groups and the absence of strong social class variation.

FIGURE 3.11: PERCENTAGE OF CHILDREN AGED LESS THAN 16 IN RECEIPT OF MEDICAL CARD OR GP VISIT CARD BY SOCIAL CLASS GROUPS



Source: SILC 2017. Authors' calculations
Note: * indicates the cell size was too small to report the statistic (CSO guidelines).

3.4 Poverty, medical card and GP visit card

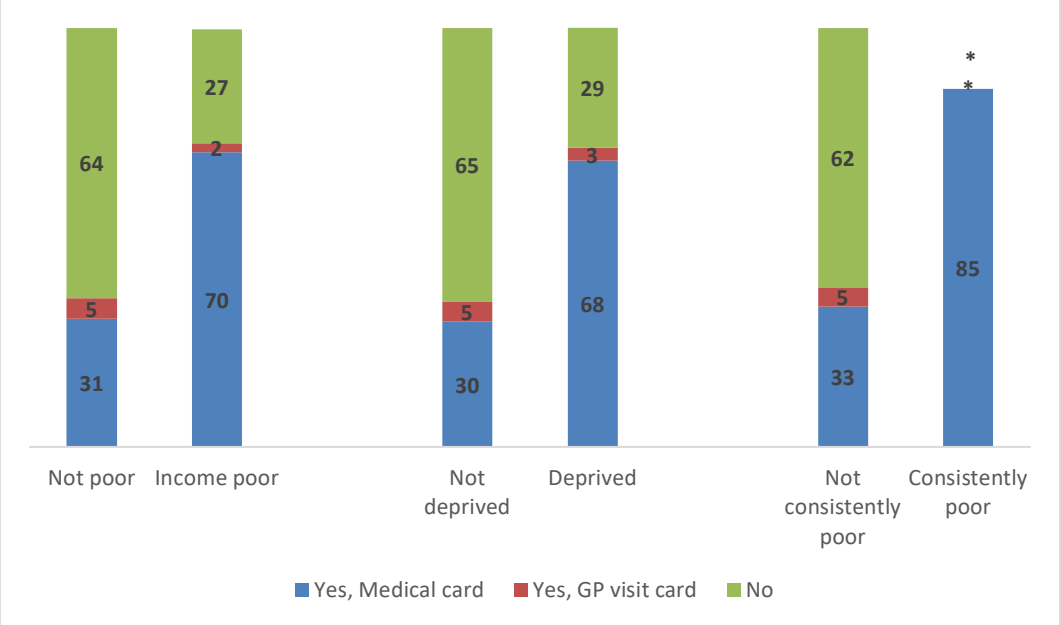
We have shown several differences in access to medical and GP card by social risk and social class group. Means-testing ensures that low income households (those most exposed to poverty, deprivation and social exclusion) are most likely to receive a medical card or a GP visit card (Keilthy, 2009; Russell and Nolan 2000). However, even with these groups, a substantial portion of households do not gain access to these resources (Keilthy, 2009; Layte et al., 2007).

We now explore the relationship between people's risk of poverty and social exclusion and whether they hold a medical card and GP visit card. Figure 3.12 breaks down access to medical and GP cards by deprivation and poverty; we consider three poverty measures, the at-risk of poverty, basic deprivation and consistent poverty. Two patterns are worth noting.

First, access to medical cards for the income poor and those in deprivation are almost identical. Over two-thirds of those that are income poor or deprived are in receipt of a medical card. However, very few respondents in this group hold a GP visit card. This pattern stands opposite to their respective reference categories, non-income poor and non-deprived.

Second, access to medical cards is most pronounced among those who are consistently poor. Almost nine out of ten respondents are in receipt of a medical card for this category. These results confirm our previous findings; medical cards target the most vulnerable group and most disadvantaged groups.

FIGURE 3.12: PERCENTAGE OF PEOPLE IN RECEIPT OF A MEDICAL OR GP VISIT CARD BY POVERTY OUTCOMES

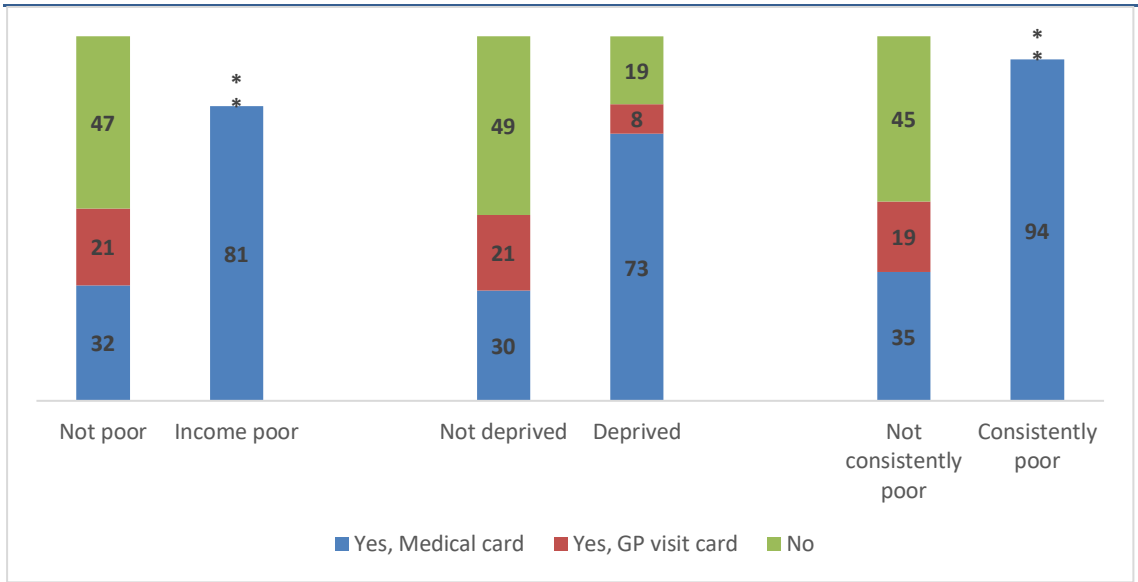


Source: SILC 2017. Authors' calculations
Note: * indicates the cell size was too small to report the statistic (CSO guidelines).

As a final confirmation of this point, we can again turn our focus only to children under the age of 16. Figure 3.13 splits access to medical cards by poverty measures. As before, in each measure of poverty and deprivation we find greater access to medical card and GP card transfers. Thus, the income poor, the deprived, and the consistently poor have greater access to medical card than their respective counterparts. Indeed, 80 per cent of

children at risk of poverty and 94 per cent of those in consistent poverty have access to a medical card. Again, the figure shows that medical cards and GP cards are well targeted in that they provide strong cover for those in deprivation and poverty.

FIGURE 3.13: PERCENTAGE OF CHILDREN AGED LESS THAN 16 IN RECEIPT OF MEDICAL CARD OR GP VISIT CARD BY POVERTY OUTCOMES



Source: SILC 2017. Authors' calculations
Note: * indicates the cell size was too small to report the statistic (CSO guidelines).

3.5 Estimating the monetary value of medical and GP visit cards

In Chapter 1 we described the complexity and challenges of attaching a monetary value to non-cash benefits. There are different approaches to estimating the value of a service, especially one that is provided free or at a reduced fee. One is a simple accounting approach (or objective), where the cost of the services provision is attached to the service itself. A second approach (subjective and more difficult) is to ask people to value access to the service themselves, although this will lead to extensively different estimates from people, depending on their characteristics, circumstances, and preferences (Smeeding, 1982). In the Irish context, we follow Keane and Bercholz (2019), to briefly describe some of the main approaches found in the literature to estimate the value of non-cash benefits starting with the

simplest method.

- The cost per capita method consists in estimating the average value of a service by dividing the total expenditure of the service by the number of people in receipt of the service.
- The usage method consists in looking at an individual's health consumption across all health services, such as the number of GP visits, dental treatment, use of in-patient services as well as medicines.
- The market value of a benefit-in-kind corresponds to the amount of spending that a person would have to pay on the market if they wanted to avail of this service. In the case of a medical card or GP visit card, the closest estimate would correspond to the price a consumer would have to pay on the private health insurance market to get the same level of provision of services. Depending on people's characteristics and the supply and demand for such services, there might be some large variation in terms of price, as well as the level of medical cover offered on the health insurance market. This makes it difficult to estimate. Moreover, in Ireland, private health insurances cover mainly in-patient services, excluding services such as the cost of GP visits, dental care and medicines, for example.
- The risk-related method is based on the cost per capita but rather than applying the same average value to everyone irrespective of some of their characteristics, they receive a value corresponding to the average expenditure corresponding to the usage based on their gender and age group. This is the method we use in this chapter for the valuation of the medical card and GP visit card. This method has been used in Ireland for the valuation of medical cards (Savage et al., 2016; Russell and Nolan 2000) as well as internationally (Saunders et al.,1992; Donaldson et al., 2002).

The brief description above of some of the methods to estimate values to non-cash benefits highlights their respective merits and limits and very often the preferred method will also be driven by the availability and quality of the data needed to produce these estimates. In the Irish context of valuation of medical services such as the medical card and GP visit card and based on

the data available to us, the preferred method is the risk-related approach.

3.5.1 Risk-related approach

We used two data sources to estimate the monetary value of medical and GP visit cards: the SILC micro-data and the annual statistics from the Primary Care Reimbursement Service (PCRS) publication. The PCRS report lists three important costs tied to our estimate; the cost of a night spent in hospital, the cost of a GP visit, and the cost of medicines. These costs are split by medical card users, GP card users, and costs for the general population. They are also split by 11 age groups (starting from 0 to 5 years and ending with people aged 75 and over) and also by gender. Based on these aggregated costs and age breakdowns, we can create the estimated value of both cards.

3.5.2 Hospital cost

The SILC data collects information about the number of nights that adults and children respectively have spent in a hospital in the12 months prior to the interview. Based on this information we get the annual average number of nights by age group, going from 1.16 nights for the younger age group to 2.35 nights for the older group. The service charge for an inpatient at the hospital is €80 per day up to a maximum amount of €800 over a 12-month period, if the person has several hospital admissions. As medical card holders do not have to pay this service charge, the estimated value of hospital stays for a medical card holder is the service charge of €80 multiplied by the average number of nights of their respective age group. The hospital cost goes from a low annual average of €36 for the five to 15 years olds to €188 for people aged 65 and over.

3.5.3 Medical card, GP visit card and medicine cost

The estimate for the value of a medical card and GP visit card is based on the PCRS annual expenditure statistics (2017). In 2017, the total payments to GPs for the provision of services to medical card and GP visit card holders was €522,374,936 and the number of medical card and GP visit card holders was 2,097,330. The annual average in 2017 was therefore €249.07 per

capita. GPs under the GMS scheme receive annual capitation fees based on their number of patients holding medical card and GP visit cards. While these fees take account of age and gender differences in the likelihood for healthcare, it is quite likely that the real cost could be underestimated or overestimated as it will vary with the extent to which patients use health services.

Using the same methodology as Russell and Nolan (2000), we estimated the usage by medical card and GP visit card holders for GP services and medicines for each age group, by using a weight based on their respective average cost of medicines as provided by the PCRS annual statistics. For example, in 2017, the average cost of medicines for children aged under five years was €85.18, and for the total population of medical card holders it was €614.87. So, the average cost for medicines for children under the age of five is 0.14 times (€85.18/€614.87), the annual average one. We then used this weight of 0.14 and multiplied it by €249.07 (annual average medical card and GP visit card cost), giving an annual average of €35. These results for all the age groups are presented in column 4 of Table 3.4, showing an increasing average cost of medical cards and GP visit cards with age reaching a high of €534 for people aged 65 and over. The cost of medicines is also based on the same weights for each age group.

Table 3.4 summarises the measures mentioned above. The final column shows the estimated total cost of hospital stays, GP visit of medicines for GP and visit card holders. The estimate varies from €149 per year for children aged five to 15, up to a maximum of €1,936 per year for people aged 65 and over.

TABLE 3.4: ANNUAL MEDICAL COST VALUATION PER USER, BY AGE GROUP, 2017

Age group	Ratio of mean number of nights at the hospital to the total average number of nights at the hospital	Annual hospital cost	Annual GP cost	Annual cost of Medicines	Total costs per user
Under 5	**1.16**	**€93**	**€35**	**€78**	**€206**
5-15 years	**0.45**	**€36**	**€35**	**€79**	**€149**
16-44 years	**0.74**	**€59**	**€114**	**€258**	**€431**
45-64 years	**0.97**	**€77**	**€283**	**€642**	**€1,003**
65 years +	**2.35**	**€188**	**€534**	**€1,213**	**€1,936**
Total	**1**	**€80**	**€249**	**€566**	**€815**

Source: Primary care reimbursement services, 2017

In comparison with the 2015 medical costs by Savage at al. (2016), Table 3.4 shows a broad pattern of an increase in hospital costs for the younger and older age groups due to an increase in the average number of hospital nights; a reduction in GP cost for the former but an increase for the latter, and finally an overall reduction in the cost of medicines across age groups. Using this table, we can create an estimated monetary value for medical and GP cards. This would give us a value for the transfer which we could then use as in the previous chapter.

TABLE 3.5: MEAN ANNUAL EQUIVALENT MEDICAL CARD AND GP VISIT CARD SUBSIDIES BY SOCIAL RISK AND SOCIAL CLASS OVER HOUSEHOLDS

Groups	Mean annual subsidy
Social risk	
Lone parent and children	**€1,010**
Adult with a disability and children	**€1,392**
Other adults and children	**€1,027**
Other over 65	**€2,046**
Social class	
High & lower professional	**€1,143**
Inter/tech/self-employed	**€1,260**
Lower service/unskilled manual	**€1,213**
Never worked/unemployed	**€1,347**
Total	**€1,206**

Source: SILC 2017. Authors' own calculations
Note: * We are unable to list values for households with a disability and households who are unemployed due to CSO rules about the minimum number of cases required. However, because in the modelling simulation below we use equivalised household income across all individuals we have enough cases to use the values that are not shown in Table 3.5.

3.6 Multivariate analysis of medical cards and GP visit cards on material deprivation

In Chapter 1 we presented the ordered logistic regression model to predict the level of deprivation across social risk and social class groups. This section uses the same methodology as in Chapter 2 to predict deprivation with a score ranging from 0 items (no deprivation) to a maximum of 11 items (deprived on all items) controlling for a range of individual and household socio-economic characteristics. We predict group differences in the probability of citing each item of deprivation from 0 (not deprived) to 11 (deprived on all items) for people holding a medical card/GP visit card. The

analysis below is done only for people stating that they hold a medical card or a GP card, so we are not including non-take-up as this would require a different simulation exercise. It is quite likely that including non-take-up would increase the effect of health support on deprivation as noted by Callan et al. (2018a); there is an under-representation of people in the bottom income distribution holding a medical card or a GP visit card and their entitlement.

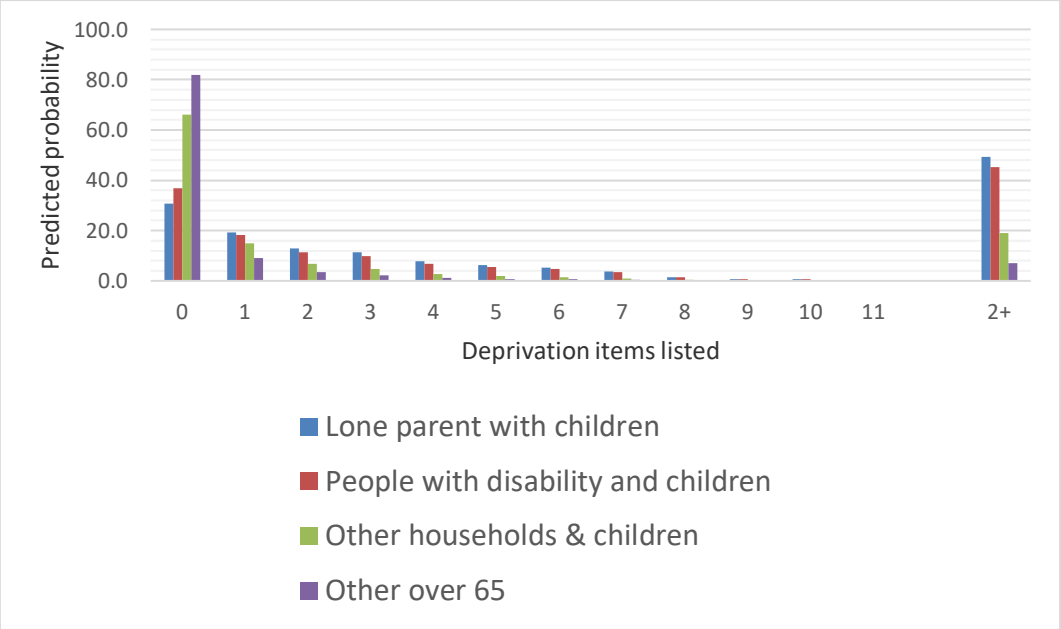
Figure 3.13 first considers group differences in social risk groups. There are significant differences here in the absolute risk of deprivation. Lone parent households with a medical card or GP visit card have a predicted probability of 0.31 of experiencing no deprivation. Households over 65 have a far higher predicted probability of citing no deprivation at 0.82. Other working-age households, (labelled other adults), with a medical card or GP visit card have a predicted probability of 0.66, which sits between these estimates.

People living in lone parent households as well as those living in a household with a person with a disability are the most exposed to experience deprivation across all levels of deprivation, even if the risk decreases as the number of items increases. While older households with medical card or GP visit cards report low predicted probabilities of citing more than three deprivation items, it is only from seven items onwards that it becomes rarer for lone parents and people in a household with a person with a disability.

At the right side of Figure 3.14 we show the predicted probability of experiencing basic deprivation (lacking at least two items) across the same groups with a medical card or GP visit card. The risk is very high for lone parents and people in a household with a person with a disability at 0.49 and 0.45 respectively, while it is less than half that for working age adults (other adults) at 0.19 and less than 0.10 for respondents over 65.

This pattern mirrors the general pattern across the overall population where the level of basic deprivation is the lowest for people aged 65 and over, while it is the highest among lone parents (CSO, 2019).

FIGURE 3.14: PREDICTED PROBABILITIES OF DEPRIVATION LEVEL FOR MEDICAL CARD OR GP VISIT CARD HOLDERS BY SOCIAL RISK GROUPS

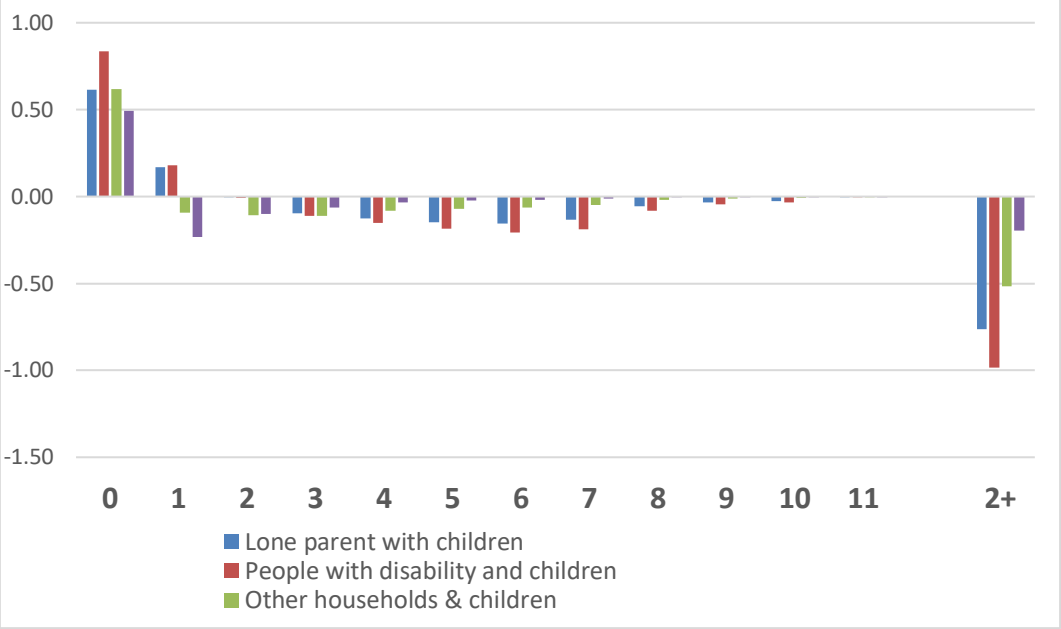


Source: SILC 2017. Authors' calculations

Following the same methodology of Chapter 2 and using the same regression specification in Table 1.1, we increased the household income across social risk and social class groups by the values estimated in Table 3.3, keeping everything else the same. We then reported the changes in the predicted probabilities of experiencing deprivation at different levels of deprivation following the increase in household income. These results are shown in Figure 3.15. People living in a household with a person with a disability report the largest reduction in deprivation followed by people in lone parent households. There is an increase of 0.8 and 0.6 percentage points in the probability of reporting no deprivation for these two groups respectively, and of 0.5 percentage points for the most protected group of people over 65. Across all groups, the reduction in deprivation probabilities are very modest; the largest reduction is for people living in a household with a person with a disability and reporting four to seven deprivation items with a reduction of almost 0.2 percentage points.

On the right side of the chart, we report the change in the probability of experiencing basic deprivation (lacking at least two items). The largest reduction is for people living in a household with a disability at one percentage point followed by people living in lone parent households at almost 0.8 percentage points.

FIGURE 3.15: CHANGE IN PREDICTED PROBABILITIES OF DEPRIVATION FOR MEDICAL CARD OR GP VISIT CARD HOLDERS BY SOCIAL RISK GROUPS

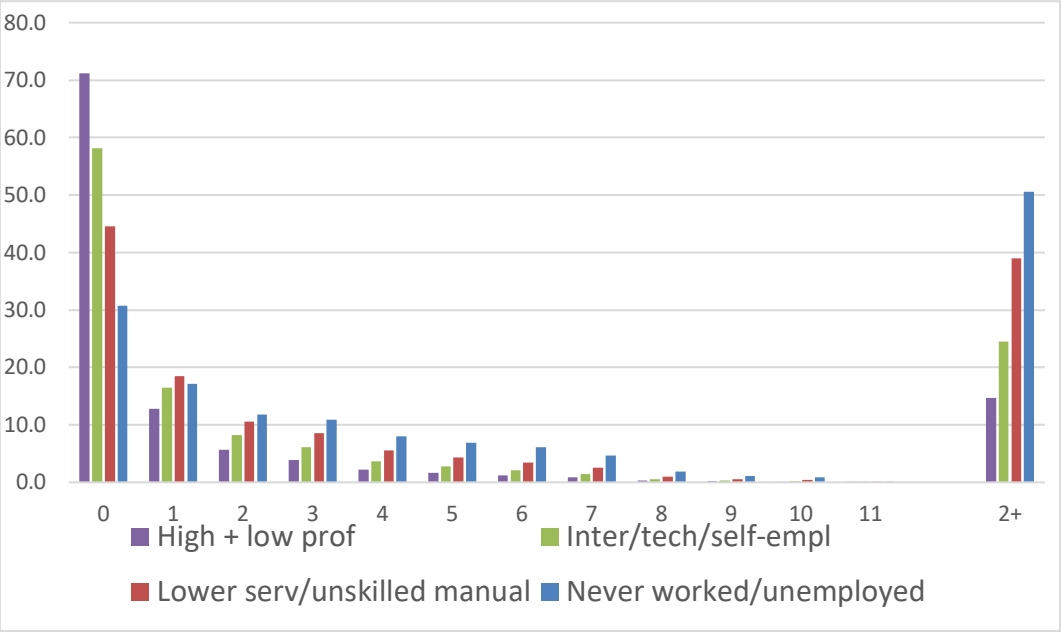


Source: SILC 2017. Authors' calculations

In Figure 3.16, we present the risk of experiencing deprivation at different levels (enforced lack of 0 to 11 items) as well as for basic deprivation (lacking two or more items) across social class groups holding a medical card or GP visit card. There is a very strong relationship between social class position and the experience of deprivation. Less than three-quarters of the higher social class with a medical card or GP visit card have no deprivation, whereas it is less than one-third for those in the never worked/ unemployed social class with a medical card or GP visit card. Across all deprivation levels, the never worked/unemployed group report the highest probability of deprivation and it is only from four items onward that the probabilities fall below ten per cent.

Looking at the risk of basic deprivation (lacking at least two items) on the right side of Figure 3.16, the probability is above 50 per cent for the never worked/unemployed groups, 39 per cent for the lower service or unskilled group. It is then much lower for the last two social classes but even among the most privileged group of higher social class and lower professional (high/low prof), the risk is almost 15 per cent.

FIGURE 3.16: PREDICTED PROBABILITIES OF DEPRIVATION LEVEL OF MEDICAL CARD OR GP VISIT CARD HOLDERS BY SOCIAL CLASS



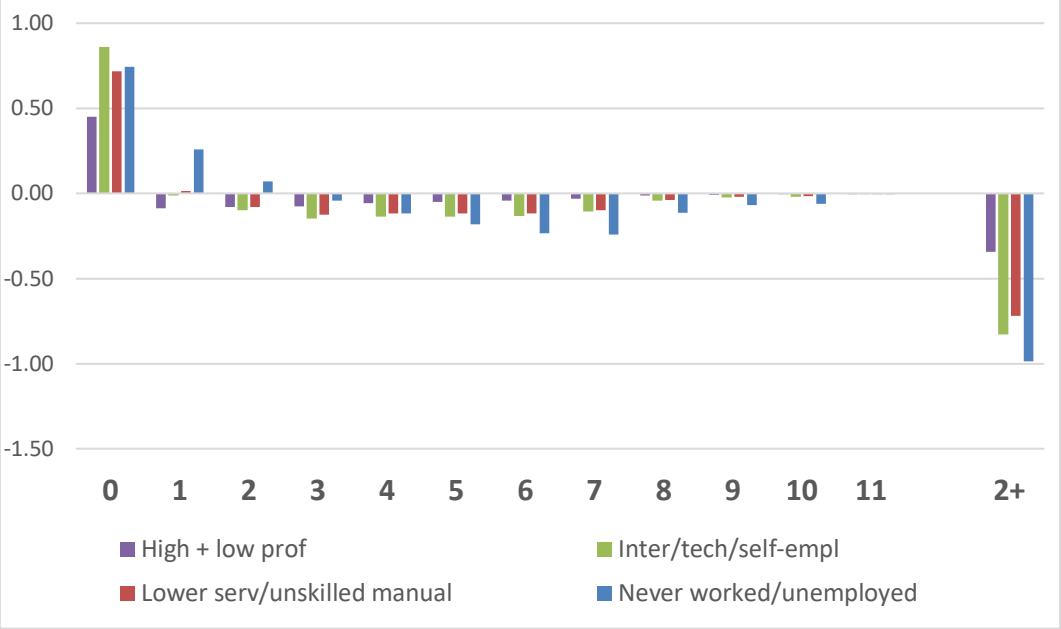
Source: SILC 2017. Authors' calculations

After increasing the household income for medical card or GP visit card holders by the corresponding estimated values of a medical card or GP visit card of the groups shown in Table 3.5, we can report the changes in predicted probability of having different levels of deprivation using the model in Table 1.1. The results are reported in Figure 3.17. For people from the three lower social classes, this increases their probability of having no deprivation by 0.7 to 0.9 percentage points while it is less than half that for the better off class. The effect is especially important for the unemployed and never worked class. The relatively large effect for this group is mostly likely due to this group's tendency to cite many deprivation items, as shown in figure 3.16. Hence, transfers increase their chances of citing just one item,

because the group is rather spread out across the deprivation scale.

As the reduction is modest at all levels of deprivation and across all social classes, the reduction in basic deprivation is therefore modest too as can be seen on the right side of the Figure. However, it is the largest with almost 1 percentage points for the never worked/unemployed, roughly 0.7 to 0.8 for the following next two social classes and 0.3 for the better-off classes.

FIGURE 3.17: CHANGE IN PREDICTED PROBABILITIES OF DEPRIVATION FOR MEDICAL CARD OR GP VISIT CARD HOLDERS BY SOCIAL CLASS



Source: SILC 2017. Authors' calculations

3.7 Summary

This chapter highlighted the distribution, use, and impact of medical cards and GP cards in Ireland. Throughout we have also focused on the social risk and social class differences in access, use, and impact of the cards. While the number of general medical cards saw a decline since 2011, we found that the number of GP visit cards was expanded, especially for children under six and respondents over 65.

We noted that vulnerable social risk groups were more likely to hold a medical or GP visit card, when compared to working age adults (Other adults). This was especially true when we limited our sample to children under the age of 16. When we considered social class, we also found that the most vulnerable class groupings were the most likely to hold a medical or GP visit card, compared to higher social class groups. Again, this result became more apparent when we limited our sample to children under the age of 16.

When considering poverty and deprivation, we found that medical card and GP visit card holders lived in households with higher rates of deprivation when compared to the households without these cards. We also found that card holders live in households with higher levels of income poverty than households without cards. Finally, consistent poverty was higher in households with cards when compared to households without cards. This was also true when we limited our sample to children under the age of 16. Generally, we find that households who hold medical cards and GP cards are from more vulnerable backgrounds than households without such cards, suggesting that coverage of the cards is generally good.

Before estimating the cards' impact on deprivation, we had to assign them a monetary value. We combined SILC data with statistics from the PCRS annual statistics report and listed the results by social risk and social class. On average, we found that medical cards were particularly valuable to the unemployed/never worked social class group and to lone parents. Once we established their value, we turned to ordinal logistic regression to consider the baseline differences in deprivation between those receiving and not receiving the cards.

We found that differences in deprivation between medical and GP card recipients could be explained by the social risk and social class of the household, but also by the characteristics of the head of the household and the household's financial circumstances.

Finally, we made two important conclusions about the simulated impact of the medical and GP visit cards on deprivation. First, although the effect was weak, the transfer had a positive effect in that it limited the deprivation of medical and GP visit card holders, if only by a fraction of a percent. Second, and most importantly, the medical and GP visit cards impact by social risk and social class, shows that it has the greatest benefit to the most vulnerable holders.

Chapter 4

Childcare support

This chapter considers the distribution of childcare supports and their effects on household deprivation. These supports are particularly important for parents in employment, education, training, or those seeking paid work. In addition, they help families with additional care obligations, such as those with both children and adults who need care (due to disability or illness). They are also important for lone parents or parents with a disabled person in the home, who must often balance childcare obligations and work. Throughout the chapter, we will discuss the supports provided,[22] who gets them, and what the net benefits of such supports are for social risk and social class groups in reducing deprivation. We note that Affordable Childcare Scheme (ACS and later National Childcare Scheme) supports that were announced in Budget 2017 – to replace four childcare subsidy schemes in existence at the time – did not appear until much later. However, we also simulate their potential effects using our data. Throughout the chapter, we focus on households with at least one child aged 12 years or younger.

4.1 Childcare transfers in Ireland

Ireland's childcare costs are some of the highest among OECD countries (OECD, 2019; Russell et al., 2009). Given that cost is a substantial barrier to childcare services, especially for vulnerable families, Ireland also has some of the highest rates of unmet need for formal childcare services (Privalko et al., 2019). Unmet childcare need is associated with higher deprivation and a greater chance of a mother's (generally the main childcare provider) non-employment (Russell et al., 2009; Privalko et al, 2019). As a result, understanding the impact of childcare supports on vulnerable groups sheds light on our understanding of deprivation, poverty, and social exclusion.

The Department of Children, Equality, Disability, Integration and Youth has implemented several childcare support schemes. The format of these schemes varies from free universal childcare (up to a certain number of

[22] We include a simulation exercise that considers one particular scheme (ACS/NCS) which was not available in 2017 but became available in 2019.

hours per week for a specific age group) to direct subsidies to childcare providers, which reduce childcare costs for families, and financial support for families who wish to provide traditional home care for children.

This chapter has four aims. First, we describe the main childcare programmes considered. Second, we outline the prevalence of child poverty across different age groups and the prevalence of access to childcare across vulnerable groups. Third, we describe the methodology used for the valuation of childcare supports and their equivalent childcare subsidies across social risk and social class groups. Finally, we use formal statistical models to see if the equivalent childcare subsidies for households with children reduce material deprivation and how these subsidies vary across social risk and social class groups.

4.2 Childcare support programmes

This section considers five main childcare schemes. These grew out of policy developments aimed at early childhood education and childcare (Child Care Act 1991, Regulations 2016; Amendment Child Care Act 1991, Regulations 2016). Table 4.1 lists the schemes, the number of recipients and the total cost of each scheme. The data is from the Department of Children, Equality, Disability, Integration and Youth (DCEDIY).

The Early Childhood Care and Education (ECCE) programme is the largest, assisting 120,000+ recipients in 2016 and 118,000+ recipients in 2018. The next largest programmes are the Community Childcare Subvention (CCS), and Community Childcare Subvention Plus (CCSPlus) programmes, which assisted 27,000+ in 2016, and 38,000+ in 2018. The Community Childcare Subvention Universal (CCSU) programme is comparable to the previous programmes in 2018, where 39,000+ recipients registered. The least common programme is the Training and Employment Childcare programme (TEC), where just 6,000+ recipients were registered in 2016, and 4,000+ in 2018. Each of these schemes differ in their openness to the public, as their access will be determined by children and parents/carers socio-economic characteristic as described below.

The schemes also differ in the level of budget allocated, at times based on the number of recipients and at times among schemes with comparable recipients. For example, the ECCE was the largest, and cost €273 million in 2016, and €242 million in 2018. In the same years, the TEC was the smallest and cost €16 million in 2016 and €11 million in 2018. As a second example, the CCS and CCSPlus cost over five times more than the CCS Universal, despite having comparable numbers of recipients.

The implementation of the National Childcare Scheme (NCS) in late November 2019, replaces several childcare support programmes shown in Table 4.1, but not the ECCE or the universal childcare subsidy. All other schemes have been closed to new applicants since October 2019 (CCS and CCSP programmes) and February 2010 (ASCC, CEC, CETS) and will terminate in August 2021. Later in the chapter we will also consider the potential gains parents make through the ACS/NCS using our simulations.

TABLE 4.1: NUMBER OF CHILDREN AND APPROVED CONTRACT VALUE BY CHILDCARE PROGRAMME, 2016/2017 AND 2017/2018

	Number of children registered		Value (€)	
	2016/2017	2017/2018	2016/2017	2017/2018
ECCE	120,821	118,899	273,753,848	242,015,900
CCS & CCSPlus	27,150	38,846	42,639,511	92,459,723
CCSU	*	39,319	*	18,439,956
TEC	6,350	4,655	16,822,504	11,817,424
Total	149,426	185,580	333,215,863	364,733,003

Source: Pobal 2018[23]
Note: *CCSU programme started in 2017/2018 so there is no data for 2016/2017. The total number of children registered is greater than the sum of the individual schemes as some children might have transitioned between schemes or might have registered in several schemes.

[23] https://www.pobal.ie/app/uploads/2018/11/ Early-Years-Sector-Profile-Report-2017-2018.pdf

Before exploring the SILC data in greater detail, we briefly present and discuss the main forms of childcare support offered to parents.

4.2.1 Early Childhood Care and Education

The ECCE is the most prominent form of childcare support (Table 4.1). Between 2006 and January 2010, in order to ease childcare costs, the Department of Social Protection provided a direct cash benefit, the Early Childcare Supplement (ECS), to qualified households with young children. The ECS was paid monthly in arrears per child up to the child's fifth birthday.[24] It was replaced in January 2010 by a universal free pre-school year in Early Childhood Care and Education (ECCE).

The ECCE scheme was available to all children between the ages of three years three months, and four years six months. It was later extended to children aged between two years and eight months, and five years and six months. It provides free childcare for three hours per day, five days per week over 38 weeks per year. Since 2016, eligibility has increased further to a total average of 61 weeks (i.e. over a period of more than one year). The ECCE programme is only available from registered childcare providers.

4.2.2 All and Community Childcare Subvention Plus

The next most common schemes are the CCS and CCSPlus. They support parents from disadvantaged backgrounds as well as those in education, training, or low-paid jobs. The service is also available for medical card and GP card holders, as well as those in receipt of other social welfare payments. Both schemes offer reduced childcare rates for children up to the age of 15, who are enrolled in either community childcare services (CCS) or private childcare service providers (CCSPlus) registered with Tusla. The schemes offer flexible childcare service options, ranging from full day-care to very short placements. With the implementation of the new NCS in November 2019, these schemes are now closed to new applicants.

[24] The scheme applied for an additional month after the child turned five.

4.2.3 Community Childcare Subvention Universal

With the previous schemes in mind, an additional scheme was launched in August 2017, parents with children aged between six months and three years who were enrolled with the CCS programmes could now receive an additional transfer to reduce the cost of childcare. Depending of the number of hours of childcare used by the parents, the transfer offers weekly payments ranging from €3.50 to a maximum of €20.

4.2.4 Training and Employment Childcare

Finally, the Training and Employment Childcare programme includes several strands of childcare supports to parents attending eligible education or training courses as well as to some parents who are returning to work. The schemes consist of subsidised childcare places; they are the Childcare Education & Training Support (CETS), the Community Employment Childcare programme (CEC) and the After-School Child Care Scheme (ASCC).

The CETS scheme provides childcare support for parents who are attending education and training programmes (these include Youthreach, vocational training courses, Further Education and Training (FET) courses). The scheme also supports parents attending Junior or Leaving Certificate programmes. Under the scheme, providers can only apply a minor charge for the service, depending on the amount of care used. The CEC offers similar childcare supports but for parents attending Community Employment schemes. Both CETS and CEC programmes offer childcare support up to a maximum of 50 weeks per year. Finally, the ASCC provides afterschool care support for children in primary school (aged four to 13). The service is available to three key groups. The first are parents who are in receipt of some benefits from the DSP. These benefits include the Working Family Payment, One Parent Family Payment, or unemployment related benefits. The second group is made up of parents who are attending a DSP employment programme to upskill or re-train. The final group is parents who have increased their level of employment. With the introduction of the NCS, registration to this programme closed in February 2020 and the programme

will end in August 2021.

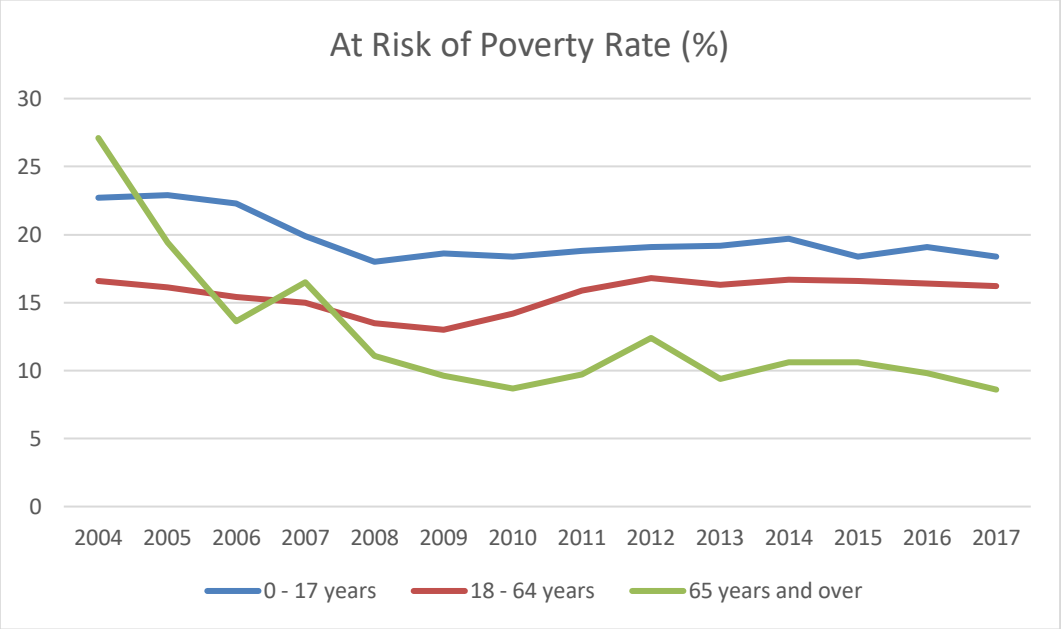
Prior to the introduction of the National Childcare Scheme in late 2019, there was a range of support offered to parents with young children. These supports are not all universal, as outlined above. Some are means-tested and designed for unemployed or inactive households. However, general support also exists. It should be noted that the main aim of the schemes and programmes is to provide children with quality care and to support families wishing to participate in the labour market.

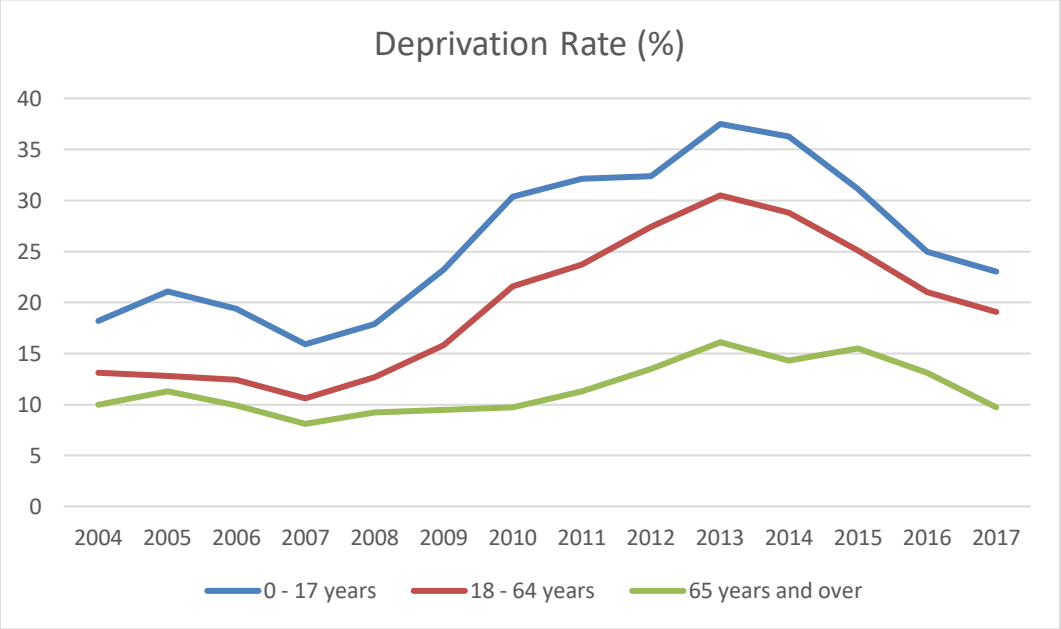
4.3 Child poverty

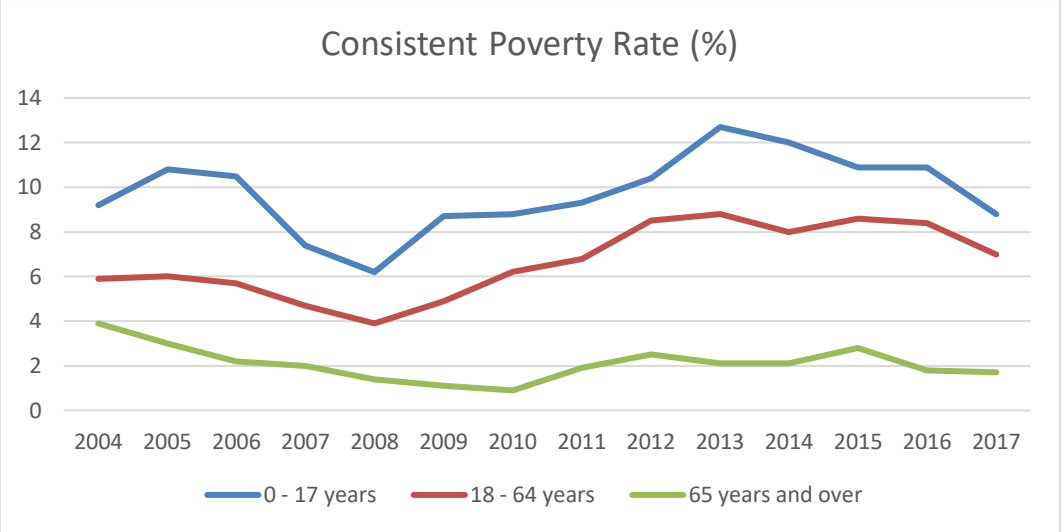
Recent figures from the CSO (2019) show that children aged under 18 years, are most likely to experience poverty compared to other broad age groups. We illustrate the trend in Figure 4.1.

Children's income poverty risk peaked between 2004 and 2005, before declining gradually but child poverty rates were still the highest across all age groups from 2005 onwards. The deprivation rate is different. For all age groups the rate rose from 2007 before peaking in 2013. It fell gradually after 2013 before levelling off in 2017. Once again, children experienced a consistently higher rate of deprivation than adults. Regarding consistent poverty, the rate began to rise from 2008 before peaking in 2013. Here too, the rate was highest among children in every year.

FIGURE 4.1: POVERTY OUTCOMES BY AGE GROUP, SILC (2004-2017)







Source: CSO Statbank [Downloaded 25th of November 2019]

Why do children live in higher rates of deprivation and poverty? While our aim here is not to explore this question, we can comment on previous findings involving children, maternal employment and deprivation. Part of the answer lies in mothers' restricted capacity to participate in employment due to demands of childcare in the context of unequal division of responsibility between parents and the high cost of childcare services. Further, unequal gender division of housework and caring responsibilities (children and/or adult dependent(s)) among couples and expensive childcare costs, place additional barriers to mothers' labour market participation (Russell et al., 2019, Privalko et al., 2019).

Many factors can influence a mother's return to work after a period of leave, from financial incentives to personal preferences, but age and the number of children in the home have a particularly strong and negative impact on mother's return to work (McGinnity et al., 2013). Mothers with an infant aged less than six months are less likely to be employed than women with older children. Further, mothers with infants who also live in larger households are less likely to use non-parental childcare (McGinnity et al., 2013). We therefore expect that mothers are more likely to provide parental childcare for young children compared to older children. This decision may increase the child's likelihood of experiencing deprivation.

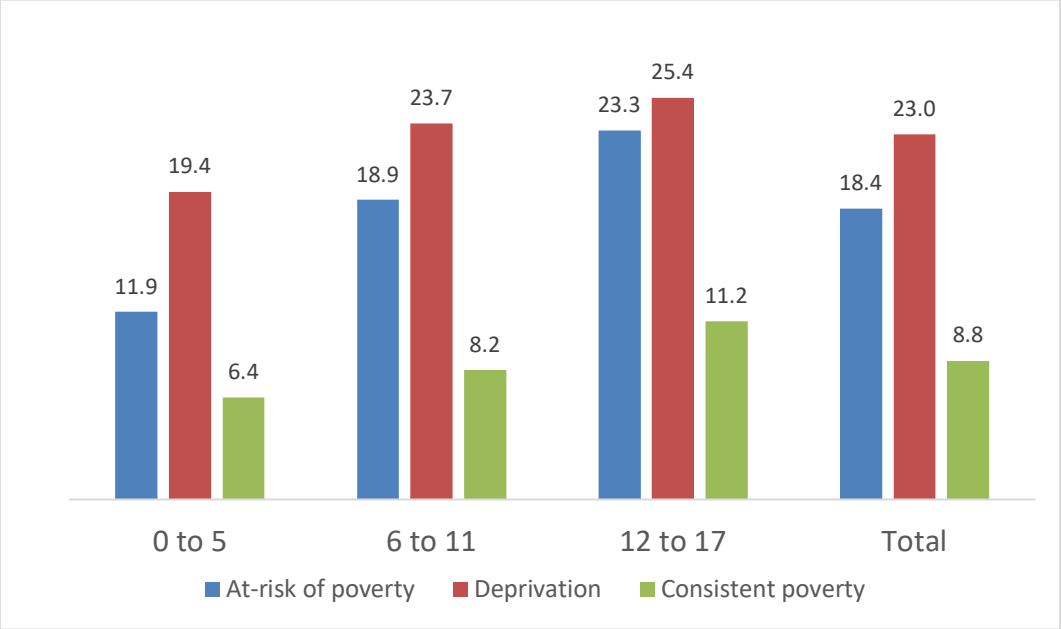
Figure 4.2 lists poverty outcomes by children's age. We broadly consider three main groups: those of pre-school age (0 to 5), those of primary school-age (6 to 11) and those of secondary school age (12 to 17). Figure 4.2 does not reflect the expectation above. In fact, for each of the three measures of poverty and deprivation, the youngest children have the lowest chance of disadvantage while older children have the highest chance of disadvantage. This pattern emerges for every measure of poverty and deprivation.

Poverty-risk increased over time from the youngest (12 per cent), to those aged six to 11 (19 per cent) and those aged 12 to 17 (23 per cent). The high rate of poverty-risk among older children could stem from the equivalence scale approach, where a child aged 14 and over receives the same weight as an adult (though the deprivation rate, which is not dependent on income, still shows a disadvantage for this group, relative to the other age groups).

The age gap is much less pronounced when looking at material deprivation. Here younger children (0-5) report a deprivation rate of 19 per cent, while those aged six to 11 and those aged 12 to 17 both report a rate of roughly 25 per cent. The sharpest difference between age groups emerges in the measure of consistent poverty, with young children citing 6 per cent and those aged 12 to 17 citing almost double the rate, 11 per cent which is due to higher at-risk-of poverty and deprivation rates for the latter age group.[25]

[25] For children aged up to five years old, poverty results broken down by age show that children aged 0-2 report higher at-risk of poverty and consistent poverty rates but lower deprivation rates than children aged 3-5.

FIGURE 4.2: POVERTY OUTCOMES BY AGE GROUP OF CHILDREN



Source: SILC 2017

4.4 Formal childcare usage

This section considers the SILC data for Ireland, describing who uses childcare services and the poverty and deprivation rates of these users.

4.4.1 Poverty and childcare usage

Access and use of formal childcare for young children depends on several factors, including the age of children, the presence of childcare facilities in their area, and the characteristics of these facilities (opening hours, availability, quality of service provided, etc.). It also depends on socio-demographic characteristics of the children's parents and their levels of entitlements (household income, number of parents or family members at work). Focusing on a broad age group of children, Privalko et al. (2019) show that vulnerable families in Ireland are more likely to report unmet need for formal childcare when compared to less vulnerable family types.[26] For example, the level of unmet need for formal childcare among lone parents in

[26] We used the same definition of formal childcare as done in Privalko et al. (2019) where formal childcare is the provision of childcare services at centre-based services, public or private.

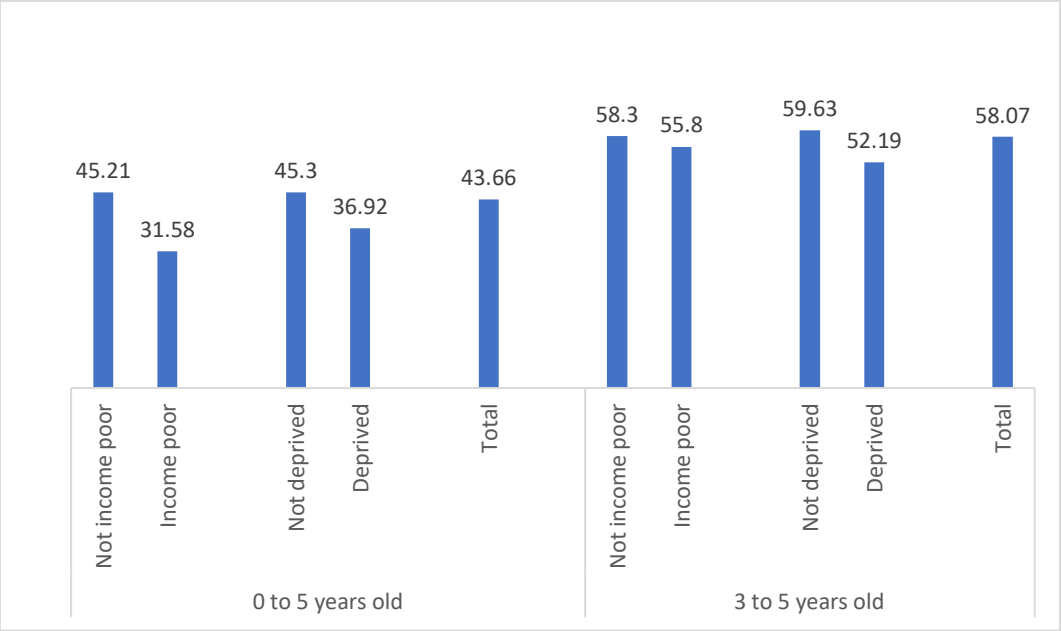
Ireland is 25 per cent compared to 13 per cent for families with two working age adults.

Figure 4.3 reports the percentage of households using formal childcare, split by different poverty types. This figure helps to compare vulnerable and non-vulnerable households in terms of access to childcare.[27] Overall, 44 per cent of children aged less than five years use formal childcare facilities. However, within this group, there are stark differences between deprived (37 per cent) and non-deprived households (45 per cent), and income poor (31 per cent) and non-income poor households (45 per cent) in their use of childcare services. Generally, children from poor households are less likely to use formal childcare when compared to non-poor households.

Crucially, this difference is reduced for children aged between three and five.[28] This age group is particularly important because the means-tested and universal childcare options noted above apply specifically to this group of children. As a result, we see an overall increase in childcare coverage in terms of the total rate, and a decline in inequality between deprived and non-deprived households. This emerges in Figure 4.3: more children are using formal childcare overall (58 per cent) and the social disparity between deprived and non-deprived children is now lower than it was for the overall category (children aged 0-5).

[27] The figure focuses only on households with children under the age of five.
[28] The number of cases of children aged under three who are either poor or deprived and using formal childcare is too small to report and therefore we cannot compare childcare use of children for this age group by poverty status.

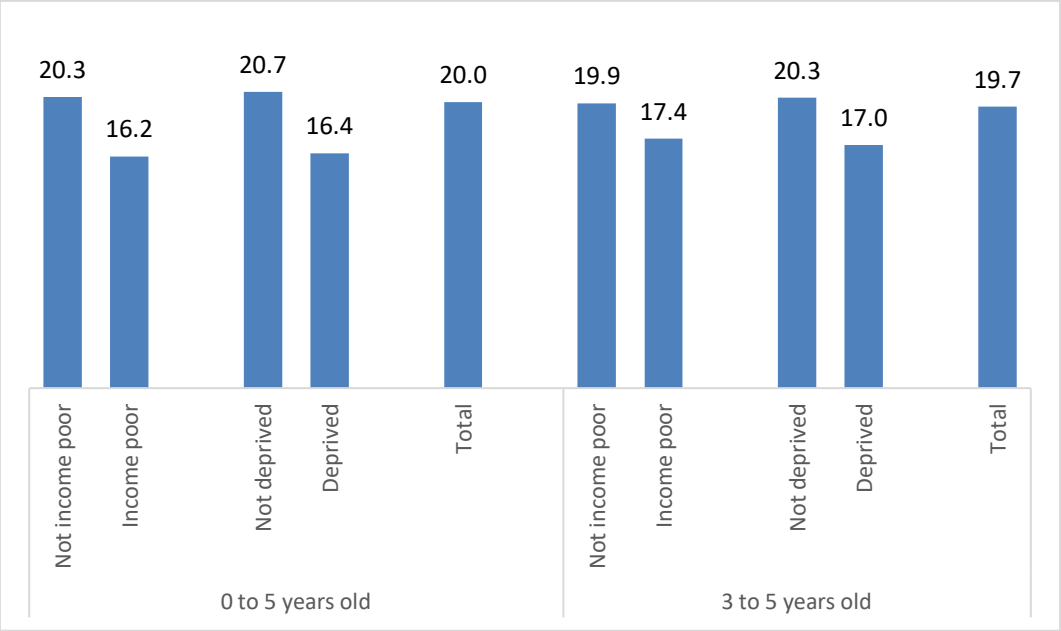
FIGURE 4.3: USE OF FORMAL CHILDCARE BY CHILDREN AGE AND BY POVERTY STATUS



Source: SILC 2017

Results from Figure 4.3 show that disadvantaged children use less formal childcare than non-disadvantaged children. However, it is also important to consider the duration of childcare services; inequality could also exist within groups that use childcare. Figure 4.4 reports the average number of hours spent in formal childcare by poverty status; this is further split by age of children. Overall, children aged 0 to 5 (who use formal childcare) spend on average 20 hours per week in childcare. However, there are significant differences in the duration of care used by poor (16 hours) and non-poor households (20 hours) who use childcare and deprived (16 hours) and non-deprived households (20 hours) who use childcare. As before, some of this gap closes when we consider children aged 3 to 5, due to the many childcare services which apply after the child turns three. However, even among these children, inequality in childcare persists somewhat.

FIGURE 4.4: MEAN WEEKLY NUMBER OF HOURS IN FORMAL CHILDCARE BY CHILDREN AGE AND BY POVERTY STATUS



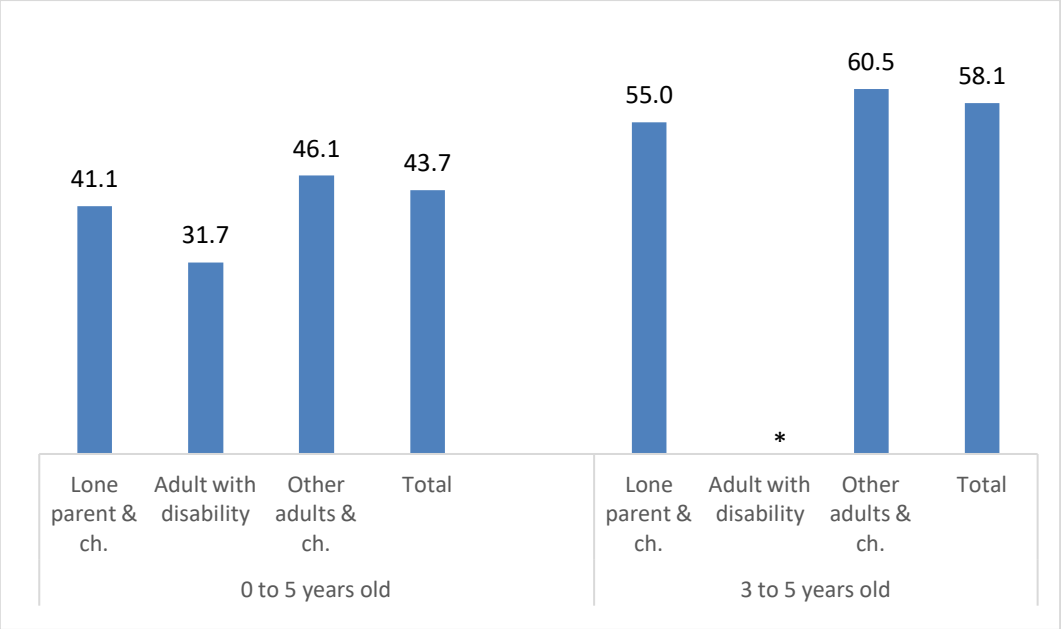
Source: SILC 2017

4.5 Social risk, social class and childcare usage

So far, we have shown that poor children have less access to childcare services than non-poor children. We have also shown that the duration of childcare differs between poor and non-poor children and households. This picture emerges too for deprived and non-deprived children or households. We now consider social risk and social class differences as possible explanations for these effects. Figure 4.5 shows that 44 per cent of children aged between 0 and 5 use formal childcare services. However, splitting this group by social risk reveals significant differences, with lone parents (41 per cent), and adults with a disability (31 per cent) reporting lower use of formal childcare than working age adults with children (46 per cent). If we consider children aged three to five, we see a general increase in overall childcare and more equality between risk groups in their levels of access, relative to "other adults" (working age adults who are not lone parents and who do not have a disability in the home). The overall increase for this narrower age group is probably due to the use of the ECCE scheme. However, it is also important to note that inequality between groups exists even here, although

it is significantly less prevalent than among all children under the age of five.

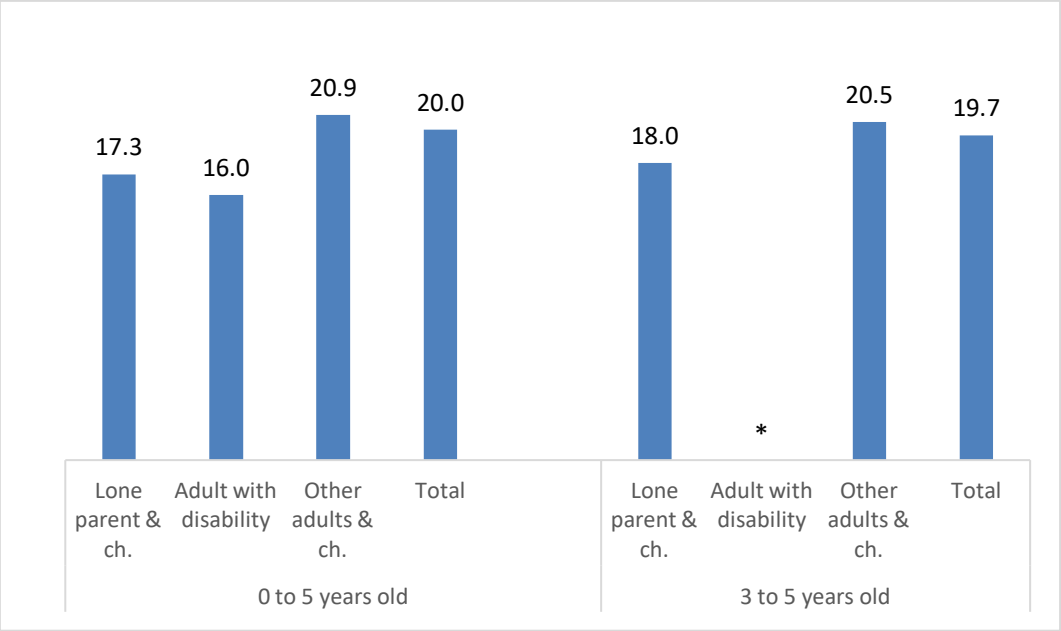
FIGURE 4.5: USE OF FORMAL CHILDCARE BY CHILDREN AGE AND BY SOCIAL RISK



Source: SILC (2017)
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 should also consider the duration of childcare among respondents with access (Figure 4.6). Children aged 0 to five from households with two working age adults (other adults and children) spend more time in childcare with almost 21 hours on average. Lone parents using formal childcare receive less care on average (17 hours), as do households with a disability (16 hours). Surprisingly, Figure 4.6 reveals that children aged three to five receive similar hours of care when compared to the overall distribution of care hours.

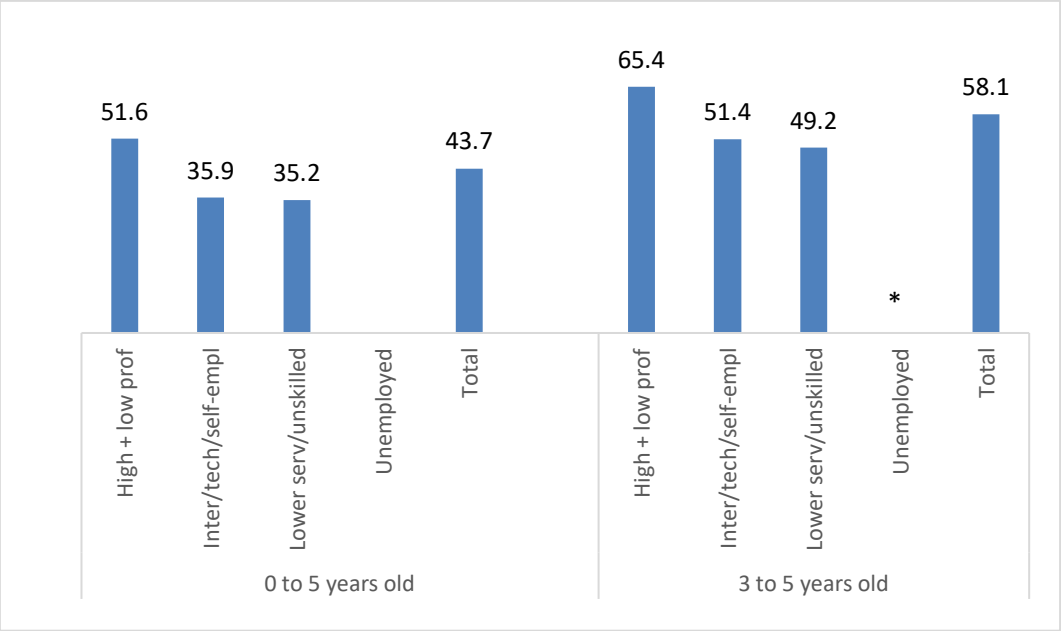
FIGURE 4.6: MEAN WEEKLY HOURS IN FORMAL CHILDCARE BY CHILDREN'S AGE AND BY SOCIAL RISK



Source: SILC (2017)
Note: The sample size for children aged 3 to 5 in families with a person with a disability is too small to be reported.

If we substitute social class for social risk categories, a similar difference emerges in terms of access to childcare services. Figure 4.7 lists the average use of formal childcare by social class, highlighting that higher social class groups (51 per cent) have the greatest level of access when compared to middle (35 per cent) and lower social class groups (35 per cent). If we limit our sample to households with children aged three to five, we again see an increase in the use of formal childcare across children, and a closure of the gap between classes. Among these households, higher social class groups (65 per cent) still have more access than middle (51 per cent) and lower-class groups (49 per cent), but this difference is now smaller.

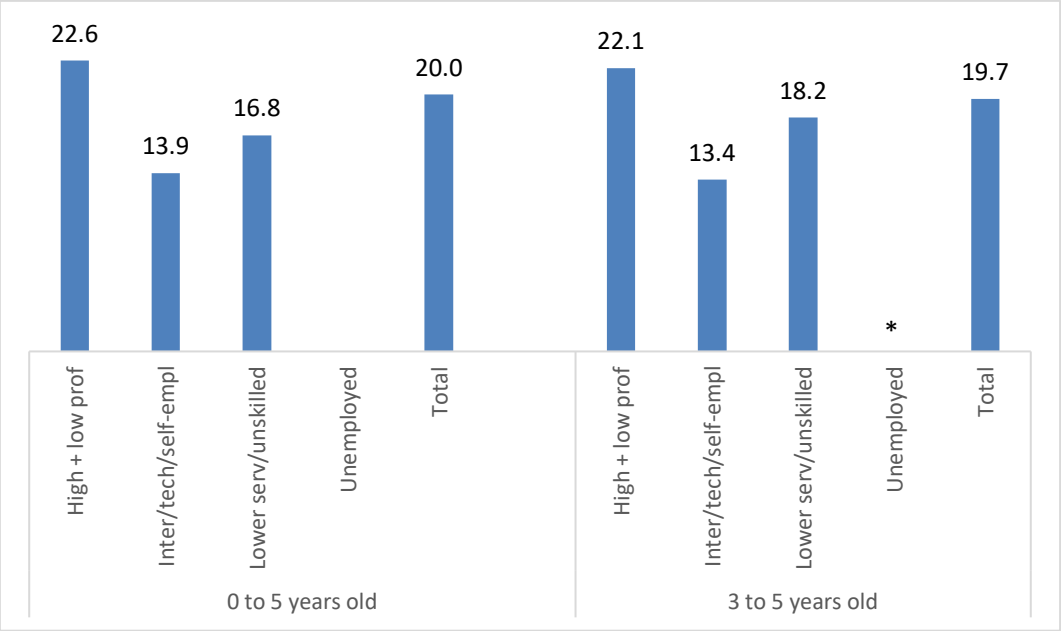
FIGURE 4.7: USE OF FORMAL CHILDCARE BY CHILDREN AGE AND BY SOCIAL CLASS



Source: SILC (2017)
Note: The sample size for children aged three to five in unemployed social class is too small to be reported.

As before, we can consider differences in hours of care, among respondents who use childcare services. Here too, higher social class households (22 hours) secure more care than middle (13 hours) and lower social class groups (16 hours). As before, this difference remains unchanged for households with children aged between three and five years, where the duration of care is near identical.

FIGURE 4.8: MEAN WEEKLY NUMBER OF HOURS IN FORMAL CHILDCARE BY CHILDREN AGE AND BY SOCIAL CLASS



Source: SILC (2017)
Note: The sample size for children aged three to five in unemployed social class is too small to be reported.

4.6 Estimating the value of childcare support

Many of the vulnerable groups above receive transfers to cover childcare costs, this section attempts to value these transfers. Starting with the overall, universal entitlements, children aged three to five were entitled to the ECCE scheme, where they could receive up to 15 weekly hours of free care. These schemes were available in 2017. Additional hours of care, beyond this 15-hour limit, are subject to childcare subsidies. On behalf of the DYCA, Pobal pays the registered childcare provider a capitation fee of €64.50 per week per child registered under the ECCE.

Also, families with children outside the eligible age for the ECCE but who are attending childcare facilities such as pre- or after-school care, may also be eligible for means tested hourly subsidies.

It is important to note while the fees paid by Pobal to the childcare providers are the same across the country, there are large variations in the fees charged by the childcare providers between and within counties, leading to

differences in out of pocket payments made by parents (Pobal,2018).

We also use the ESRI's SWITCH (Simulating Welfare Income Tax Childcare and Health) model to simulate a cash value of subsidies available to families entitled to care under the Affordable Childcare Scheme. The first payments in this scheme were made in 2019 but we are interested in the impact of this scheme on deprivation had the scheme been made available in 2017 as announced in Budget 2017. The simulations are based on the version of the scheme that was described in DCEDIY documentation in 2017 (DCYA, 2016) and that families would have been entitled to if the scheme had been introduced at the time. SWITCH simulates the full set of tax-benefit parameters that were in place in 2017. These simulated income sources are then used to calculate means using the means testing rules underlying the National Childcare Scheme. The entitlement and amount of subsidies available to families with children are based on the parental labour force status, the household income, the age of the child, the educational enrolment status of the child and the childcare usage. These are calculated at the individual level for each family. However, the SWITCH model is currently based off a pooled sample of 2013, 2014 and 2015 waves of SILC. As such, we do not directly observe the subsidy entitlement for families in 2017 SILC. Instead, we impute the average value of hourly subsidy rates for families in 2017 SILC by using average subsidy rates based on family level disposable income from the outputs produced by SWITCH. [29] These nominal 2017 rates are shown in Table 4.2.

We then multiply these rates by the number of hours of childcare usage reported by households in the 2017 SILC dataset. This captures current patterns of childcare usage in Ireland.[30]

[29] Detailed description of the SWITCH simulation of the subsidies is available in DCEDIY (2017).
[30] An alternative model procedure would be to impute average weekly values directly from SWITCH. This method relies on childcare usage patterns from 2013 to 2015, which likely underestimates recent changes in demand for childcare, given the sharp change in employment since the 2008 Great Recession.

TABLE 4.2: MAXIMUM HOURLY SUBSIDIES IN 2017

Category	SHS/EHS*
Hourly rate for a child under 1 year	**€5.11**
Hourly rate for a child aged 1 year	**€4.37**
Hourly rate for a child aged 2 years	**€4.18**
Hourly rate for a child aged 3-5 years and not in school	**€3.95**
Hourly rate for children of primary school-age	**€3.76**
Hourly rate for children of secondary school-age	**€3.76**

Source: DYCA (2017) from SWITCH
Note: * Standard Hours Subsidy (SHS) are subsidised hours when at least one parent is not at work/education and Enhanced Hours Subsidy (EHS) when both parents (and only parent) are in work/education.

Based on these rates and on the average number of hours children (up to the age of 13) spend in formal childcare, Table 4.3 reports the corresponding estimate of childcare subsidies (ECCE and hourly subsidies) across social risk and social class groups. As mentioned previously, these are imputed values based on reported hours of usage.

TABLE 4.3: MEAN HOURS OF FORMAL CHILDCARE AND ANNUAL EQUIVALENT CHILDCARE SUBSIDIES BY SOCIAL RISK AND SOCIAL CLASS HOUSEHOLDS

GROUPS	Mean weekly hours formal childcare (children aged 0-12 years)	Mean annual childcare subsidies
Social risk		
Lone parent and children	19.8	€3,244
Adult with a disability and children	*	*
Other adults and children	23.3	€1,357
Social class		
High & lower professional	25.6	€1,076
Inter/tech/self-employed	16.1	€2,180
Lower service/unskilled manual	17.9	€2,447
Never worked/unemployed	*	*
Total	**22.4**	**€1,638**

Source: SILC (2017)
Note: We are unable to list values for households with a disability and households who are unemployed due to CSO guidelines about the minimum number of cases required. However, because in the modelling simulation below we use equivalised household income across all individuals we have enough cases to use the values that are not shown in Table 4.3.

Having imputed these values in the data, we can consider their impact on measures of deprivation for families.

4.7 Reduction effect of childcare support on material deprivation

In Chapter 1 we presented the ordered logistic regression model to predict level of deprivation across social risk and social class groups. This section uses the same methodology as in Chapter 2 to predict deprivation with a score ranging from 0 items (no deprivation) to a maximum of 11 items (deprived on all items) controlling for a range of individual and household socio-economic characteristics. We predict group differences in the

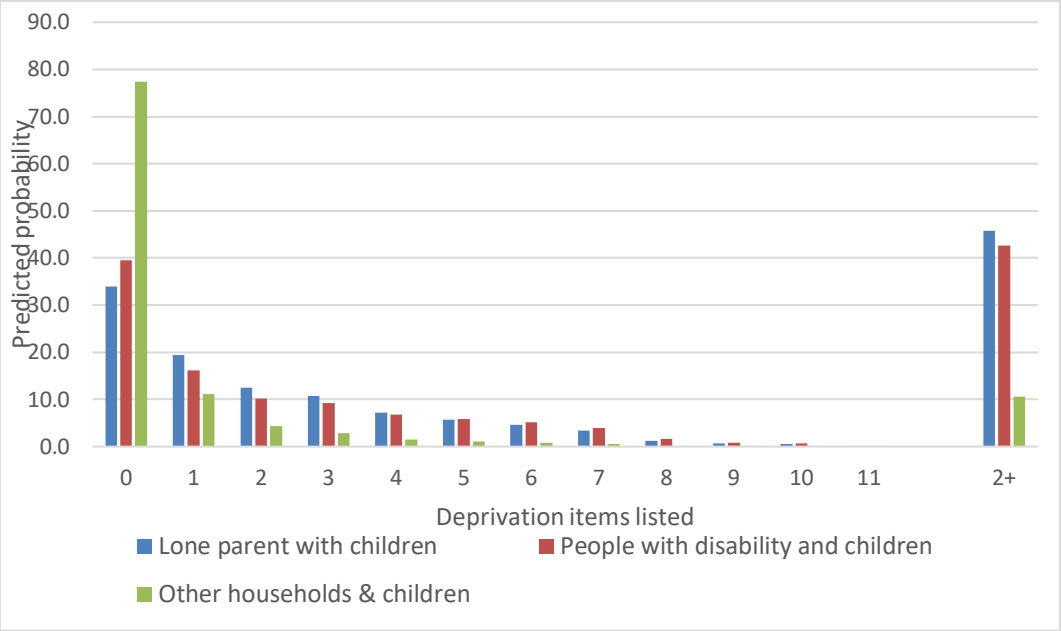
probability of citing each item of deprivation from 0 (not deprived) to 11 (deprived on all items) for people in receipt of childcare support.

In Figure 4.9 we report the predicted probabilities of experiencing different level of deprivation (from 0 to 11 items) as well as experiencing basic deprivation (score of at least two items) controlling for socio-economic and household characteristics as shown above.[31]

Thinking first of the social risk groups, other working-age households with children (other adults) have the highest predicted probability of citing “no deprivation” (77 per cent). In contrast, lone parent households have a far lower predicted probability of citing “no deprivation” (below 34 per cent) as do families with a person with a disability (below 40 per cent). There is then a downward trend as we move to cumulatively higher levels of deprivation. Here, deprivation is higher for lone parents and families with a person with a disability, while it is almost non-existent for other working age households (other households). This is especially true after three items. The final bars on the right side of the chart shows the predicted probabilities of experiencing basic deprivation (two+ items) with very little difference between lone parent households and families with a person with a disability, respectively at 46 per cent and 43 per cent while it is only 11 per cent for other households with children (working-age adults).

[31] The predicated probabilities for experiencing basic deprivation (at least two items out of 11 items) are drawn from a logistic regression available in the Appendix (Table A.1).

FIGURE 4.9: PREDICTED PROBABILITIES ON DEPRIVATION LEVEL BY SOCIAL RISK GROUPS, SILC 2017



Source: SILC (2017). Authors' calculations. Households with children in formal childcare

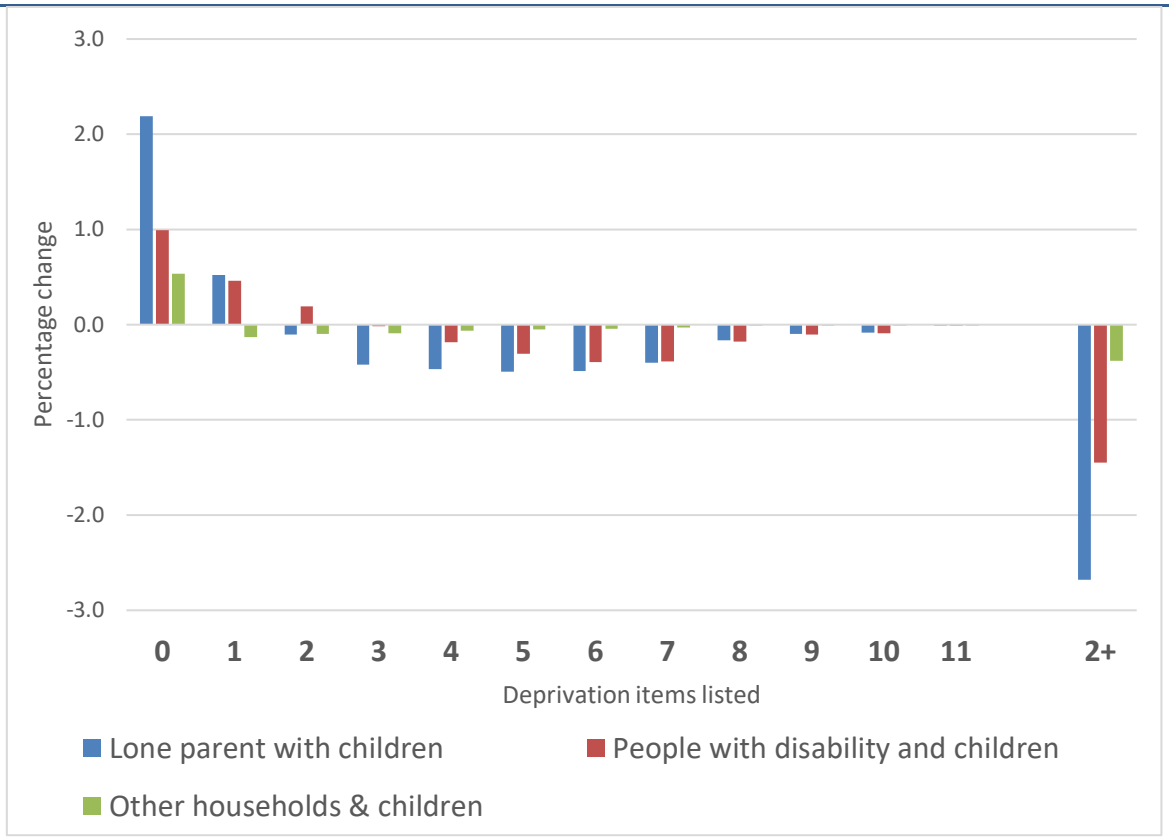
We now consider the effects of childcare transfers in limiting deprivation. We do this in two steps. First, following the ordered logistic regression, we predict the probability of experiencing different levels of deprivation (as shown in Figure 4.9). Second, we add the equivalent childcare subsidy to our current measure of household income and run the prediction a second time. We then compare both sets of predicted probabilities and report the change.

Figure 4.10 shows that the cash value of childcare support would likely increase the odds of experiencing 0 deprivation for lone parents (2.2 percentage points) and households with a disability (one percentage point). There is also an increase in the predicted probability of experiencing one deprivation item only, which adds up to approximately half of a percentage point for lone parents and households with a person with a disability. As we move along higher deprivation levels, the percentage of vulnerable households experiencing deprivation is reduced slightly (the change becomes negative) and the relative larger reduction occurs at about three to six deprivation items before fading away. This result suggests that those with

a high score of deprivation (over the top-half of the distribution) only experience a slight improvement in their level of deprivation. For these families, this could mean that their level of deprivation is so high that the equivalent subsidies of childcare support are not large enough to improve their economic circumstances. There is also no improvement for other households and children at all deprivation levels.

Looking at the measure of basic deprivation (deprived on at least two items) on the right side of the chart, the percentage of lone parents and families with a person with a disability experiencing basic deprivation is being reduced respectively by almost three percentage points and one and a half of a percentage point but with almost no effect for other households with children. The effect is greatest for lone-parent households.

FIGURE 4.10: CHANGE IN PREDICTED PROBABILITIES ON DEPRIVATION LEVEL BY SOCIAL RISK GROUPS



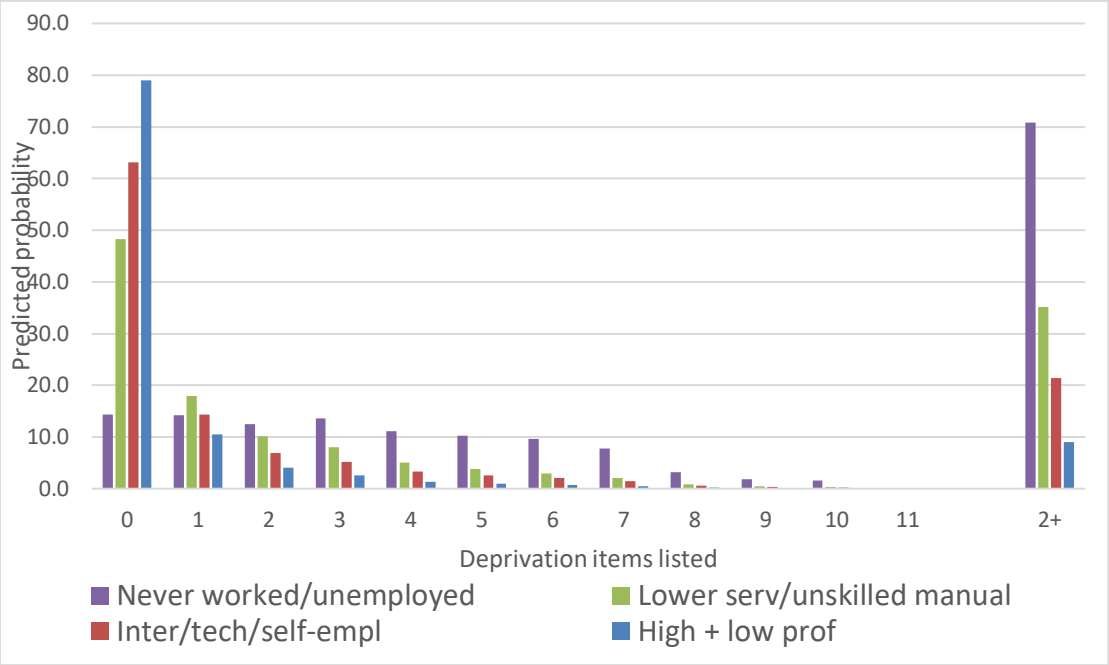
Source: SILC (2017). Authors' calculations. Households with children in formal childcare

Figure 4.11 presents the predicted probabilities of experiencing different

levels of deprivation and basic deprivation across social class groups. There is a very strong social class pattern in the risk of deprivation. Starting with having no deprivation at all, there is a strong contrast between the most disadvantaged group of the never worked/unemployed group and the other groups. Indeed, while only 14 per cent of the never worked/unemployed group have no deprivation at all, it increases to 48 per cent for the lower services, 63 per cent for the inter/tech and 79 per cent for the high social class group. There is thus very little difference in the probability of being deprived on one item only between the bottom three social classes with values ranging between 14 per cent and 18 per cent. As we move then along higher levels of deprivation, all social class groups are reporting decreasing probabilities of deprivation except for the never worked/unemployed group and it is only from four to five items and over that their probability decreases.

As a result, this sharp social class differentiation appears in the probability of experiencing basic deprivation (lacking at least two items) presented in the right part of the chart. The risk is 71 per cent for the never worked/ unemployed, 35 per cent for the lower services, 21 per cent for the intermediate/technician and a low of nine per cent for the high professional social class.

FIGURE 4.11: PREDICTED PROBABILITIES ON DEPRIVATION LEVEL BY SOCIAL CLASS



Source: SILC (2017). Authors' calculations

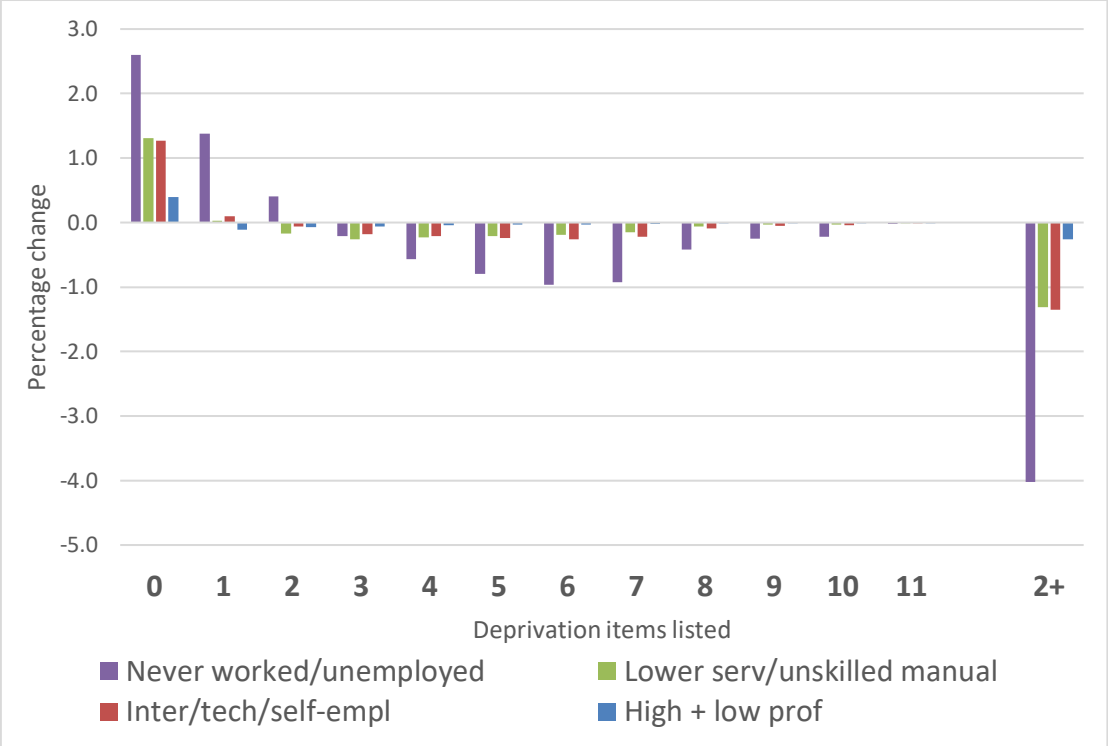
After having imputed a corresponding value for childcare support, we report in Figure 4.12 the changes in the predicted probabilities for each level of deprivation as well as for experiencing basic deprivation across social classes. The mean cash values of childcare support shown in Table 4.3 suggest that we might expect a greater effect on deprivation for the lower social classes. Looking at the effect in the probability of experiencing no deprivation, the never worked/unemployed class has the largest increase with 1.5 percentage point, followed by the lower services at 0.6 percentage point and then the inter/tech at almost half a percentage point. There is also an increase of 0.6 percentage point in the probability of experiencing one deprivation item for the never worked/unemployed but no increase for the other classes. Most of the reduction for the bottom three classes happens at three to six/seven items but mostly for the never worked/unemployed group. Overall, the higher social class group does not benefit from any reduction in deprivation though being relatively quite low originally.

Focusing on the measure of basic deprivation (two+ items) on the right-hand

side of the chart, the never worked/unemployed group experiences the largest reduction of deprivation. This group has a fall of 4 percentage points and it is around 1.3 percentage point for the next two social classes but there is no reduction for the better-off social class.

These results suggest that the most disadvantaged social class group benefits the most in the reduction of deprivation once we take account of the cash equivalent attached to the provision of childcare support, but their level of deprivation still stays extremely high.

FIGURE 4.12: CHANGE IN PREDICTED PROBABILITIES ON DEPRIVATION LEVEL BY SOCIAL CLASS



Source: SILC (2017). Authors' calculations

4.8 Summary

This chapter considered childcare supports and their impact on material deprivation. Ireland has produced several schemes aimed at aiding families with young children, some of these are universal in that they focus on all families with children under five years of age, others are aimed specifically at

vulnerable groups which likely need additional assistance from the state. We find that differences in deprivation tied to social risk and social class can be explained by differences in income, debt, and other resources, as well as household composition and the number of children in the home.

Crucially, we find that social risk groups with young children are the most likely to cite deprivation in the home. Although we find that the cash equivalent of childcare supports has a minor effect on deprivation, we note that vulnerable groups experience the largest deprivation-reduction derived from these supports when compared to other working-age adults with children under five. This result also emerges for social class groups, especially the unemployed. While there are class differences in material deprivation, the benefits of childcare supports are particularly pronounced among unemployed and lower social class groups.

Chapter 5

Cumulative effect of tied transfers

This chapter considers the three tied supports and transfer types together to capture their cumulative effect. We consider how the three benefits are distributed and what their impact on deprivation is. We also consider the social risk and social class differences of these.

5.1 Distribution of receipt of tied transfers and non-cash benefits

Notten (2015) notes that Ireland's benefits are especially common, with coverage of 70 per cent. We find a similar rate in Table 5.1, with just 31 per cent of households not receiving any of the transfers or schemes mentioned. Most households receive one transfer (44 per cent), with a minority receiving two or more (25 per cent). A very small portion of respondents receive each of the three transfers, which is highly uncommon.

TABLE 5.1: PORTION OF RECIPIENTS BY NUMBER OF TIED SCHEMES RECEIVED (%), 2017

Number of schemes received	% of households
0	31.0
1	44.3
2	22.1
3	2.6
Total	100.0

Source: SILC (2017). Authors' calculations

There are important differences between social risk groups in the use of schemes (Table 5.2). Most lone-parent households rely on two schemes or more (48 per cent), and only a minority of lone parents do not access a scheme at all (16 per cent). For households with a disability, a majority access one scheme (40 per cent), although a significant portion of households rely on two or more schemes (38 per cent); as before, only a minority of homes with a disability do not take a scheme or transfer.

This pattern is reversed when we consider working-age households (Other adults and children). Here, most households do not receive any transfer or scheme (40 per cent), and few receive more than one scheme (23 per cent). However, households with older adults (Other over 65) again contain a majority reliant on one scheme (69 per cent) and a minority reliant on more than one scheme (23 per cent). In short, the distribution of schemes seems to depend on the social risk group of the household.

TABLE 5.2: NUMBER OF SCHEMES RECEIVED BY SOCIAL RISK GROUP (%)

Social risk groups	0	1	2+	Total
Lone parent & children	16.4	34.8	48.8	100
Adult with disability & children	21.2	40.0	38.7	100
Other adults & children	40.4	36.5	23.2	100
Other over 65	17.7	69.7	12.6	100
Overall population	31.0	44.3	24.7	100

Source: SILC (2017). Authors' calculations

We find similar patterns when we consider social class. High social class groups are split by those who receive no transfer or scheme and those who receive just one transfers or scheme (39 per cent). A minority receive two or more schemes (21 per cent). Intermediate or middle-class groups are more reliant on schemes, with a majority claiming just one scheme (45 per cent) and a minority claiming two or more schemes.

The latter two class groups are far more dependent on the transfers and subsidies compared to the higher groups. Lowest social class groups mostly rely on at least one scheme (50 per cent), and a minority rely on none of them (18 per cent). The unemployed social class also resemble this pattern with 52 per cent using one scheme and 17 per cent using none.

TABLE 5.3: NUMBER OF SCHEMES RECEIVED BY SOCIAL CLASS (%)

Social risk groups	0	1	2+	Total
High + low prof	39.3	39.4	21.3	100
Inter/tech/self-empl	34.2	45.2	20.6	100
Lower serv/unskilled	17.8	49.9	32.2	100
Unemployed/never worked	16.8	51.7	31.6	100
Overall population	31.0	44.3	24.7	100

Source: SILC (2017). Authors' calculations

Regarding households who receive two or more schemes or transfers, we find that most of these households rely on a combination of housing payments and medical cards or GP visit cards. The other permutations are less common (Table 5.4).

TABLE 5.4: NUMBER OF SCHEMES RECEIVED BY TYPE OF SCHEME RECEIVED (%)

Number of schemes received	Schemes received	% of households
0	None	31.0
1	Housing OR medical/GP card OR childcare support	44.3
2	Housing AND medical/GP card	16.9
	Medical/GP card AND childcare support	4.3
	Housing AND childcare support	0.9
3	Housing AND medical/GP card AND childcare support	2.6
	Total	100.0

Source: SILC (2017). Authors' calculations

These differences can be further split by social risk and social class. Table 5.5 shows that social risk groups differ in terms of their most common choice. Vulnerable social risk groups are more likely to use a housing related transfer and a medical card or GP visit card, while working-age adults use neither scheme. Older households typically use just one scheme or transfer.

TABLE 5.5: TIED TRANSFERS RECEIVED BY SOCIAL RISK GROUP, HOUSEHOLDS (%)

	Lone parent & children	Adult with disability & children	Other adults & children	Other over 65
None	16.4	21.2	40.4	17.7
Housing OR medical/GP card OR childcare support	34.8	40.0	36.5	69.7
Housing AND medical/GP card	34.9	34.2	12.5	12.4
Housing AND childcare support	*	*	1.5	*
Medical/GP card AND childcare support	*	*	6.3	*
Housing AND medical/GP card AND childcare support	*	*	2.9	*
Total	100	100	100	100

Source: SILC (2017). CSO rules prevent us from reporting on categories with few observations. These are marked with a star [*] symbol

Table 5.6 suggests a similar relationship emerges for social class groups, where the more vulnerable groups are more likely to rely on both the housing transfer and the medical card or GP card service.

TABLE 5.6: TRANSFERS RECEIVED BY SOCIAL CLASS GROUP, HOUSEHOLDS (%)

	High + low prof	Inter/tech/ self-empl	Lower serv/ unskilled	Unemployed/ never worked
None	39.3	34.2	17.8	16.8
Housing OR medical/ GP card OR childcare support	39.4	45.2	49.9	51.7
Housing AND medical/GP card	11.1	14.6	26.2	26.2
Housing AND childcare support	*	*	*	*
Medical/GP card AND childcare support	5.8	3.9	*	*
Housing AND medical/GP card AND childcare support	*	*	2.9	*
Total	100	100	100	100

Source: SILC (2017). CSO rules prevent us from reporting on categories with few observations. These are marked with a star [*] symbol

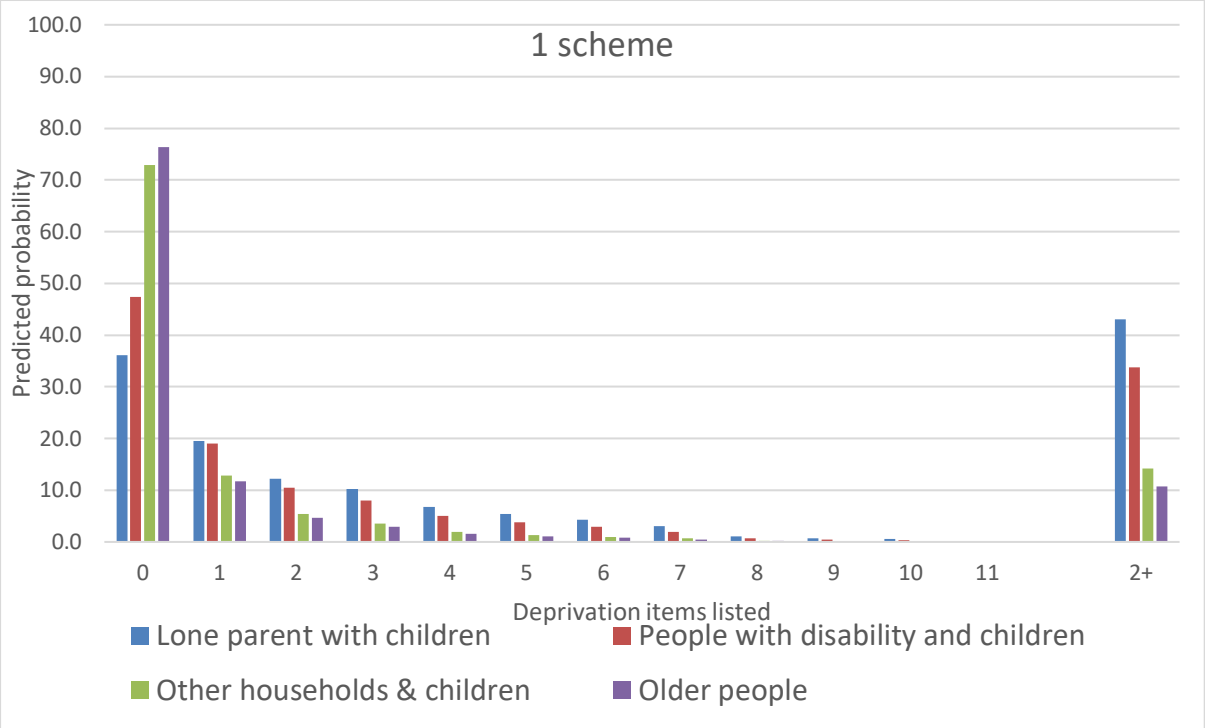
As in the previous chapters, we turn to differences in deprivation between those receiving transfers and those not in receipt of transfers. However, in this section we are particularly interested in the difference in deprivation between those receiving no transfers, those receiving one, and those receiving multiple transfers.

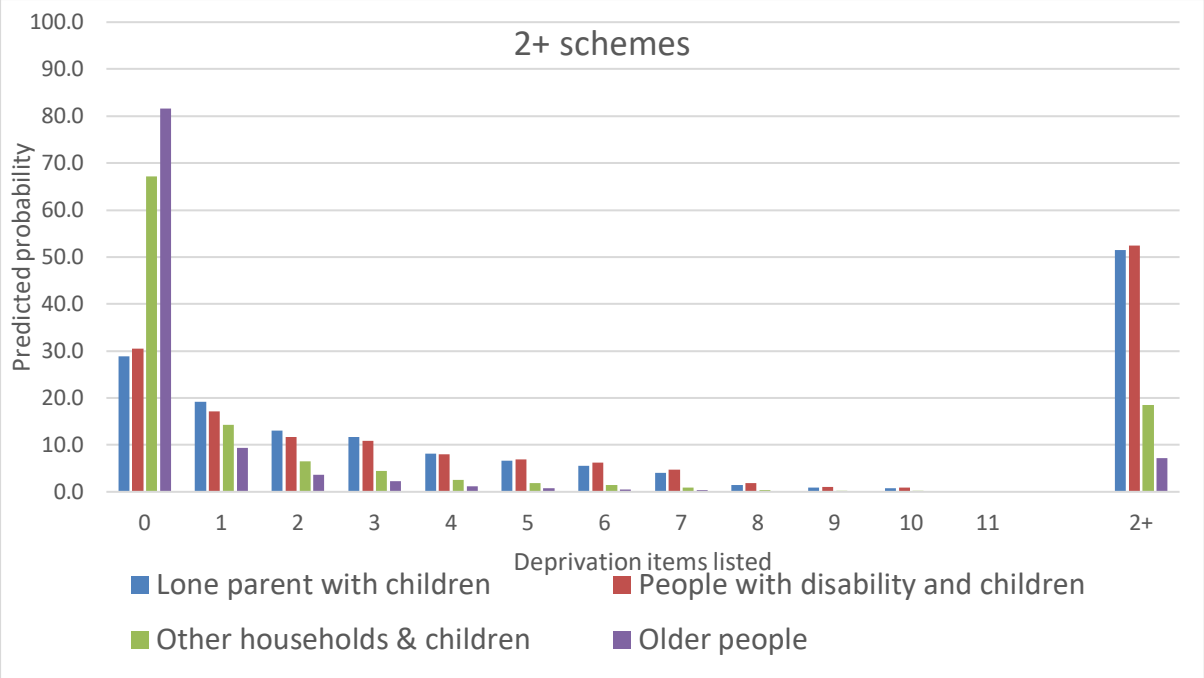
From the model presented in Chapter 1, we consider the predicted probability of each value of deprivation for households receiving one scheme and two schemes or more separately. To make these differences more apparent, we fix the *y*-scale to a value of 100.

We first consider social risk groups receiving one transfer or supplement, finding that lone parents and households with a disability are the most likely to experience deprivation. Most advantaged groups are typically unlikely to

cite a deprivation. However, among respondents receiving two or more transfers, we find that predicted probabilities of having no deprivation are smaller, suggesting these households see more deprivation than their counterparts receiving only one scheme. For example, half of children in lone-parent households and those in a household with a person with a disability lack at least two items, while it is 43 percent and 34 percent respectively for their counterparts in receipt of one scheme. Older respondents who receive two schemes are the least likely to experience deprivation.

FIGURE 5.1: PREDICTED PROBABILITIES ON DEPRIVATION LEVEL BY NUMBER OF SCHEMES RECEIVED BY SOCIAL RISK GROUPS (%)

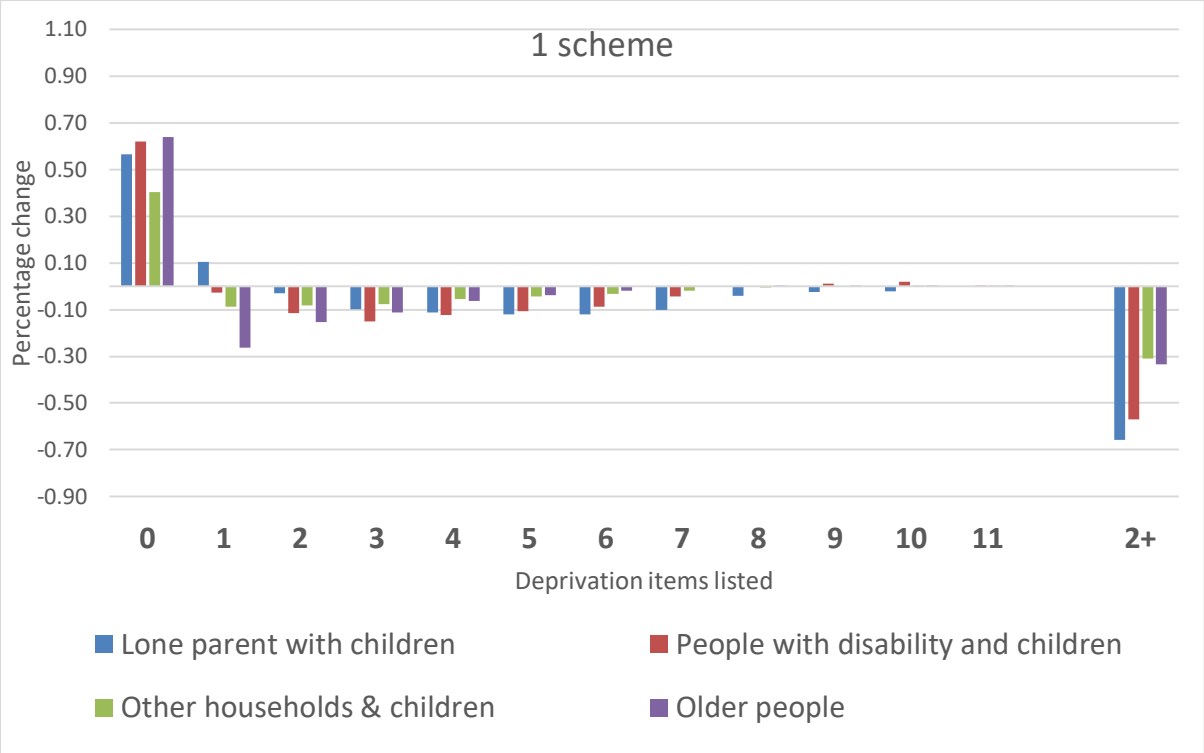


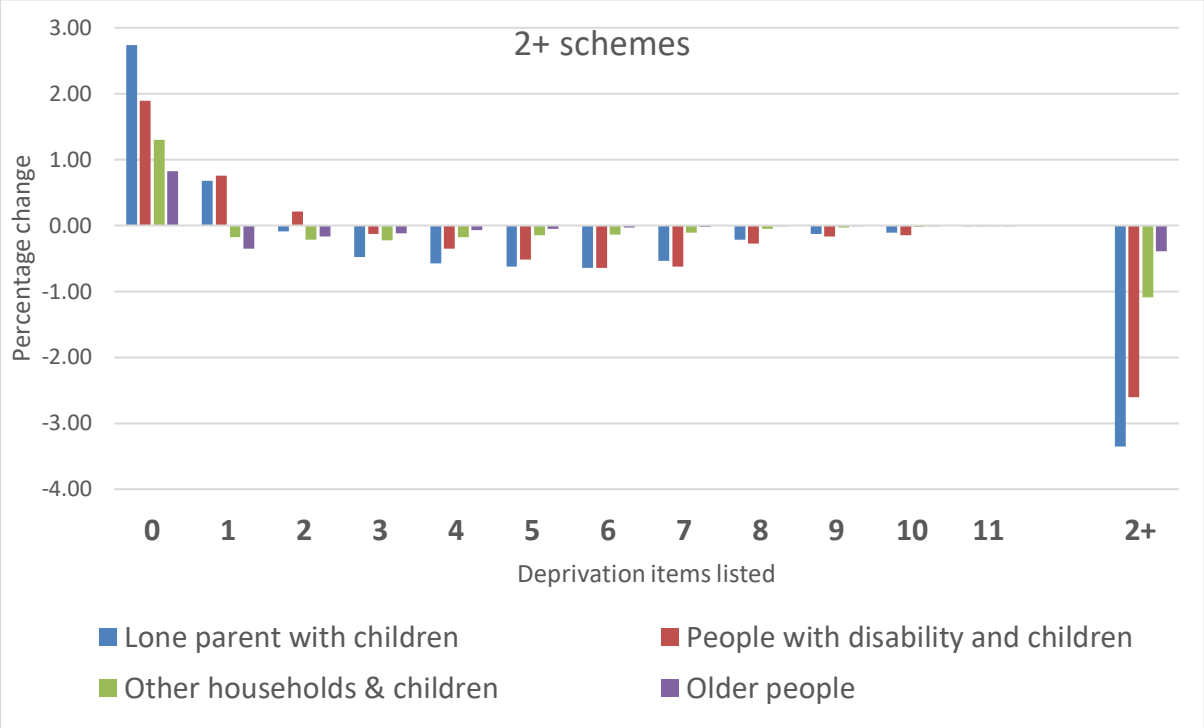


Source: SILC (2017). Authors' calculations

When simulating the effects of transfers, we note two separate patterns for those receiving one transfer. Among households receiving one transfer, each social risk group experiences a minor increase in their predicted probability of citing no deprivation, on average (less than 0.7 percentage point). However, among households receiving two transfers or more, we note that transfers have a far larger effect, and that vulnerable social risk groups benefit the most from these transfers. Indeed, there is a reduction of just above three percentage points of children in lone parent households lacking at least two items, and less than three percentage points for children in a household with a person with a disability. This could be due to a size effect with the number of schemes they receive or that they receive the most beneficial schemes.

FIGURE 5.2: CHANGE IN PREDICTED PROBABILITIES OF DEPRIVATION BY NUMBER OF SCHEMES RECEIVED BY SOCIAL RISK GROUPS (% POINTS)





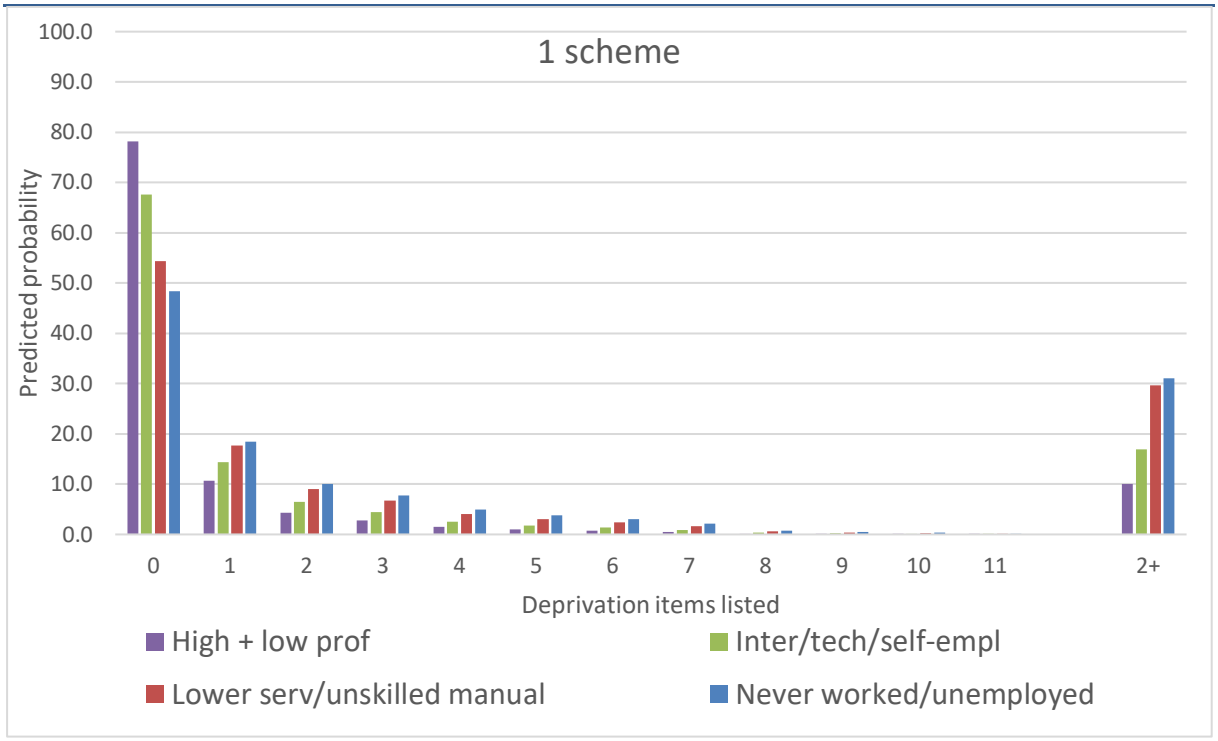
Source: SILC (2017). Authors' calculations

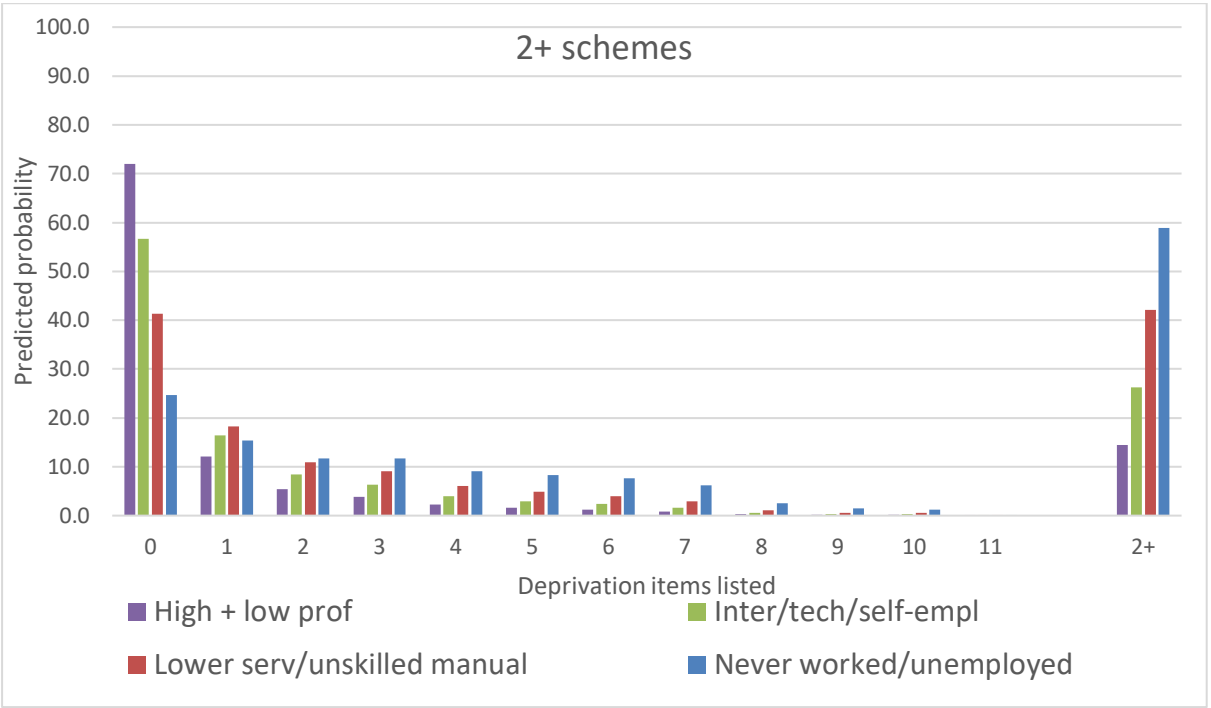
We can take a similar approach for social class groups, taking the predicted probability of each value of deprivation. We consider respondents receiving one scheme and two schemes separately. To make these differences more apparent, we fix the *y*-scale to a value of 100.

Those receiving one scheme are more likely to cite no deprivation than those receiving two or more schemes, and the difference is particularly large for the never worked/unemployed group. Within each category, however, higher social class groups are the least likely to cite deprivation and gradually this rate declines between class groups. The majority of those who are in the unemployed category cite one or more deprivation items. This is not the case with the other class groups, where the majority experience no deprivation.

Among those who receive two or more transfers, higher social class and middle social class groups have a majority where citing no deprivation whatsoever. The two lower social class groups have a majority that cites at least one level of deprivation. This is especially true for the unemployed social class group, where the majority is in deprivation (almost 60 per cent cites two or more deprivation items).

FIGURE 5.3: PREDICTED PROBABILITIES ON DEPRIVATION LEVEL BY NUMBER OF SCHEMES RECEIVED BY SOCIAL CLASS (%)



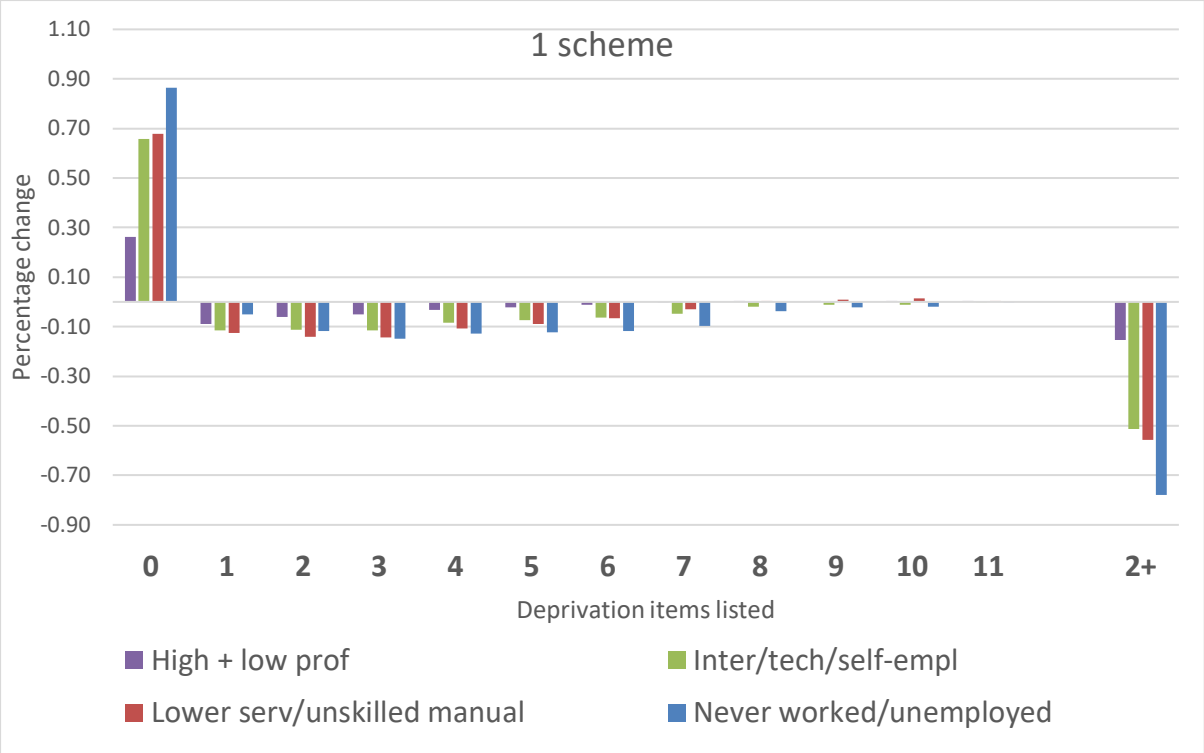


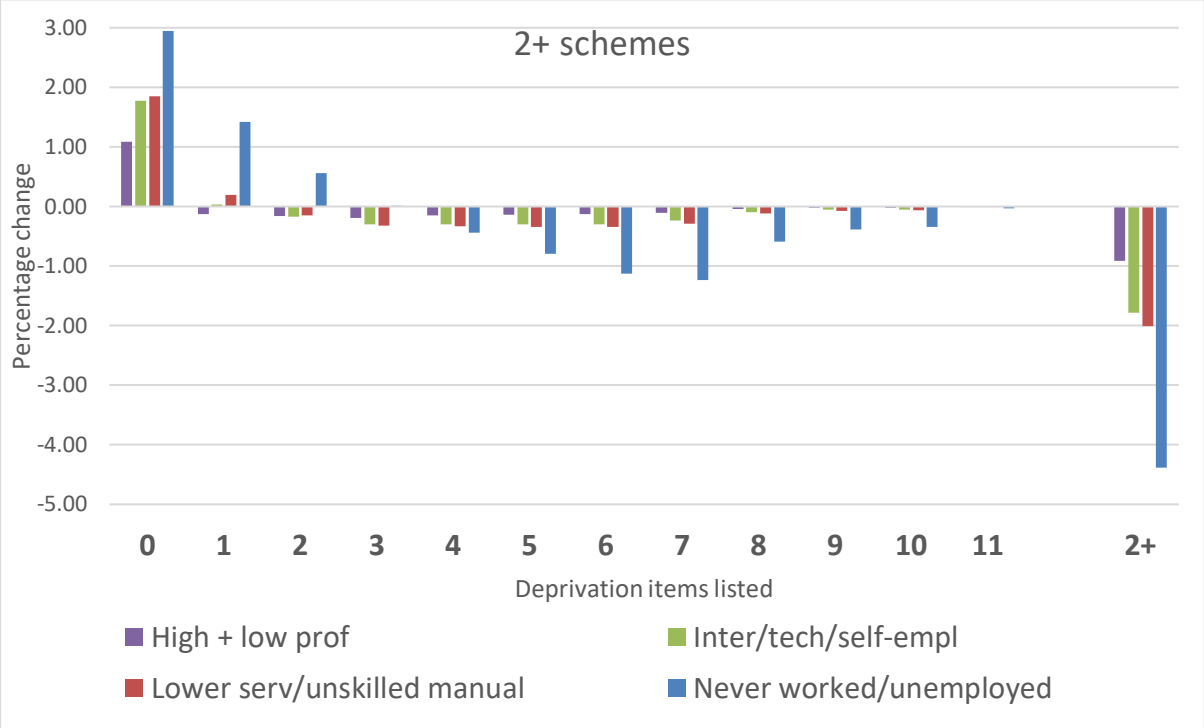
Source: SILC (2017). Authors' calculations

As before, we can simulate the effect of transfers for social class groups. Thinking of those who receive only a single transfer or subsidy, the effect of the transfer is relatively minor, with unemployed social classes benefitting the most, and the highest social classes benefitting the least. There is only

an increase of less than one percentage point reporting no deprivation for the unemployed social class and less than 0.3 percentage points for the higher social class. The reduction is also relatively small across social class groups for those reporting at least two deprivation items. The reduction pattern is much stronger for those receiving two transfers, but mostly for the most vulnerable. First, there is a large increase of three percentage points of the unemployed group reporting no deprivation (and above one percent for one deprivation item) and it is almost two percentage points for the inter and lower service social class. Second, the unemployed group also sees its deprivation level being reduced at about one percentage point halfway on the distribution of deprivation. Because of these large changes, there is a reduction of more than four percentage points for the unemployed social class lacking at least two items, half that for the inter and lower service social class and almost one percentage point for the higher class.

FIGURE 5.4: CHANGE IN PREDICTED PROBABILITIES OF DEPRIVATION BY NUMBER OF SCHEMES RECEIVED BY SOCIAL CLASS (% POINTS)





Source: SILC (2017). Authors' calculations

5.2 Summary

This chapter considered all schemes together, exploring who receives multiple schemes and whether these recipients were less likely to cite deprivation. Multiple schemes were not common but vulnerable social risk and social class groups were more likely to have two or more schemes. We also found that those with multiple schemes saw a greater effect in deprivation reduction, and that vulnerable social risk and social class groups were the most likely to benefit from multiple schemes, although single schemes also lowered their predicted probability of citing deprivation. The reduction effect for those lacking at least two items and in receipt of two schemes was strong for children in lone-parent households and those in households with a person with a disability but it was even stronger for children in never worked/unemployed social class.

Chapter 6

Conclusion

Throughout this report we have looked at a range of supports which captured the coverage and effectiveness of social transfers tied to housing, childcare, and medical needs. These tied transfers are particularly important as they cover childcare, healthcare and housing, which are pivotal expenses for any family. They were prevalent: almost 70 per cent of households received at least one type of transfer and almost 25 per cent of households received at least two. They were also specific: in terms of coverage, we found that vulnerable social risk groups often had the highest chances of securing transfers and non-cash benefits when compared to working age adults. We also found that vulnerable social class groups such as the unemployed or those who have never worked had high chances of securing these transfers and services.

Most importantly, we noted that tied transfers and support services have a variable but positive effect, in that they limit the chance of deprivation. Finally, we noted that vulnerable social risk and social class groups are the most likely to benefit from transfers and services, when compared to groups that are better insulated from poverty and social exclusion, like those in the highest social class grouping. We briefly consider each transfer type and summarise the conclusions of each of these benefits.

Regarding housing transfers, we found a negative relationship between the value of transfers and deprivation, meaning that transfers are associated with lower predicted probabilities of deprivation. Finally, we noted group differences in this effect, where housing transfers were the most effective for vulnerable social risk and vulnerable social class groups.

Regarding health-related transfers, we found a difference in deprivation between those receiving a medical card or a GP visit card and those who do not receive these. Once again, we could explain this difference by considering the financial situation of the household. As with housing transfers, this difference between recipients and non-recipients could be explained by differences in financial circumstances and hardship, as in many cases access to medical cards is based on household means. We also found that medical support reduced the predicted probability of material

deprivation. Lastly, we again found group differences in this effect, with vulnerable social risk and vulnerable social class groups having benefitted more from medical supports than more protected groups as we would expect with a very high coverage for the former groups.

Regarding childcare transfers, we could not compare the recipients of subsidies to non-recipients of subsidies, since these are universal for families with children in certain age groups. However, we were able to simulate the impact of these subsidies on material deprivation by attaching a cash value to the care provided. We found that childcare support subsidies limited the impact of deprivation and that, as before, this reduction was most prominent among vulnerable social risk and social class groups.

In general, we recommend that future research explores the link between transfers, services and social exclusion. This is especially true for childcare subsidies, which could support greater participation in the labour market, and as a result lower deprivation for the household. Previous research has shown that Ireland reports high rates of unmet need for formal childcare (Grotti et al., 2019), and that this rate is higher in Ireland when compared to several European countries (Privalko et al., 2019). More specifically, childcare transfers may have important implications for parents' participation in the labour market, in that increasing transfers may encourage employment or job seeking. We offer the following policy implications.

1. The benefits 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 a "customary life", especially for lone parents and the unemployed.
2. Those receiving the 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 we find that 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 varied between social risk groups: housing transfers were particularly important for lone parents and respondents 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.

6.1 Limitations

The analysis presented here comes with one specific limitation and one general limitation. The first specific limitation is tied to housing transfers.

We could not include HAP transfers when considering housing transfers. This measure was not available in SILC 2017 data, despite the existence of HAP at that time. As a result, we lack a substantial transfer from our analysis. SILC data on HAP is available for 2018. Here too, there is likely an association between this scheme and lower rates of deprivation among its beneficiaries.

The more general limitation is that because of the relatively small sample size, we are not able to make social risk and social class conclusions about more specific entitlements such as **housing benefits** versus **housing supplements**. Given the small sample size of housing supplement recipients, it is not possible to further split these values by subgroups, due to CSO limitations on cell sizes.

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Appendix

TABLE A.1: MODELS PREDICTING HIGHER LEVELS OF DEPRIVATION, SILC (2017)

VARIABLES	OLS	Poisson	Negative binomial	Zero-inflated	Ordinal
Ref: Other people over 65					
Lone parents	0.69**	0.36*	0.21	0.31*	0.48
Adult with disability & children	0.51***	0.39**	0.41**	0.30*	0.63**
Other adults & children	-0.02	-0.09	-0.14	0.00	-0.13
Ref: Highest social class					
Middle social class	-0.05	0.07	0.04	-0.12	0.08
Lowest social class	0.18	0.30**	0.32**	0.23*	0.36*
Unemployed or never worked	0.37	0.19	0.17	0.21	0.32
Ref: Head of household male					
Head of household female	0.16*	0.28**	0.39***	0.14	0.38**
Age of head of household	0.01	0.01	0.01	0.01	0.01
Ref: Head of household born in Ireland					
Head of household born not in Ireland	-0.34***	-0.35**	-0.34*	-0.10	-0.56**
Ref: Head of household working					
Head of household unemployed	0.74***	0.62***	0.57***	0.45**	0.83***
Head of household in education	0.57	0.51*	0.25	0.59**	0.27
Head of household on home duties	0.28*	0.27*	0.02	0.35*	0.10
Head of household retired	0.09	-0.01	-0.14	0.28	-0.10
Head of household illness or disability	1.23***	0.74***	0.65***	0.54***	1.06***
Head of household not yet at work	0.04	-0.11	-0.04	-0.05	-0.19

Ref: Head of household has tertiary degree					
Head of household has primary degree	0.25	0.29*	0.31**	0.10	0.40*
Head of household has secondary degree	0.08	0.16	0.18	-0.03	0.28*
Log equivalised Household income	-0.43***	-0.57***	-0.97***	-0.21*	-0.94***
Ref: Household 2 adults					
1 Adult	0.21	0.27	0.21	0.30*	0.15
3+ Adults	-0.28	-0.10	0.05	-0.09	-0.03
1 adult with children aged under 18	0.10	0.31	0.38	0.12	0.28
2 adults with 1-3 children aged under 18	-0.07	0.19	0.19	0.04	0.18
Other households with children aged under 18	0.01	0.27	0.45*	0.14	0.32
Number of children under 18	0.10	0.05	-0.00	0.06	0.08
Number of adults 18-64	0.11	0.07	-0.02	0.13	-0.04
Number of adults 65+	-0.16	-0.32*	-0.42**	-0.23	-0.48*
Live in rented accommodation	0.59***	0.49***	0.51***	0.24**	0.68***
Constant	3.97***	3.87***	8.04***	1.07	n/a
Observations	12,251	12,251	12,251	12,251	12,251
AIC	43,170	29,779	25,985	25,262	25,511
BIC	43,377	29,986	26,200	25,684	25,793

Note: *** p<0.001, ** p<0.01, * p<0.05

TABLE A.2: GLOSSARY OF SCHEMES

Scheme	Description
Fuel Allowance	A Fuel Allowance is a payment under the National Fuel Scheme to help with the cost of heating homes during winter. It is paid to people who are dependent on long-term social welfare payments and who are unable to provide for their own heating needs. It is a means tested payment.
GP Visit card	GP visit cards cover the costs of GP visits. People who do not qualify for a medical card may qualify for a GP visit card under the following criteria: People aged over 70 years of age without a means test people aged under 70 years of age if they meet the means test People in receipt of full or half-rate of Carer's Benefit or Carer's Allowance Children under the age of six
Housing Benefits (TV License, Electricity or Gas Allowance)	The Housing Benefits Package (HBP) helps homes with the cost of the TV licence and electricity or gas bills. Only one person in a household can get the Package. The Package is designed for those aged 70 or over, regardless of whether they receive a State pension. The package is not means tested. It can also be available to people under 70 years subject to certain conditions.
Medical card	Medical cards are designed to cover the costs of medical services in Ireland. The qualification for medical card is either based on a means test or on some automatic criteria. For the means test there are different rules depending of the age of the person distinguishing those under and over 70 years of age. Automatic qualification applies to the following: People with EU (European Union) entitlement (example of people in receipt of social security pension from another country) Children under 18 years of age who have been diagnosed

	with cancer within the last five years People affected by the drug Thalidomide Women who have had a symphysiotomy People who live in direct provision accommodation Children in foster care Women who were resident in certain institutions In addition can qualify also, people aged 16–25 (including students) whom parent or guardian has a medical card and children whom parent or guardian in receipt Domiciliary Care Allowance.
Mortgage Interest Supplement	Mortgage Interest Supplement (MIS) provided short-term support to help households pay with mortgage interest costs. The scheme has been closed to new entrants since January 2014. It is designed for those who were able to cover their mortgage costs originally, but due to personal circumstances can no longer finance the payments.
Rental Allowance	Rental Allowance is payable to tenants "*of certain dwellings affected by the decontrol of rents on 26th July 1982*". This scheme is designed with a unique group of tenants in mind, those affected by rent control legislation passed in July 1982.
Rent Supplement	Rent Supplement is a means-tested payment for certain people living in private rented accommodation who cannot provide for the cost of their accommodation from their own resources. It is a short-term income support for people in the private rented sector. It is paid directly to the tenant.
Telephone Support Allowance	Telephone Support Allowance is a weekly payment for people who live alone and are already in receipt of certain other social welfare payments. It assists the cost of communications and or home security solutions. It is paid at a single rate of €2.50 a week.