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Working Paper

The Take-Up of Social Benefits

IZA Discussion Papers, No. 1103

Provided in Cooperation with:

IZA – Institute of Labor Economics

Suggested Citation: Currie, Janet (2004) : The Take-Up of Social Benefits, IZA Discussion Papers, No. 1103, Institute for the Study of Labor (IZA), Bonn

This Version is available at:

<https://hdl.handle.net/10419/20338>

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IZA DP No. 1103

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April 2004

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ABSTRACT

The Take-Up of Social Benefits*

This paper offers a review of recent literature regarding the take up of social programs in the U.S. and U.K. A few general conclusions are drawn: First, take up is enhanced by automatic or default enrollment and lowered by administrative barriers, although removing individual barriers does not necessarily have much effect, suggesting that one must address the whole bundle. Second, although it may be impossible to devise a definitive test of the “stigma hypothesis”, other, more concrete types of transactions costs are probably a good deal more important. Third, although people generally have means-tested programs in the United States in mind when they discuss take up, low take up is also a problem in many non means-tested social insurance programs and in other countries.

Historically, economists have paid little attention to rules about eligibility, and virtually no attention to how these rules are enforced or made known to eligibles. Hence, the marginal return to new data about these features of programs is likely to be high in terms of understanding take up. In an era of social experiments, it might also prove useful to consider experimental manipulations of factors thought to influence take up.

JEL Classification: I38

Keywords: take up, social programs, targetted assistance

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* This paper was prepared for a conference in honor of Eugene Smolensky held at Berkeley, December 12 and 13th, 2003. The author thanks Alan Auerbach, David Card, Sheldon Danziger, Irving Garfinkel, Robert Haveman, John Quigley, and conference participants for helpful comments. Princeton’s Center for Health and Well Being provided financial support. Graciana Rucci provided excellent research assistance.

Virtually all developed countries and many developing countries have a system of income maintenance. In countries with universal programs, the aim of these systems is to maintain a minimum level of income for all individuals, at a reasonable cost to government. In the United States, the goal is to maintain such a standard for selected groups of vulnerable or “deserving” individuals, such as children, the elderly, and the disabled. One of the main problems with designing such programs, is that the government typically has imperfect information about the income-generating capacity of any given individual. Hence, a central problem is to design a system that aids the vulnerable while minimizing work disincentives given these information asymmetries. For example, Besley and Coate (1995) present a model in which a negative income tax policy supplemented by workfare for the lowest earning individuals, is optimal.

Besley and Coate (1991) argue that redistribution from rich to poor can also be achieved through the provision of in-kind goods at a quality level such that the rich “opt-out” and purchase the good privately, while Blackorby and Donaldson (1988) show that in-kind provision provides a way to get people with special needs to self-select into the group receiving aid, and can thus be a second-best optimum in a world in which the government cannot judge needs perfectly. Bruce and Waldman (1991) offer a third, dynamic scenario, in which persons offered a cash transfer in the first period have incentives to spend it in a way that maximizes their eligibility for additional transfers in future periods. Offering a tied (i.e. in-kind) transfer to the target group in the first period avoids this problem. These papers build on an insight from early work by Nichols, Smolensky, and Tideman (1971) discussing the way that waiting times can be used to ration public goods.

Notwithstanding this literature on optimal targeting, most developed countries other than

the United States continue to provide many social programs universally rather than targeting them to particular groups. Smolensky, Reilly, and Evenhouse (1995) offer an in-depth discussion of targeting and outline several costs that may offset the potential budgetary benefits. First, targeting may in fact be administratively expensive, though costs can be reduced by means of applying categorical screens and providing benefits in a way that causes the target group to select into the program while others select out. Second, targeting may be socially divisive to the extent that it divides society into those who give and those who receive. Conversely, programs that offer universal benefits may enjoy greater political support.

The third problem with targeting is the subject of this essay, and that is the fact that targeting will always be imperfect. Some of those who take up benefits will not “deserve” them, and some of those who are eligible for benefits will not take them up. If take up by eligible individuals is low, then the targeted program may fail to reach its main goal of providing a minimum bundle of goods for the target group. If take up by ineligibles is too high, then government revenues will be diverted from other productive uses.¹

This chapter reviews what we know about the take up of social programs, most of which offer in-kind benefits in a targeted fashion. Section I provides some comments about an economic model of take-up. Section II reviews the literature on the take up of means-tested programs in the United States with an eye towards what we can learn about the way that program characteristics affect participation. In Sections III and IV, I also consider what can be learned from the take up of several important non-means tested or universal programs in the United States, and provide a brief survey of the evidence regarding take up of programs in the United

¹ In his comments, Irving Garfinkel identifies another cost of targeted transfers, which is that they create disincentives for the poor to work and to marry. There is a large literature on the labor supply and demographic

Kingdom, the country outside of the United States that has inspired the most work on these questions. Section V offers some conclusions and directions for future research.

1. An Economic Model of Take Up

Moffitt (1983) was one of the first to model non-participation in social programs as a utility-maximizing decision. His model emphasizes “stigma” as the main cost of participation in a means-tested program, but the model can easily be extended to include other types of costs, such as transactions costs. In Moffitt’s model, utility is given by:

$$(1) U = U(Y + aPB) - bP.$$

Here, Y is income in the absence of the program, and B is the benefit derived from the program. P is an indicator equal to one if a person participates, and zero otherwise. Moffitt distinguishes between “flat” stigma, which is a fixed cost associated with participation in the program, and “variable” stigma, which is a function of the size of the benefit received. Flat and variable stigma correspond to b and a , respectively.

The two types of stigma(costs) have different implications for participation, since with only flat stigma, participation will always be increasing in the size of the benefit, whereas with variable stigma, this may not be the case. If $B = G - tWH - rN$, where G is the guarantee level, t is the marginal tax rate, W is the wage, H is hours of work, r is the marginal tax rate on non-wage income, and N is non-wage income, then flat stigma implies that the probability of participation is increasing in G , and decreasing in t , W , H , R , and N , holding Y constant. If there is variable stigma, then the individual will only participate if $a > 0$.

Moffitt goes on to add the individual’s leisure to the utility function, and to consider the

fact that eligibility for targeted welfare programs is contingent on being below an income threshold (as Burtless and Hausman (1978) show, the latter gives rise to a non-linear budget, which creates work disincentives). In this model, stigma increases the cost of participating in the program, so that some households who would participate in the absence of stigma choose not to participate.

The review of the literature below suggests that other costs associated with the takeup of social programs are more important than stigma. Individuals eligible for means-tested programs face costs of learning about, and applying for the programs. These costs may be sufficient to deter some individuals from using them. Moreover, the costs may be highest for precisely those individuals in greatest need, and in cases where the beneficiary is a young child or an infirm adult, the costs may be borne by an individual other than the beneficiary. To the extent that the principal's agent bears the costs of utilizing the program while the principal receives the benefit, agents may be less willing to bear the costs than the principal would be if he/she were in a position to choose for themselves. Agency problems provide an additional rationale for providing benefits in kind rather than in cash.

This basic cost/benefit framework has remained the basis for empirical investigations of non-participation in social programs. However, there have recently been two interesting additions to the basic model. First, there is growing interest in the role of social networks in potentially reducing the costs of participation. For example, Bertrand, Luttmer and Mullainathan (2000) show that a woman's propensity to use welfare increases with the number of coethnics in the area, if those coethnics have a high propensity to use welfare nationally. This work builds on earlier research by Borjas and Hilton (1996) which showed that the types of benefits received by earlier immigrants influenced the types of benefits received by newly arrived immigrants

from the same origin country. Hence, they speculated that there might be ethnic networks that transmitted information about the availability of particular benefits to new immigrants, or reduced stigma.

However, as Manski (1993, 2000), Brock and Durlauf (2001), Moffitt (forthcoming) and others have highlighted, these correlations could reflect an *endogenous effect* where the propensity of an individual to behave in a particular way is causally influenced by the behavior of other members of the group; an *exogenous effect* where the individual's behavior is influenced by an exogenous characteristic that defines group membership; or a *correlated effect* where individuals from the same group tend to behave the same way because they have similar individual characteristics, or face similar constraints.

Aizer and Currie (2004) attempt to distinguish between these effects by exploiting a rich panel of Vital Statistics data from California, and examining the propensities of women in different groups to use publicly funded prenatal care services. They find that the use of public programs is highly correlated within groups defined using race/ethnicity and zip codes. These correlations persist even when they control for many unobserved characteristics by including zip code-year fixed effects, and when they focus on the interaction between own group behavior and measures of the potential for contacts with other members of the group (Bertrand, Luttmer and Mullainathan's concept of "contact availability").

However, the richness of our data allows us to go further and to test the hypothesis that networks affect take up through information sharing. In particular, we find that the estimated effects are as large or larger among women who have previously used the program as among first-time users. Thus, these effects cannot represent information sharing, since women who have already used the program already know about it.

It is also worth noting Duflo and Saez's (2001) experimental study of the effects of information on the take up of a retirement plan option by employees. Employees were randomly selected to receive payments if they attended a workshop providing information about the benefit. Duflo and Saez then look at whether giving information to one person in a group affected the behavior of other members of the employee's work group. They find effects which are statistically significant, but small.

A second theoretical insight comes from the growing field of "behavioral economics". O'Donoghue and Rabin (1999) argue that conventional economic models incorrectly assume exponential discounting—that is that "a person's relative preference for well-being at an earlier date over a later date is the same no matter when she is asked" (page 103). They further argue that a more accurate model would allow time inconsistency in the sense that people tend to put more weight on the present than on the future in making decisions. The model allows for this feature by adopting hyperbolic rather than exponential discounting.

The model has an obvious application here, in that many of the costs (though perhaps not the stigma) of enrolling in social programs are borne immediately, whereas the benefits are in the future. Hence, a person with time-inconsistent preferences might put off enrolling the program, even though she would find it utility maximizing to be a participant at some later date. This might be particularly true of programs such as public health insurance, where the benefit might not even be needed until a future health shock occurs.

So far, there has been little research investigating the applicability of this model to participation in public programs. Some of the most convincing evidence in favor of the model comes from studies of the participation in private benefit programs, such as 401K plans. For example, Madrian and Shea (2000) analyze a change in one company's policies towards 401K plans

that replaced a system in which employees had been required to elect participation in the plan, to one in which they were automatically enrolled in a default plan. They find that participation was significantly higher after the change, and that a substantial fraction of the enrollees stuck to the default plan, even though most enrollees prior to the change had not selected the default. These results suggest substantial stickiness in behavior, even though enrollees could have changed their plan at any time with a simple phone call.

While these results are striking, they do not necessarily imply hyperbolic discounting rather than high costs of changing the default rule. While it is true that a phone call is not costly, most people would have to spend substantial time and mental effort to inform themselves about the various options available and make a decision. This too, can be regarded as a cost. Moreover, in the context of non-participation in social programs, it is not clear that the two hypotheses (i.e. that non-participants in social programs are “irrational” in the sense that they have time-inconsistent preferences or that non-participants just face high costs of enrollment) have different policy implications. Both suggest that reducing the immediate costs associated with enrollment, or adopting default enrollment, would increase participation. Of course, if participants in social programs are on average more “present-oriented” than other people, then this may still have implications for the appropriateness of paternalistic government policy (c.f. O’Donoghue and Rabin, 2003).

2. Take Up of Means Tested Programs in the United States

Table 1 provides a selective overview of the literature about the take up of means-tested transfer programs in the United States, focusing on more recent studies. Most of these programs are surveyed in more detail in Moffitt (2003). Table 1 provides a thumbnail sketch of each program in terms of when it started, what it does, who it serves, and at what cost. The programs

are grouped by type and expense.

Perusal of the Table suggests several broad conclusions. First, take up varies a great deal across programs. In the case of programs that are not entitlements, take up often appears to be constrained by the amount of funding available (e.g. public housing programs, and child care subsidies). However, even among entitlement programs offering similar services, there is a good deal of variation both across programs and across different groups eligible for the programs.²

For example, take up of the new State Children's Health Insurance Program (SCHIP) has been very low (8 to 14%), with the result that the number of uninsured children has changed relatively little since the introduction of the program. Estimates of the take up of Medicaid coverage among children also suggest that it is low. For example, Currie and Gruber (1996b) estimated that while the fraction of children eligible for Medicaid increased by 15.1 percentage points between 1984 and 1992, the fraction covered increased only 7.4 percentage points, while Card and Shore-Sheppard (2004) find that expansions of eligibility to all poor children born after September 30, 1983 led to about a 10 percentage point rise in Medicaid coverage for children born just after the cutoff date. In contrast, they estimate that the further extension of Medicaid to children under 6 in families with incomes below 133 percent of the poverty line had relatively small effects.³

On the other hand, 35 to 40 percent of all U.S. births are now paid for by the Medicaid program, suggesting extremely high take up of that program by eligible women who are

² An entitlement program is one in which all qualified applicants are served. In contrast, non-entitlement programs have fixed budgets, and cannot serve more people than the funding allows.

³ The Card and Shore-Sheppard estimates of take up are lower, because they include child age-specific trends in their model, while Currie and Gruber (1996), and Cutler and Gruber (1996) (discussed below) did not. Nevertheless, all three sets of authors emphasize the low take up of the Medicaid expansions, relative to take up of many other

delivering. Interestingly, take up of Medicaid-covered prenatal care lags take up of Medicaid covered delivery services (Ellwood and Kenney, 1995).

a) Explanations for Variations in Take Up

Three explanations for low take up are generally offered in the literature. They are stigma, transactions costs, and lack of information. Of course, these are not entirely separate explanations. In particular, a person's incentive to obtain information about a program, may be influenced by the size of the benefit relative to the transactions costs/stigma associated with applying. For example, Daponte, Sanders and Taylor (1998) find that people are more likely to know about Food Stamps when they are entitled to larger benefits. And it has proven difficult to define stigma and transactions costs as completely separate constructs. For example, a person who is required to fill in a 30 page application form that asks about a great deal of personal and seemingly irrelevant information, may well feel stigmatized. Nevertheless, the next few paragraphs will focus on what is known about the relative importance of these factors.

There is considerable evidence that transactions costs are important determinants of take up rates. For example, Currie's (2000) finding that enrollments in Medicaid among immigrant children increase with family size strongly suggests that it is benefits relative to transactions costs (or stigma) that matter. Those with more children benefit more while facing a similar cost of enrollment. Moreover, her finding that enrollments follow a seasonal pattern, with enrollments spiking before school entry in the fall also suggests that transactions costs or stigma rather than information plays the dominant role since people are apparently timing their window of enrollment to coincide with a period when they know that they will need services.

Blank and Ruggles (1996) study of participation in AFDC and the Food Stamps Program showed that participation increased with the size of the benefits people were eligible for, suggesting an important role for transactions costs/stigma. Daponte, Sanders, and Taylor (1999) conducted an experiment, and found that informing people about their eligibility for the FSP increased the probability of participation. However, people eligible for larger benefits were more likely to take them up, once again suggesting a non-trivial role for transactions costs/stigma.

On a cautionary note, both sets of authors also find that it is likely to be difficult to assess eligibility for most social programs accurately using survey data. An important problem is that most surveys have little information about assets. For example, Hu (1998) found that adding asset information increased estimated take up of SSI by 60% (since people who were ineligible because of their assets were excluded from the denominator). This problem may be particularly acute in the low-income population, where even employment and wages are often inaccurately reported (Haveman and Wallace, 2003).

Currie and Grogger (2002) focus directly on transactions costs, and show that reducing re-certification intervals had a negative effect on participation in the Food Stamp Program, particularly among single heads and people in rural areas, both groups that could be expected to have relatively high transactions costs. While it is possible that single mothers and people in rural areas feel more stigmatized by participation in the Food Stamp Program than others, the available evidence for rural areas suggests the reverse (McConnell and Ohls, 2000). Moreover, the introduction of electronic-debit cards for Food Stamps, which might have been expected to reduce the stigma associated with food stamps by allowing people to use the program more discretely, had no detectable effect on Food Stamp take up rates, suggesting that stigma is not a

major cause of low take up of the Food Stamp Program.

There has been a great deal of debate over the extent to which the dramatic decline in AFDC/TANF roles over the 1990s can be attributed to welfare reforms that increased the stigma/costs of being on welfare rather than to favorable economic conditions (see Blank (2002) for a summary) but most studies suggest that at least a third and possibly as much as two thirds of the decline is due to “reforms” which increased the cost of using the program. Moffitt (2003c) examines specific policies that accompanied welfare reform and documents that non-financial factors including work requirements, sanctions, and “diversion” (the practice of trying to prevent people from applying for welfare by meeting some immediate need) were important determinants of entry and exit into the TANF program in Boston, Chicago, and San Antonio.

Grogger (2002) and Grogger and Michaelopolous (2003) examine the effect of the PWRORA provisions limiting benefit receipt to five years, and provide evidence that this change had a profound effect on the way that women used their benefits. In models that interact child age with time limits, they find that women with young children were less likely to use their benefits other things being equal, presumably because they wanted to conserve benefits “for a rainy day”. On the other hand, among women with older children the benefits have a “use it or lose it” quality, so that there was no reduction in the probability of benefits receipt in this group. These results suggest that women make fairly sophisticated cost-benefit calculations when deciding to participate in this program, and that such decisions are not driven primarily by stigma (which presumably would be larger for mothers of older children than for mothers of young children).

Medicaid, AFDC/TANF, and the FSP are large, well-established programs and it is likely that most low income people know of them. Therefore, to the extent that information is lacking,

it is likely to be very specific information about exactly how one qualifies or applies for the program.

Lack of information could be a greater problem for take up of some of the smaller programs. For example, in their study of current and former welfare recipients, Meyers and Heintze (1999) asked mothers eligible for employment-related child care subsidies why they were not receiving them. The majority replied that they were not aware of the programs. Still, given that transactions costs associated with the program have not been systematically examined, it is impossible to draw any conclusion about their importance relative to lack of information.

The Bound, Kossoudji, and Ricart-Moes's (1998) finding that in Michigan, 2/3 of the people applying for SSI in 1990-1991 had just been kicked off of General Assistance is particularly striking since the benefits available under SSI were always much higher than those available under GA. Apparently, people doing the cost/benefit calculation did not find it worthwhile to pursue SSI when GA was an option. It is also possible that the state helped direct people who had been kicked off of GA onto the federally-funded SSI program thereby changing the relative transactions costs associated with the two programs. One would expect the stigma associated with GA (welfare for the truly indigent) to be much greater than the stigma associated with SSI, so stigma cannot explain the Bound et al. results.

Finally, there is considerable evidence that transactions costs associated with WIC matter. Brien and Swann (1999) show in cross-sectional data that requiring income documentation of WIC applicants reduced participation rates. Bitler, Currie, and Scholz (2003) find in a panel, that requiring more frequent visits to the WIC office also reduces participation, while Chatterji et al. (2002) find that restricting the types of foods that can be purchased (i.e. reducing the value of the benefit) discourages take up. Hence, even in smaller programs,

transactions costs relative to benefits appear to be very important determinants of take up.

These observations about the importance of transactions costs and other non-financial barriers to participation raise two questions: 1) Are the non-financial barriers screening out the “right” people? That is, are the various administrative requirements attached to these transfer programs targeting benefits to the neediest eligibles? And 2) To the extent that needy individuals are not being served, what can be done to increase their take up rates?

b) Do Non-Financial Barriers Screen Out the Right People?

In many cases attempts to answer the first question are hampered by the fact that we do not have a very precise idea of who is eligible. For example, in the case of SSI, we need to know not only that someone has low income, but also that they are “disabled” a concept that is socially determined and liable to change over time. Benitez-Silva, Buchinsky, and Rust (2003) look at “classification errors” in the SSI and DI programs (see Table 2 for DI) under the assumptions a) that the individual’s report to the Health and Retirement Survey about their disability status is the truth and b) that both the Social Security Administration’s assessment of the individual’s disability status and the self-report are noisy but unbiased measures of true disability. Under either assumption, they find that 28% of the SSI/DI applicants who are ultimately awarded benefits are not disabled (by their own reports to HRS), while 61% of the applicants whose applications are denied are disabled.

They construct a computerized model of disability based on a subset of relatively objective health indicators and argue that it may be possible to do better than the current regime in terms of reducing both type I and type II errors. In any case, taken at face value, their results suggest that the SSI system does not do a very good job of identifying and assisting the neediest

individuals, perhaps because the neediest people are least likely to be able to endure a lengthy and complicated application process. Similarly, Reeder (1995) finds that the poorest households are less likely than slightly better off households to live in public housing, again perhaps because these vulnerable households are unable to get through the application process.

Evidence about racial and ethnic differences in participation also suggests that programs are not always reaching the neediest people. Duggan has found that conditional on being poor, Hispanic children are less likely to be enrolled in the SSI program. Similarly, Currie (2000) finds that immigrant children, many of whom are Hispanic, are less likely to be enrolled in Medicaid conditional on being eligible. This finding mirrors a large literature on the determinants of welfare participation among immigrants which generally finds that while immigrants are more likely to be eligible for welfare, they are less likely to take it up, other things being equal. However, immigrants become more likely to take up benefits with assimilation (c.f. Blau (1984); Borjas and Trejo (1991, 1993); and Borjas and Hilton (1996); Baker and Benjamin (1995) and Regina Riphahn (2002) find similar results for Canada and Germany, respectively).

An interesting exception is that, as Hu (1998) documents, elderly immigrants have similar welfare take up rates to elderly native born persons, and have higher overall usage of these programs. The difference is particularly pronounced among immigrants who arrived after age 55. It is possible that barriers to participation are less formidable for elderly immigrants than for prime-age immigrants with children, or that elderly immigrants are selected differently than prime age ones. For example, the elderly immigrants might come intending to take up benefits, while prime aged immigrants come primarily to work.

On the other hand so programs do seem to serve the neediest applicants. For example,

participation in the National School Lunch program is higher among children in poor families, and Head Start, which is required to serve the neediest children first, seems to fulfill this mandate. This may be because Head Start programs are required to set out specific criteria for identifying needy children. Similarly, the WIC program guidelines lay out a very clear hierarchy for which groups should be served if funds are insufficient to serve all eligibles, and WIC participants appear to be much more disadvantaged than other eligibles, on average. Hoynes (1996) and Moffitt (1998) provide evidence that take up of AFDC decreases with expected wages, suggesting that at least on average, it is the poorest who take up the benefits. Hence, the evidence regarding whether the neediest are being served is somewhat mixed, and program specific.

Households may also be receiving aid when they do not appear to be eligible, but it is important not to assume that all these households are in violation of program rules. Recertification intervals provide a potential reason for households with incomes above the thresholds to be on public assistance. We know, for example, that households tend to seek out public assistance when their income is unusually low (c.f. Ashenfelter, 1983). In this case, we might expect household income to rise after program enrollment, whether or not the family was involved in a public program. Since families tend to be certified for a fixed period, such a pattern might lead us to observe many families in a cross section who participated in a public program even though their incomes were above the threshold. In some programs, families are required to report any improvement in their incomes, but enforcement of this provision is often weak. In other programs, such as WIC, families are certified for fixed periods, regardless of what happens to their income during this period.

The question of whether benefits have been correctly targeted to those in need has

recently been perhaps most exhaustively studied in the case of the Medicaid program. Many authors have attempted to judge the extent to which expansions of the Medicaid program led to increases in the take up of public insurance by the target group--people who would otherwise have been uninsured. These authors have also attempted to gauge the extent to which the expansions led people who would otherwise have had private insurance to take up Medicaid. The latter phenomena has been dubbed "crowd out".

Despite the dramatic increases in eligibility for public insurance coverage documented in Currie and Gruber (1996a,b) the fraction of children without insurance coverage has stayed remarkably constant in recent years because private health insurance coverage has fallen by about the same amount that public insurance coverage has risen (U.S. General Accounting Office, 1995b). However, private health insurance coverage has also been falling among groups that one would not expect to be affected by the Medicaid expansions, such as single men (Shore-Shepard, 1996). Thus, it is not obvious to what extent the relationship between increases in public insurance and decreases in private insurance is causal.

Estimates of the extent of crowd out are sensitive to the methods used to control for possibly pre-existing trends in the provision of private health insurance coverage. At the high end of the spectrum of estimates, Cutler and Gruber (1996, 1997) estimate that for every two people covered by the Medicaid expansions, one person lost private health insurance. However, some of these people (such as household heads who decided they would no longer purchase health insurance once their children became eligible) were not themselves eligible for Medicaid--so not all of the people crowded out ended up getting insurance at public expense. They calculate that in fact about 40 percent of those crowded out ended up on Medicaid.

Other observers have posed the question somewhat differently, and come up with

correspondingly different estimates. For example, Dubay and Kenney (1997) find that about 22 percent of the increase in Medicaid coverage came from people who used to be privately insured. Since not everyone who became eligible for Medicaid did so as a result of the expansions, this number is necessarily smaller than Cutler and Gruber's estimate. Finally, one might ask what share of the overall decline in private insurance coverage is a result of the Medicaid expansions. The answer to this question is about 15 percent which suggests that a great deal of research remains to be done on the causes of this decline.

One issue obscured by the focus on crowd out is the fact that Medicaid insurance coverage may be better than what is privately available to many families. For example, many private policies do not cover routine pediatric preventive care such as immunizations, and most have co-payments and limits on what they will pay. Hence, the substitution of Medicaid for private insurance coverage may improve children's health care, and this improvement should be valued when the costs and benefits of the expansions are weighed. Also, from a societal point of view, it does not matter whether private or public insurers pay for health care, except in so far as taxation creates a dead-weight loss, and public insurance transfers resources to families with children. Still, policy makers reluctant to raise (or eager to cut) taxes remain deeply concerned about crowdout. The crowd out literature suggests that it is extremely difficult to target programs only to those who need them, such as children who would not otherwise have health insurance.

c) What Can be Done to Increase Take Up?

Turning to the second question of what can be done to increase take up among the

“deserving” eligibles, the research summarized in Table 1 suggests some hypotheses but yields few definitive answers. For example, it may be the case that the high take up of the EITC program and of Medicaid among pregnant women reflects the fact that businesses as well as individuals have a stake in promoting take up of these programs. In the case of the EITC, anecdotal evidence suggests that commercial tax preparers have moved into low income areas in response to the EITC. Many preparers advertise instant cash back, which is essentially the person’s EITC credit less the preparer’s fee. Subsidies for H&R block may not be the most desirable use of government funds, but the example does illustrate the potential role of institutions in enhancing take up.

In the case of Medicaid, hospitals have a stake in getting pregnant women who are eligible signed up, because they are required to serve women in active labor whether or not the women can pay (as long as the hospital accepts any payments from Medicare). There is evidence that pregnant women were responsible for much of the uncompensated care provided by hospitals prior to the Medicaid expansions (Saywell, 1989). Many hospitals have subsequently established Medicaid enrollment offices on site. These offices assist people in completing applications and tell them how to obtain necessary documentation. Hospitals in at least 32 states and the District of Columbia began to employ private firms to help them enroll eligible patients in the Medicaid program (GAO, 1994).

Conversely, Medicaid enrollment rates may have remained low for other groups despite increases in income cutoffs because of lack of support for the program among vendors of medical services. Baker and Royalty (1996) use data from a longitudinal survey of California physicians observed in 1987 and 1991 and find that expansions of Medicaid eligibility to previously uninsured women and children increased the utilization of care provided by public

clinics and hospitals but had little effect on visits to office based physicians. This is consistent with much previous evidence that many providers either do not accept Medicaid payments, limit the number of Medicaid patients in their practice, or otherwise limit the amount of time that they spend with Medicaid patients (Sloan, Mitchell, and Cromwell, 1978; Decker, 1992).

This failure of private providers to “take up” the Medicaid program is likely to be related to the costs of doing business with the states, relative to the benefits represented by reimbursement levels. Andreano, Smolensky, and Helminiak (1986) document the problems that some vendors in Wisconsin had getting reimbursed from the Medicaid program. Gruber (2003) summarizes the literature relating Medicaid reimbursement levels to physician participation (starting with Currie, Gruber, and Fischer, 1995) and concludes that there is a strong relationship.

These examples suggest that giving businesses (or other entities) a stake in getting people enrolled could boost participation rates. This approach has been tried recently in California. Aizer (2003) studies a program of application assistance in which community organizations were paid \$50 per successfully completed Medicaid application. Aizer finds that this program had a large impact on Medicaid enrollments, particularly in the Hispanic and Asian communities, and that the increase in Medicaid coverage resulted in fewer preventable hospitalizations among eligible children. In contrast, statewide advertising of Medicaid and the Healthy Families program seemed to have effects only on the enrollment of infants. It appears that people with older children already knew about these services.

Direct attempts to reduce the barriers to participation by government have not always been as successful. Currie and Grogger (2002b) show that prior to welfare reform, receipt of Medicaid by pregnant women was closely tied to receipt of cash welfare, even though earlier expansions of eligibility meant that most low income women were eligible for coverage of their pregnancies

even if they were not on welfare. The key seems to be that women who are on welfare are automatically eligible for Medicaid, and do not have to undergo the Medicaid application process. One might think then, that measures states took to make it easier for pregnant women to apply for Medicaid would have had some impact. These measures included: presuming that pregnant women were eligible for Medicaid while their applications were being processed and/or expediting the processing of applications for pregnant women; “outstationing” Medicaid eligibility workers in hospitals that serve low income women; dramatically shortening and simplifying application forms; and eliminating the requirement for face-to-face interviews by allowing mail-in applications from pregnant women. However, Currie and Grogger (2002b) were unable to find any consistent effects of these measures, suggesting either that they were insufficient or that they were ineffective.

Yelowitz (2000) provides evidence that altering enrollment requirements for one program can have spillover effects onto the enrollments in other programs. He estimates that for every 10 newly eligible families who took up Medicaid benefits, four also took up the Food Stamp Program. It is possible that families learned about their eligibility for the FSP when they went to the welfare office to apply for Medicaid. Alternatively, it may be more worthwhile to bear the application costs in the case of Medicaid and the FSP together than in the case of FSP alone. Thus, making it easier to apply for multiple programs might increase take up among eligibles.

Conversely, reductions in the welfare caseload have impacted enrollments in other programs. For example, Zedlewski and Brauner (1999) and Currie and Grogger (2002) find that these reductions reduced enrollment in the Food Stamps Program. And changes in other programs can also affect AFDC(TANF) caseloads--Garrett and Glied (2000) find that many families switched from AFDC to SSI after the 1990 case of *Sullivan v. Zebley* expanded eligibility for the SSI

program among children. Moreover, families were more likely to switch from AFDC to SSI where the difference between SSI and AFDC benefit levels was greatest.

In summary, this section suggests that take up will be higher a) the more people want the service; b) the fewer the barriers that are place in their way; and c) where institutions (including private ones) have incentives to assist individuals in taking up their benefits.

3. Take Up of Non Means-Tested Programs

Take up is generally considered to be a problem associated with means-testing. Therefore, it is worth considering whether anything further can be learned about take up from studying a few large non means-tested programs in the United States. For example, one might expect the stigma involved in participating in a non means-tested program to be less than the stigma associated with participation in a means-tested one. Hence, if participation rates were universally higher in the former than the latter, then this might be taken as indirect evidence of the importance of stigma costs.

Table 2 provides an overview of four large social security programs in the U.S. that are not means-tested. The most striking thing about this table is that there is almost as much variation in the take up of these non means-tested programs as there is in the take up of the means-tested programs that were reviewed in Table 1, which would seem to provide some indirect evidence against the stigma hypothesis.

For example, Medicare forms an interesting contrast to Medicaid, because there is almost 100% take up of the optional Part B coverage of outpatient services. This is perhaps surprising because it is not free--people have to pay premiums for Part B insurance, even though those

premiums are highly subsidized. A key difference between the two programs is that when people turn 65 years old, they have to fill out a form in order to decline Part B coverage, whereas people have to go through a complicated process in order to apply for Medicaid coverage.

Thus, Part B works very much like the 401K intervention studied by Madrian and Shea (2001).

The three other programs outlined in Table 2 all suggest that take up may be a problem even for non means-tested programs. It is difficult to estimate the size of the eligible pool for Social Security Disability Insurance (DI) and Workmen's Compensation (WC) given that we do not know which people are truly disabled or injured. However, Table 2 summarizes a good deal of evidence that participation in these programs varies with the size of the benefits, suggesting that take up is more likely when benefits are higher relative to costs of enrollment. Similarly, take up of Unemployment Insurance (UI) is generally much less than full (generally similar to take up of programs such as AFDC and Food Stamps), and varies with the size of the expected benefit, as well as with the tax treatment of benefits (Anderson and Meyer, 1997).

These less than full take up rates suggest that eligibles perceive substantial costs associated with participation even in non means-tested programs (otherwise, take up would be 100 percent for any positive benefit). If those costs were driven primarily by stigma, the evidence would suggest that the stigma associated with non means-tested social insurance programs is of the same order of magnitude as stigma associated with using "welfare" programs. If we believe, on the other hand, that the stigma associated with using non means-tested social insurance programs (which everyone pays into) is less than that associated with means-tested programs, then we would have to conclude that transactions costs are major determinants of participation in all types of programs.

4. Take Up in the UK

Low take up of social programs is also often perceived as a peculiarly American problem, possibly because of the U.S.'s heavy reliance on means-tested programs in its social security system. Hence, it is also of interest to examine take up of social benefits in another country, such as the United Kingdom.⁴ Table 3 provides a brief overview of the main social benefits available in the U.K. It is less complete than Tables 1 and 2, given this author's relative unfamiliarity with these programs, and less emphasis on the take up issue in the British literature (although see Craig (1991) for an early survey).

The main point, is that many U.K. programs also exhibit less than full take up. Estimates of take up of the Working Families' Tax Credit (which is similar to the American EITC) by single mothers range from 67 to 81%, which is comparable to Scholz' estimate of 80 to 87% for the EITC. Take up of Income Support among non-pensioners, which (at least for lone mothers) corresponds roughly to AFDC, seems to be higher in the U.K. than in the U.S., though at 80%, is still much less than full. Take up of Income Support for pensioners (which corresponds to SSI for the elderly) is somewhat higher than in the U.S. at between 64 and 78%, but again, is much less than full.

These rough comparisons suggest that perhaps more attention should be paid to factors determining take up of social benefits outside the U.S. It is interesting to note that the one U.K. program with near universal take up is the Child Benefit. Mothers receive the application materials for this program in hospital, which presumably greatly reduces application transactions costs.

⁴ Take up estimates for various other countries and programs are also available. C.f. Koning and Ridder (1997) who study a rental assistance program in the Netherlands and find a 64% take up rate, and Storer and Van

The introduction of several new programs, such as the “New Deal” for the unemployed in 1998, would seem to offer an interesting opportunity for research. The New Deal made participation in jobs programs compulsory for many groups of unemployed. It would be interesting to know what effect this had on the probability of participating, and which categories of recipients dropped out. More generally, cross-country collaboration between researchers might uncover variations in transactions costs and other factors that affect take up, and could help to isolate their effects.

The discussion of social benefits in the U.K. might also lead us to think beyond the question of “who takes up programs?” to “do recipients make optimal use of programs that they have taken up and if not, why not?” Research on the National Health Insurance program suggests that although there is universal take up, the rich receive more services than the poor, conditional on their health status. Possible reasons range from higher transactions costs (e.g. lack of transportation, or inability to take time off from work); superior connections and communication skills and/or better rapport with medical providers; and differences in attitudes towards illness and medical care (Dixon et al, 2003). This example suggests that the same factors that inhibit take up may also affect utilization of social programs.

5. Summary and Conclusions

It is generally agreed that people do not take up benefits if the costs outweigh the benefits. But after many years of research, we still have relatively little insight into precisely what types of costs matter most, and what types of measures are most likely to reduce them. A few general conclusions can be drawn, however. First, take up is enhanced by automatic or

default enrollment and lowered by administrative barriers, although removing individual barriers does not necessarily have much effect, suggesting that one must address the whole bundle.

Second, although it may be impossible to devise a definitive test of the “stigma hypothesis”, it seems clear that stigma cannot be the only cost facing participants. Other, more concrete types of transactions costs are probably a good deal more important to most people than stigma or lack of information. Third, although people generally have means-tested programs in the United States in mind when they discuss take up, low take up is also a problem in many non means-tested social insurance programs and in other countries.

Historically, economists have paid much attention to rules about eligibility, and virtually no attention to how these rules are enforced or made known to participants. This review suggests that the marginal return to new data about these features of programs is likely to be high in terms of understanding take up. The anecdotal evidence that exists, suggests that there is a great deal of variation in the ways that similar types of programs are implemented both within and across countries, and this variation could be exploited to identify the most important barriers to participation.

For example, some states implemented SCHIP as an extension of their Medicaid programs, while others created separate, stand-alone programs in order to reduce the stigma associated with receiving public insurance. However, to my knowledge, this difference has not been exploited to investigate the “stigma hypothesis”. About half of the 109 Food Stamp offices surveyed in a recent USDA program access study provided services such as extended hours, while a small number of programs required applicants to attend a series of meetings before they were even permitted to sign their application forms (Gabor et al., 2003). Procedures such as requiring third party verification of income are not standardized across locations either, and

could easily explain variation in take up across areas. More systematic collection and analysis of this type of data would add a great deal to the study of take up.

In an era of social experiments, it might also prove useful to consider experimental manipulations of factors thought to influence take up. For example, it might be possible to design an outreach program that would directly test the hypothesis that take up is influenced by information exchange among members of social networks. Similarly, parameters such as application procedures, recertification intervals, payments for community enrollment assistance, and incentives to service providers to give application assistance could be varied across areas in order to study their effects.

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Table 1: Take-up of Means-Tested Programs in the United States

Means-Tested Program	Take-up estimates	Reasons for low/high take-up	Selected Literature
<p>Medicaid Established in 1965. Provides health insurance for low-income women and children, the disabled, and elderly in nursing homes. Eligibility for the program greatly expanded over 80s and 90s to women and children who were not on welfare. Income cutoffs depend on child age, and state. Projected to serve 34 million people at a federal cost of \$159 billion dollars in 2003 (state matching cost will be > 100 billion) (Centers for Medicare and Medicaid Services, 2002).</p>	<ul style="list-style-type: none"> - As of the early 1980s, children on welfare were automatically eligible and take-up in this group was close to full. -By 1996, 31% of children were eligible, but only 22.6% were enrolled, for an average take-up rate of 73% (Gruber, 2003). - Cutler and Gruber (1996a) and Currie and Gruber (1996a,b) estimate that of newly eligible children and women of childbearing age only 23% and 34% respectively took up coverage, but many of these eligibles were already covered by other insurance. - Over 35% of births in the U.S. now covered by Medicaid (NGA, 2002). - No take-up estimates are available for the elderly and disabled, although they account for over two-thirds of Medicaid spending. 	<ul style="list-style-type: none"> - Applicants who are not on welfare may be required to show birth certificates and/or citizenship papers, rent receipts and utility bills to prove residency, and pay stubs as proof of income. Many states have a time limit on the number of days the applicant can take to provide documentation and applicants are often required to return for several interviews. Up to a quarter of Medicaid applications are denied because applicants do not fulfill these administrative requirements: They cannot produce the necessary documentation within the required time or fail to attend all of the required interviews (GAO, 1994). - Coverage may need to be re-established as often as every six months. - Many physicians do not treat publicly insured patients because of low reimbursement rates. - Conversely, those who are sick may be able to retroactively obtain Medicaid coverage. - The newly eligible may not be aware of their benefits, particularly if they have not previously used public programs. 	<ul style="list-style-type: none"> - Currie and Gruber (1996a) find that the take-up was higher among newly eligible women who were likely to have had contact with other welfare programs, than it was among newly eligible women of higher income levels. May reflect slow diffusion of information about coverage among new eligibles. - Currie (2000) finds that immigrant children are more likely to be eligible for Medicaid but less likely to participate given eligibility. Probability of participation is higher in larger families and there is a strong seasonal effect in participation with people most likely to take-up benefits prior to start of school each year (when immunizations and checkups for school are mandated). - Currie and Grogger (2002) find that loss of welfare leads to loss of Medicaid coverage among pregnant women although most women leaving welfare remain eligible. They find little impact of state efforts to reduce non-price barriers to Medicaid coverage, such as shortening enrollment forms. - Aizer (2003a,b) compares the effects of application assistance and advertising on enrollments in California’s Medicaid program. She finds that while a positive impact of application assistance is found for children of all ages, the effect of advertising is limited primarily to infants. - Aizer and Grogger (2002) find that making parents eligible for Medicaid increases child coverage. Effects were largest among black and Hispanic children. - Card and Shore-Sheppard (2002) find that the expansion of eligibility to all children born after September 30, 1983 in poor families led to about a 10 percentage point rise in Medicaid coverage for children born just after the cutoff date, and a similar or rise in overall health insurance coverage. Expansions to children under 6 in families with incomes below 133 percent of the poverty line had relatively small effects.
<p>State Children’s Health Insurance Program A block grant to states begun in 1998, SCHIP provides funds to cover health insurance for children in families with incomes > the State’s Medicaid-eligibility threshold but < 200% of poverty. States may either expand Medicaid or develop stand-alone programs. It is not an entitlement program.</p>	<p>LoSasso and Buchmueller (2002) estimate take-up rates that range from 8.1% to 14% of the newly eligible.</p>	<ul style="list-style-type: none"> - The newly eligible may not be aware of their benefits, particularly if they have not previously used public programs. 	<ul style="list-style-type: none"> - LoSasso and Buchmueller (2002) use CPS data from 1996 to 2000 and find that SCHIP had a small but statistically significant positive effect on insurance coverage. - Aizer (2001) finds that gains in enrollment were larger in status that contracted out outreach for SCHIP.

<p>Supplemental Security Income Program (SSI) Enacted in 1972, but began paying cash benefits in 1974. Provides federal assistance for aged, blind and disabled individuals with low incomes. It has grown to become the largest federal means-tested cash assistance program. Served 6.5 million people in January 2003, total costs for 2002 were \$31.6 billion (Social Security Administration, 2003).</p>	<ul style="list-style-type: none"> - Daly and Burkhauser (2003) calculate that participation among the poor elderly declined from 78.5 percent in 1974 to 53.6 percent in 1982. Since then, participation rates have fluctuated from year to year, but have remained well below the highs recorded in the early years. - Reciprocity rates among poor working age adults rose from 14.8 percent in 1974 to 20.7 percent in 1998. - Reciprocity rates for poor children also increased rapidly during the 1990s, rising from 2.1 percent in 1989 to 6.6 percent in 1998 due to a change in the definition of disability for children with Sullivan vs. Zebley in 1990. - Estimated participation rates among the poor elderly range between 45 and 60 percent (Menefee, Edwards and Schieber (1981); Warlick (1982); Coe (19 85); Shields et al. (1990); McGarry (1996)). 	<ul style="list-style-type: none"> - Low enrollment among the elderly could be due to lack of knowledge about the program and eligibility criterion; stigma; or transactions costs. - Participation among low-income working age adults and among children is also likely to be affected by the benefits and costs of participation in SSI relative to other programs. 	<ul style="list-style-type: none"> - Coe (1985) reports that of the SSI nonparticipants classified as eligible (48 percent of all eligible individuals), a significant fraction were not aware of the program or did not think they were eligible. Coe also finds that benefit levels were positively and significant related to participation. - Warlick (1982) concludes that lack of program information and difficulty applying were the primary reasons for low participation rates among the eligible elderly. - McGarry (1996) used detailed asset and income information from the 1984 SIPP to more accurately identify eligibility. She concludes that participation is determined primarily by the financial situation of eligible individuals and by their health status and finds little evidence that welfare stigma or informational program costs affect participation. - Daly and Burkhauser (2003) conclude that the elderly poor are not generally constrained by transaction costs. - Bound, Kossoudji and Ricart-Moes (1998) found 2/3 of new applicants for SSI in Michigan between 1990 and 1991, were people who had been terminated from General Assistance. The Fact that these people had not applied for more generous disability payments to begin with, suggests that it is onerous to apply. - Daly and Burkhauser (1998): two-thirds of children found eligible for SSI in the early 1990s were in families already receiving some type of welfare assistance. - Kubik (1999): a 10 percent increase in SSI benefit generosity increases the probability of SSI participation among families with less educated heads by 0.39 percentage points. - Benitez-Silva, Buchinsky, and Rust (2003) estimate that 28% of SSI/DI applicants who get benefits are not disabled, while 61% of applicants who are denied are disabled. - Garrett and Glied (2000) find that the larger SSI benefits are relative to AFDC, the more likely it is that children switched programs after Sullivan vs. Zebley made it easier for them to qualify. There was no effect on adults, who were not affected by SZ.
<p>The Earned Income Tax Credit (EITC) Established in 1975, it is now the largest cash antipoverty program. There were three large expansions of the credit in 1986, 1990 and 1993. The EITC grew from \$3.9 million in 1975 (\$99) to \$31.5 billion in 2000. It is estimated that 5 million people were raised out of poverty by the credit in 1999 (NGA, 2002).</p>	<ul style="list-style-type: none"> - Scholz (1994) calculates that 80 to 86 percent of taxpayers eligible for the EITC received it in 1990. - The IRS (2002^a) estimated that between 82.2 and 87.2 percent of eligible households filed tax returns and hence claimed the EITC. - Scholz (1997) reports that roughly 95 percent of EITC claimants are either legally required to file tax returns or would file to recover the over-withheld taxes. 	<ul style="list-style-type: none"> - The marginal cost of obtaining the EITC for someone who is filing is simply the cost of filling out Schedule EIC. - Claiming the credit becomes more likely in cases where the potential credit is larger and where the filer's familiarity with the program and the U.S. tax system is greater. - Commercial tax preparation firms can reap substantial profits by targeting those eligible for EITC and offering "rapid refunds". - The IRS notifies all taxpayers who do not claim the credit but appear to be eligible for it based on their filing information. 	<ul style="list-style-type: none"> - IRS (2002) calculations suggest that the EITC changes between 1990 and 1996 had relatively little net effect on EITC participation. - Hotzblatt (1991), McCubbin (2000), and others find that a significant fraction of taxpayers receive the EITC when they are not technically eligible. Violation of the qualifying child eligibility criteria (i.e. misreporting a child) is a major reason. - Hotz, Mullin and Scholz (2000a, 2000b) find that the EITC has large, positive effects on the employment of adults from welfare families in California. The implied elasticity of labor force participation with respect to net income ranges from .97 to 1.69. - Similarly, Meyer and Rosenbaum (2001) find that the EITC is responsible for much of the recent rise in labor force participation among low income single mothers. - Liebman (2002) matches tax records to CPS data and finds that

			<p>most overpayments went to families with children and that ineligible families are likely similar to eligible ones.</p> <p>-Hotz and Scholz (2003) provide an overview of the recent literature.</p>
<p>The Temporary Assistance for Needy Families Program (TANF)</p> <p>Created in 1996 to replace the Aid to Families with Dependent Children (AFDC) program. To be eligible, income must be less than a state-determined needs standard. In contrast to AFDC, the TANF program has strong work requirements, time limits on receipt, options for provision of non-cash assistance, and by a block grant financing structure. The federal block grant has been 16.8 billion through 2002. States must contribute an additional 10.4-11.1 billion.</p>	<p>- Reciprocity fell from 11.5 to 7.2 million recipients between 1990 and 1999. In 1990, 12.1% of all children were on AFDC, compared to 7.2% of all children on TANF in 1999 (Green Book, 2000).</p> <p>- Blank (2001) estimates AFDC take-up rates among families with female heads over time. They range from 80 to 90% when she uses administrative data, and from 60 to 70% when she uses CPS data for 12 states (two-thirds of the caseload). Blank (2002) summarizes literature investigating whether the decline in the caseload should be attributed to welfare reform or to economic expansion. Welfare reform accounts for between 1/3 and 2/3 of the decline.</p> <p>- Moffit (2003b) shows TANF participation rates over time for single mothers and for poor single mothers. Both decrease over time, and are about 40% for single mothers and 50-55% for poor single mothers. Moffitt (2003c) shows that non-financial factors had a large effect on entry and exit from TANF.</p>	<p>- The cost of being on welfare is raised by many rules that TANF recipients must obey.</p> <p>- With a few exceptions, the studies show pre-TANF waivers allowing states to impose work requirements and other requirements on AFDC recipients had a negative effect on participation.</p>	<p>- Blank and Ruggles (1996) estimated that single mothers used AFDC in 62 to 70 percent of the months in which they are eligible. Women who are eligible but do not participate tend to be older, white, and nondisabled, with fewer children and more education. Higher benefits also encouraged participation. These results suggest that the AFDC was used by those with the greatest long-term need, and whose alternative earning opportunities were limited.</p> <p>- Hoynes (1996) and Moffit (1998) estimate participation equations which confirm that participation is positively affected by a guaranteed level of benefits and negatively affected by the marginal tax rate on benefits. Participation is also negatively affected by the hourly wage rate available and by non- program nonlabor income.</p> <p>- Grogger and Michalopoulos (2003) use data from a randomized experiment, the Florida Family Transition Program and find that time limits affect welfare use before they become binding (people save their 5 years of eligibility for a “rainy day”). In the absence of other reforms that increased welfare use, FTP’s time limit would have reduced welfare receipt by 16 percent. Grogger (2003) finds that time limits had a much greater effect on women with younger children, since women with older children had no incentive to conserve eligibility for benefits.</p>
<p>Housing Programs</p> <p>Began in 1937. Programs typically reduce rent to 1/3 of the families income. Most assistance reserved for households with incomes less than 50% of the local median income. Early programs built public housing. Since 1982, most new assistance has been in the form of voucher programs. In 2000, 5.1 million households were assisted at a cost of \$20.3 billion (Green Book, 2000).</p>	<p>- For the entire system of housing subsidies, the participation rate among eligible households is far below 50 percent for each combination of income and family size (Olson, 2003).</p> <p>- Reeder (1985) examines the percentage of households in each income and family size class who participated in any HUD program in 1977. The highest participation rate in any of the 77 classes was less than 25 percent. For unknown reasons, the poorest households of each size have very low participation rates. Within each income class, participation rates are highest for one-person households, reflecting the strong preference received by the elderly in housing programs.</p>	<p>- Assistance is available only to a fraction of eligible households and many housing authorities have lengthy waiting lists, and/or closed waiting lists.</p> <p>- Participants whose income rises above the thresholds for admission are rarely terminated, and local housing authorities are allowed to admit people with incomes higher than the 50% of median income cutoff. So persons of higher income may crowd out persons with lower income.</p>	<p>- Wallace and others (1981) compare the fraction of eligible households and participants in the Section 8 Existing and New-Construction Programs. For Section 8 Existing they find that in 1979 the percentage of participants who were elderly was about the same as the percentage of eligibles in this category, that minorities were a slightly larger fraction of participants than eligibles, and very-low income households were a noticeably larger fraction of participants than eligibles. For Section 8 Construction, elderly, white, females, and small families were greatly overrepresented in the sense that they were a higher fraction of participants than eligibles.</p> <p>- Olsen and Barton (1983) finds that in public housing in New York City in 1965, blacks had a much higher participation rate (about 20 percentage points) than whites with the same characteristics.</p> <p>- Crews (1995) used data from 11 metropolitan areas in 1987 and found that the poorest households, nonwhites, food stamp and welfare participants, the unemployed, and the elderly had higher participation rates.</p> <p>- Currie and Yelowitz (2000) conclude that the participation in housing programs increases with the size and is influenced by the sex composition of the family (due to program rules)., It declines with the age of the head, is much lower for married heads, and is</p>

			highest among blacks and those with less than high school education.
<p>Food Stamp Program (FSP)</p> <p>Established in 1961 as a pilot program and became nationwide in 1975. It serves households with gross incomes < 130% of poverty, without other categorical requirements. FSP provides coupons that can be redeemed for food with few restrictions on the type of foods. The federal cost is 19 billion (\$1998) and FSP served 20.8 million persons per month in 1998 (Currie, 2003).</p>	<p>- Only 69% of households eligible for the FSP participated in 1994. A 40% increase in enrollments between 1988 and 1993 was due mainly to a higher participation rate among eligibles rather than to an increase in the number of eligibles (Currie, 2003).</p> <p>- Take-up of FSP is high among some sub-groups of eligibles, but low among others. In 1994, 86% of eligible children participated, but only one-third of eligible elderly persons. Virtually all eligible single-parent households were enrolled compared to only 78% of eligible households with children and two or more adults. Participation rates were higher in some state than in others. Participation rates also tended to fall as income rose (U.S. Committee on Ways and Means, 1998).</p> <p>- Blank and Ruggles (1996) found that participation in the FSP increased with the size of the benefits. They also estimate take-up rates that range from 54 to 66 of all eligibles.</p>	<p>- Possible reasons for non-participation include: lack of knowledge about eligibility; transaction costs associated with enrolling in the program; and stigma associated with participation.</p> <p>- Transaction costs: The average FSP application took nearly 5 hours of time to complete, including at least two trips to a FSP office. Out-of-pocket application costs averaged about \$10.31 or 6% of the average monthly benefit (Currie, 2003).</p>	<p>- Three-quarters of non-participating households said that they were not aware that they were eligible. Only 7% of households gave stigma as their main reason for non-articipation, but half answered affirmatively to at least one of the survey questions about stigma (Currie, 2003).</p> <p>- Haider, Schoeni and Jackowitz (2002) find that many elderly people who are eligible for FSP say that they do not need benefits, which may indicate that there is stigma associated with using the program unless one is very needy.</p> <p>- Currie and Grogger (2002) show that recertification intervals have a negative effect on participation. The introduction of electronic debit cards instead of coupons, which might have reduced stigma, had little effect.</p> <p>- Daponte, Sanders and Taylor (1999) conduct an experiment and find that informing people about their eligibility increases participation. The effect is greater, the larger the benefit that people are eligible for.</p> <p>- Yelowitz (2000) estimates that for every 10 newly eligible families who took up Medicaid benefits, 4 also took up FSP. This fact suggests either that those who applied for Medicaid learned about FSP, or that it was more worthwhile to apply for both programs than to apply for only one (i.e. that benefits relative to the cost of applying matter).</p>
<p>National School Lunch Program (NSLP)</p> <p>Established in 1946. It cost 5.8 billion and served 27 million lunches in 1998 (Currie, 2003). Lunches are free to those with incomes<130% of poverty.</p>	<p>-99% of public schools and 83% all (public and private) schools participate. Nationally, 92% of students have the program available at their school (Burghardt et al., 1995).</p> <p>-In 1996, 57% of the children enrolled in participating institutions participated in the NSLP. Eighty-six percent of these participants received free lunches.</p> <p>- 87.2% of children 5-17 with incomes less than 130% of poverty participated in 1998 (Currie, 2003).</p>	<p>- In addition to the usual reasons for non-participation, families may not enroll in the program if their children are unlikely to eat the meals.</p>	<p>- Participation in the NSLP is higher among children from the poorest families.</p> <p>- Gleason (1995) finds that the characteristics of the meals are important determinants of participation. Glantz et al. (1994) find that if children indicate that they will not eat the meals, then parents do not apply.</p> <p>- Burghardt et al. (1993) found that over half of eligible non-participants believed they were ineligible, 10% thought the certification process was onerous, and 20% cited stigma.</p>
<p>The Special Supplemental Nutrition Program for Women, Infants and Children (WIC)</p> <p>Begun in 1972 as a pilot program and became permanent in 1974.</p>	<p>- The USDA estimates that 75% of eligible persons, participated in the program in 1995. Among infants take-up has been estimated to exceed 100% (Rossi, 1998).</p> <p>- Bitler, Currie & Scholz (2003) include those who were adjunctively eligible through participation in other programs and calculate that 58% of all infants in any given month in 1998 were eligible for WIC. The take-up rate among eligible infants was 73.2%. Among</p>	<p>- Possible reasons for non-participation include: lack of knowledge about eligibility; transaction costs associated with enrolling in the program; and stigma associated with participation.</p> <p>- In addition, WIC is not an entitlement program, so that funds may not be sufficient to serve all eligibles who present. However, in practice, there have been no waiting lists in recent years (National Research Council, 2003).</p> <p>- Estimates of takeup are complicated by the fact</p>	<p>- Brien and Swann (1999) show that administrative barriers such as requiring income documentation discourage people from applying for WIC.</p> <p>- Chatterji et al. (2002) show that in addition, restrictions on the type of food that can be purchased discourage participation.</p> <p>- Bitler, Currie and Scholz (2003) find that requiring more frequent visits to WIC offices also has negative effects on participation.</p>

<p>Offers nutrition education, supplemental food, and referrals to health and social services to children (<5), pregnant women and nursing mothers with incomes < 185% of poverty. The federal cost is 4 billion (\$1998) and it served 7.4 million people per month in 1998 (Currie, 2003).</p>	<p>children 1 to 4, 57% were eligible for WIC and 38% of eligible children received benefits. Estimates for pregnant and post-partum women are less accurate because of lack of information about infant feeding practices: It is estimated that 54% of all pregnant and post-partum women are eligible for WIC and that 66.5% of these women received benefits.</p>	<p>that one must be at nutritional risk to qualify. However, it appears that virtually everyone who meets income criteria is likely to meet nutritional risk criterion (National Research Council, 2003). - Participants in other programs including Medicaid are automatically eligible for WIC. USDA has ignored this linkage, resulting in under-estimates of the number of eligibles and over-estimates of participation rates.</p>	
<p>Child Care Subsidy Programs First established in 1954. PRWORA consolidated 4 major programs into the Child Care Development Fund in 1996. Program provides subsidies to working/training families with income<85% of state median income (or lower cutoff). Average monthly number of families served in 1998=907,351 at a cost of \$5.1 billion (Green Book, 2003).</p>	<p>- It is estimated that the CCDF serves only 15% of eligible children (Administration for Children and Families, 1999). There is no systematic information available on how CCDF funds are allocated among eligible children though info is available on type of care subsidized. - No figures are available on the percentage of eligible children served by other subsidy programs. - Witte (2002), using administrative data and survey data for states that guarantee subsidies for all eligible families, and estimates the family-level take-up rate for child care subsidies to be around 40% in early 2000. There are large variations across states.</p>	<p>- The enrollment process may be particularly difficult for working parents. - Some child care providers do not accept state subsidies. - It may be difficult to maintain continuous eligibility for the subsidy if income is variable. - It is difficult to get information about the various programs available. - There is insufficient funding to meet the demand. In addition to the CCDF block grants, status reallocated a billion dollars of their TANF block grants to child care in 1998.</p>	<p>- Meyers and Heintze (1999) examine a sample of current and former welfare recipients in four counties of California in 1995. 16% of employed mothers received a child care subsidy, 30% of mothers enrolled in education or training programs received a subsidy, and 34% of mothers in neither activity received a subsidy (including Head Start). The acceptance rate of mothers who applied for a subsidy was 72%. - Fuller et al. (1999) estimate a model of the child care subsidy take-up decisions of mothers enrolled in TANF using data collected in San Francisco, San Jose and Tampa in 1998. Of the women in their sample who used any non-maternal child care, 37-44 percent received a subsidy, depending on the site.</p>
<p>Head Start Established in 1964. A preschool program for mostly poor 3 and 4 year old children. In 2000, Head Start served 860,000 children at a cost of 5.3 billion (see Currie and Neidell, 2003).</p>	<p>- In 2000, about 2/3 of poor 3 to 4 year old children were served. It is not known how many of the remaining children were constrained by lack of supply. - Black and Hispanic children participate at higher rates than other children. - Programs are required to identify and take the most disadvantaged applicants.</p>	<p>- Most programs are part-day, which means that they do not satisfy all child care needs of working families. - Program has never been fully funded and many programs have waiting lists.</p>	<p>- Currie and Thomas (1995, 2000, 2002) investigate Head Start participation. Participation falls with income and maternal AFQT scores, but is higher at all levels of income for blacks than for whites. - Currie and Neidell (2003) find little evidence that children in high-spending programs are selected differently than children in low spending programs.</p>

Table 2: Take-up of Non Means-Tested Programs in United States.

Program	Take-up estimates	Reasons for low/high take-up	Selected Literature
<p>Medicare Signed into law in 1965. Provides health coverage for the elderly and disabled. It consists of two parts: Part A: mandatory hospital coverage and Part B which provides optional outpatient insurance. Since 1997 Part C has provided optional insurance for services not included in the traditional package. In 2001 40.1 million persons were covered of whom 34.4 million were elderly and 5.7 million disabled. Expenditures in 2001 totaled \$241 billion or \$6,199 per enrollee.</p>	<p>In 2002, 33,410,000 people were enrolled in Part A and 32,000,000 in part B. So the implied take-up of Part B is 96%. http://www.ssa.gov/OACT/STATS.</p>	<p>One reason for high take-up of Part B is that everyone is automatically enrolled in Part A when they turn 65 years old and they have to fill out a form to decline Part B.</p>	<p>McGarry (2002) provides an overview of Medicare: Part A is financed by a payroll tax instituted for this purpose and accounts for about 60% of Medicare spending. Part B is financed from general revenues and a monthly premium paid by beneficiaries. In 2002, the premium was \$54 per month, and represented about 25% of the cost of the insurance. In addition, enrollees pay deductible and co-payments on most covered services.</p>
<p>Social Security Disability Insurance (DI) The largest U.S. income replacement program directed towards non-elderly adults. Established in 1956, it is an insurance program that provides monthly cash benefits to workers who are unable to work because of long-term severe disabilities. In 2001, it provided benefits to 6.7 millions individuals at a cost of \$55 billion.</p>	<p>After the 1984 liberalization of the Federal Disability Insurance Program, the fraction of non-elderly adults receiving DI rose by 60% (Autor and Duggan (2003)). The number of beneficiaries increased from 2.8 million in 1988 to 5.5 million in 2002. The number of applications increased from 1 to 1.7 million and the number of awards from 409,000 to 750,000. http://www.ssa.gov/OACT/STATS/dibStat.html). These figures suggest that take-up increased since it is unlikely that the number of disabled was rising so rapidly</p>	<p>Applicants provide detailed medical, income, and asset information to the Social Security Administration office. Individuals currently in the labor force are not normally eligible. It is difficult to estimate the eligible group. Some work suggests that minorities and low SES people are more likely to be disabled (Bound et al. 1995, 1996) though self-reports of disability status may be biased (Bound, 1991). Benítez-Silva, Buchinsky and Rust (2004) provide an overview of the long and complicated application process. Yelowitz (1996) concludes that rising health insurance costs over 1987-1993 were an important reason for participation in DI, since DI recipients are automatically eligible for Medicaid.</p>	<p>Bound and Waidman (1992) find that half of the decline in labor force participation among men 45-54 between 1949 and 1987 could be due to the expansion of programs such as DI. Mitchell and Phillips (2002) find that older people initially in poor health and of low economic status are more likely to apply for DI. Autor and Duggan (2003) find that DI benefits impact labor supply. State-level reductions in benefits induced large increases in labor force participation of male and female high school dropouts from 1979-1984, followed by large declines during the DI expansion of 1984-1998. Benítez-Silva, Buchinsky and Rust (2004) look at the magnitude of classification errors in the award process assuming that self-reports of disability status are correct and find that 28% of the SSI/DI applicants who are ultimately awarded benefits are not disabled while 61% of applicants who were denied benefits are disabled. This is consistent with Bound's (1989) earlier finding that less than 50% of rejected DI applicants work.</p>
<p>Unemployment Insurance (UI) An unemployed worker must satisfy three sets of requirements: 1) no job in the covered sector & searching for work; 2) minimum waiting period; 3) previous minimum level of earnings, weeks, or hours. Approximately, 97% of all wage and salary workers are in jobs that are covered by unemployment insurance. UI benefits are typically paid on a weekly basis, and typically replace 50-60% of lost earnings. Federal law levies a 6.2% tax on the first \$7,000 in wages per year and the law</p>	<p>Blank and Card (1991) estimate a take-up rate of 70.7 in 1977 falling to 65.8 in 1987. They also find that rates vary widely across states. Over 1980-82, they find a take-up rate of 83% using micro data and 72% using state data. Less than 40% of the unemployed received UI in the recent years, because many do not meet eligibility requirements (Krueger and Meyer (2002)).</p>	<p>Blank and Card (1991) find that at least half of the decline in take-up rates over the past decade is due to a shift in unemployment from high to low take-up states. Benefit levels and state unionization rates have a strongly positive affect on take-up, while the disqualification rate. The average number of weeks worked in the last year in the unemployed pool also has a negative impact. In individual-level data, there is little evidence that declining take-up is due to increasing administrative strictness by state programs or changes in eligibility. Instead, demographic variables and household characteristics are significant determinants. Krueger and Meyer (2002) note that individuals</p>	<p>While Blank and Card (1991) find that about one quarter of the decline in take-up is still unexplained, Anderson and Meyer (1997) use administrative data from the late 1970s and early 1980s from UI system in six states, and find that a change in the tax treatment of UI benefits could be totally responsible for the unexplained portion of the decline over the early 1980s. (In 1979 UI became subject to income taxes). Card and Levine (1998) study the effects of changes in the duration of unemployment insurance on the behavior of UI claimants. They find that the New Jersey Extended Benefit Program (i.e. 13 additional weeks for the large majority who were initially eligible for 26 weeks of benefits) raised the fraction of UI</p>

<p>provides a credit of 5.4% to employers that pay State taxes under an approved UI system. In 2002, the UI system paid out \$41.6 billion in benefits, and took in \$21.4 in revenues (http://workforcesecurity.doleta.gov/unemploy/contents/data_stats).</p>		<p>who are new entrants or reentrants to the labor force, who have irregular work histories, or who quit or are fired are typically ineligible. Meyer (1995) surveys a series of experiments that paid bonuses to people who left unemployment and concludes that such economic incentives affect the speed with which people leave UI. Lemieux and MacLeod (2000) find that response to a 1971 increase in the generosity of the Canadian UI system increased with an individual's experience of the system, leading to long-term increases in unemployment as individuals who became unemployed discovered their new entitlements.</p>	<p>claimant who exhausted their regular benefits by 1-3 percentage points. Moreover, for individuals who were receiving UI when the extension was passed, the rate of leaving UI fell by about 15%. Anderson and Meyer (1997) estimate that a 10% increase in the weekly benefit amount would increase the take-up rate by 2-2.5 percentage points, while a similar increase in the potential duration of the benefits would increase take-up by .5-1 percentage points. A tax increase that decreased the value of after-tax benefits by 10% would lower take-up by 1-1.5 percentage points. Assuming take-up rates of .40-.60, they estimate benefit elasticities between .33-.60.</p>
<p>Workman's Compensation (WC) Each state runs their own program. Employers are required to purchase insurance or self-insure to provide a specific amount of cash benefits, medical care, and in some cases rehabilitation services to workers who are disabled. In 1985, this program covered 87% of the workforce and paid out a total of 22.5 billion in benefits (Krueger, 1990).</p>	<p>Krueger and Meyer (2002) state that about 97% of the non-federal UI covered labor force is covered, plus all federal employees. However, many workers ineligible for UI are eligible for WC since workers are eligible when they begin work. It is difficult to estimate take-up, given the difficulty in accurately identifying the eligible.</p>	<p>Benefits are about twice those of UI and are not taxable (hence the actual replacement rate may be near one) (Krueger and Meyer (2002)).</p>	<p>Krueger (1990) finds that higher workers' compensation benefits are associated with greater participation in the case of men, and that the waiting period has a substantial negative effect on participation. In particular, a 10% increase in temporary total benefits would lead to a 4.6-6.7 percentage increase in workers' compensation reciprocity overall. Card and McCall (1995) ask if workers' compensation is covering uninsured medical costs. They find that workers without medical coverage are no more likely to report a Monday injury than other workers; and employers are no more likely to challenge a Monday injury claim – even for workers who lack medical insurance. Krueger and Meyer (2002) summarize the empirical evidence on WC and say that more generous WC is associated with higher reported injury rates, but that the effect is small.</p>

Table 3: Take-up rates of Programs in the United Kingdom

Program	Takeup estimates	Reasons for low/high takeup	Selected literature
<p>Working Families' Tax Credit A refundable tax credit for low-income families with children and a adult who works 16 hours a week or more. It began in 1999 as a replacement for the Family Credit (introduced in the late 1980s). It is more generous than FC in terms of maximum benefits, the income level where the phase out begins, and the phase-out rate. Once granted, entitlement continued for six months, regardless of whether the family's financial circumstances changed. It includes a new nonrefundable Childcare Tax Credit. In addition, the nonrefundable Children's Tax Credit provides income support to low income families with children.</p>	<p>Clark and McCrae (2001) find that official estimates of take-up of the Family Credit (72%) are much higher than what they simulate using the TAXBEN model: 48%. Take-up rates vary widely across groups: e.g. 67% of single parents take-up compared to 40% of couples. Take-up also increases with the size of the benefit. Brewer et al (2002) estimate take-up rates as over time: 77% in 1993/4 and 81% in 1998/9 for lone parents (66% and 58% for couples).</p>	<p>Because the credit operates through the tax system, stigma effects should be minimized (Blundell (2002)). Dorsett and Heady (1991) note the close relationship between the Family Credit and Housing Benefit (see below). Finds that HB entitlement is an important determinant of take-up of both FC and HB.</p>	<p>Clark and McCrae (2001) find that 26% of people who received the benefit were not eligible. This may reflect the fact that the entitlement period is six months regardless of changes in family circumstances.</p>
<p>Child Benefit Began in 1945. A universal transfer program for families with children. Fifteen pounds (10) a week for the first (subsequent) child. Normally paid to the mother. When a child is born, the mother receives the claim package at the hospital.</p>	<p>Brewer (2000): Take-up of the child benefit was almost 100% in 2000-2001.</p>		<p>Brewer and Gregg (2001): There has been little change in the Child Benefit over time.</p>
<p>Income Support Formerly called "Supplemental Benefit". Means-tested benefits paid to the household head in workless families, make up the difference between income and a minimum guarantee level.</p>	<p>Brewer (2000): Income Support take-up is estimated to be around 80%. Duclos (1995) take-up among eligibles (in 1985) is 64%, but about 82.8% of the value of the benefit is received. About 6% of recipients are ineligible.</p>	<p>Duclos (1995) finds that take-up higher when the value of the benefit is greater. Less than full take-up reflects transactions costs.</p>	<p>Brewer and Gregg (2001): Income Support benefit rates have greatly increased since 1998.</p>

<p>Job Seeker's Allowance Begun in 1995, it replaced income support among the unemployed. Benefits are tied to previous wages. Must be 18 or older and have savings less than 8,000 pounds and be working less than 17 hours per week.</p>		<p>Recipients must abide by a "job seekers agreement" or risk losing benefits.</p>	
<p>New Deal Programmes Introduced in 1998. Means-tested programs for the unemployed. For 18-50 year olds include personal advisors, a gateway period of 4 months then one of: training or education, subsidized work, volunteer work, public sector employment. Help with childcare and travel costs. Less intensive services offered to those over 50, lone parents, and the disabled (Brewer et al. 2002).</p>	<p>At the end of June 2003, there were 91,380 youths 18-24 participating (Blundell, 2002).</p>	<p>Participation is compulsory after 6 months for 18-24 year olds and after 18 months for 25-50 year olds. Eligible individual who refuse to participate lose their entitlement to benefits.</p>	
<p>Income Support for Pensioners (now Minimum Income Guarantee) provides the difference between ones weekly income and a minimum benefit level. MIG will be replaced in 2003 with a new program called Pension Credit. It is expected that roughly 1/2 of elderly will be eligible for PC (Hancock et al., 2003).</p>	<p>Among those pensioners eligible for income support in 2000-2001, between 64% and 78% received the benefit (Department of Social Security, 2001)</p>	<p>Forms are complex and those eligible for small amounts may not apply. Also, stigma may be greater for income support than other forms of support such as Council Tax Benefit (Hancock et al. 2003).</p>	<p>Income support for pensioners rose considerably from 1997 to 2002: for example, by 31% for a single pensioner under 75, and 25% for a pensioner couple where one is aged 75 or over (Brewer et al, 2002).</p>
<p>Programs for the Disabled Incapacity Benefit: A social insurance program that pays fixed (high/low) benefits to people unable to work. Requires medical evidence. The Severe disablement allowance and Disability Living Allowance are non-contributory, non means-tested programs that also make small fixed payments. Those unable to work may also be eligible for income support. Disability working allowance: eligibles must be in paid work >= 16 hours per week, with an illness or disability which creates a disadvantage in securing employment, have savings of 16,000 pounds or less, and be in receipt of a qualifying benefit such as Disability Living Allowance.</p>			
<p>Housing Programs Housing Benefit: A means tested payment designed to subsidize the rent of those with low incomes. It is paid by local councils. Council Tax Benefit: A means-tested program that pays the council "rates" of</p>	<p>Brewer et al (2002) estimates take-up rates for housing benefits of : 89% for pensioners, 99% for non-pensioners with children and, 92% for non-pensioners without children, in 1999/2000. Department for Work and</p>	<p>Clark, Giles, and Hall (1999) note that the Council Tax Benefit is very complex which discourages take-up. However, those entitled to Income Support are automatically entitled to HB and CTB and forms are issued</p>	<p>Blundell et al. (1988) use the 1984 Family Household Survey and find that there is positive relationship between take-up and the level of entitlement. This support the view that there may be significant costs (ignorance or stigma) associated with claiming. Household characteristics affect takeup rates. The effect of extra household income is to reduce take-up significantly. Those in local authority</p>

<p>eligible families. It is the most commonly received means-tested program in Britain.</p>	<p>Pensions (2003) estimates that 7% of elderly eligible for HB do not receive it, compared to 31% of elderly eligible for the CTB.</p>	<p>together which is likely to increase take-up for IS (Hancock et al., 2003).</p>	<p>rented accommodation are more likely to take-up their entitlement than those in private rented and rent-free accommodation. Among those either in or seeking employment, part-time workers and unemployed with no record of occupation are more likely to take-up. Those under retirement age are substantially less likely to take-up than those over that age. Both age and education have a negative effect on take-up for the employed/unemployed. The presence of both additional adults and older children in the family increases the probability of take-up, although younger children appear to have no significant impact.</p>
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