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Obligations and Sanctions Rapid Evidence Review Paper 7: Social Obligations

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Executive summary

This paper provides a rapid evidence review that summarises the limited available research on social obligations in welfare benefit and cash transfer programmes. It describes New Zealand's current settings and examples of use of social obligations in other countries. It summarises evidence on the effectiveness of conditionality that involves social obligations.

Current Settings are that people receiving a main working-age welfare benefit in New Zealand must take reasonable steps to meet social obligations as a parent or a caregiver. These obligations require them to take all reasonable steps to ensure their child is enrolled with a medical practice, is up to date with Well Child/Tamariki Ora checks, and is enrolled and attending early childhood education or school.

Few high-income countries apply social obligations within their welfare benefit and other payment systems. **Examples of other countries** where they are applied include Australia (where some benefits are conditional on children receiving vaccinations, and conditioning payments on children enrolling in and attending school has been trialled), the United States (US) (where some states have social obligations relating to, eg school attendance and immunisations) and France (where family benefits were made conditional on school attendance but this was subsequently reversed). A few other OECD countries have payments for pregnant women or children that are conditional on accessing specified universal pre- or post-natal services.

In a number of low- and middle-income countries, the introduction of new cash transfers has been made conditional on, eg children's school attendance, or this kind of 'conditional cash transfer' (CCT) approach has been trialled. This approach has also been trialled in recent 'Family Rewards' demonstration studies in the US.

Empirical Evidence on the effects of social obligations attached to welfare benefits and other payments in high income countries is limited.

Research on the effectiveness of social obligations in Australia has mixed results. Social obligations appear to have been successful in increasing the number of children getting immunised. However, it is not clear that they were successful in increasing school attendance.

Overall, the empirical evidence on CCT's in middle- and low-income countries indicates that they have been effective in achieving their goals. There is debate about whether it is the 'conditional' part of CCT's that makes them effective, or whether simply giving families unconditional cash transfers (UCTs) would produce similar benefits.

The recent US 'Family Rewards' CCT demonstration studies have had mixed results, achieving a few of the improvements in outcomes for children sought, but leaving other important outcomes unchanged.

Purpose

This rapid review provides an overview of:

- New Zealand's **current settings** for social obligations applying to parents supported by benefit
- **International examples** of social obligations attached to welfare benefits or cash transfers
- empirical evidence on the **effects of social obligations**.

A separate paper in this series (Paper 1) provides an overview of the use of obligations and sanctions in welfare benefit policy, covering their rationale, frameworks for understanding how they might influence behaviour and outcomes, ways of categorising studies and effects, and approaches that might help minimise the need for sanctions to be used as a means of achieving public policy goals.

Current settings

Currently, people in receipt of a benefit are expected to take reasonable steps to meet social obligations as a parent or caregiver. These social obligations were introduced in 2013, and aim to use the benefit system to reinforce social objectives relating to child education and child health (Bennett, 2012). They require that children are:

- enrolled with a general practitioner or a medical practice that is part of a Primary Health Organisation
- enrolled in and attending one of the following from the age of three until they start school:
    - an approved early childhood education programme, eg
        - Kohanga Reo, Punanga Reo, Aoga and other programmes with a language and culture focus
        - parenting and early childhood home education programmes
        - kindergartens
        - preschools
        - childcare centres
        - play centres
        - home-based care services
    - Te Aho o Te Kura Pounamu – The Correspondence School
    - another approved parenting and early childhood home education programme
- if aged under five, up to date with core Well Child/Tamariki Ora checks through their provider (eg Plunket, a Māori health provider, or a Pacific health provider)
- enrolled in and attending school from the age of five or six (depending on when they start school). [1]

If a client has been through a regular engagement and support process and is not taking all reasonable steps to meet one of their social obligations and they do not have a good

[1] Social obligations are set out in sections 127-137 of the Social Security Act 2018.

and sufficient reason for failing to meet their social obligation, then an obligations failure may be initiated. In practice, there has never been an instance in which an obligations failure has been initiated for failure to comply with social obligations – no sanction has ever been applied.

International examples

There are few high-income countries where social obligations are applied within welfare benefit systems.

In the late 1990s, in an attempt to increase the number of children who were vaccinated, **Australia** made childcare benefits and lump sum maternity payments conditional on having children immunised. From 1 July 2012, immunisation was made a condition for receipt of the Family Tax Benefit. These obligations remain in place today, and the Australian government has signalled an interest in being more strict about exemptions from the policy (Taylor, Gray, & Stanton, 2016).

Other OECD countries also have some monetary payments for pregnant women or children that are conditional on accessing specified universal, free pre- or post-natal services (Austria, Finland, France, Hungary, and the United Kingdom (UK)). The UK Sure Stat Maternity Grant, for example, is conditional on a health professional certifying that the parent has received advice on maternal health and the health and welfare of the child before the birth and the health and welfare of the new child post-birth (OECD, 2009 p177).

Australia trialled social obligations attached to main welfare benefits relating to children's school enrolment and attendance in selected areas in the 2009-2012 School Enrolment and Attendance through Welfare Reform Measure (SEAM) trial (Former Department of Education, Employment and Workplace Relations, 2014), and these requirements continued to operate in some Northern Territory schools until December 2017.[2]

Under the **US** welfare reform introduced in 1996 (and in experiments that preceded welfare reform), some states have imposed behavioural requirements on children, adults or both. Children may be required to maintain a minimum grade point average or attendance (36 out of 50 states as at 2013), to receive immunisations (24 states) and to receive regular health check-ups (seven states). Sanctions can be applied for non-compliance (Ziliak, 2016 p320).

In 2010, **France** introduced a policy where family benefits could be suspended if a family's child consistently missed school. However, this policy was reversed three years later after it was found to violate the European Committee of Social Rights Collective Complaints procedure (Watts & Fitzpatrick, 2018).

In a range of **middle- and low-income countries,** conditional cash transfers (CCTs) have been introduced or trialled, and their use has expanded in recent decades (Watts & Fitzpatrick, 2018; OECD, 2009). CCTs provide cash transfers to poor families to reduce immediate hardship and poverty. They condition these transfers on families' efforts to improve their 'human capital', usually through children's educational participation and achievement and participation in health care, with the aim of also reducing intergenerational poverty (Riccio et al., 2013).

[2] See https://www.pmc.gov.au/indigenous-affairs/education/school-enrolment-and-attendance-measure

From 2007, inspired by CCTs, **US 'Family Rewards'** demonstration studies were carried out in New York City and Memphis, Tennessee. These demonstration studies offered cash rewards to low-income families to reduce immediate hardship, provided they met certain criteria related to family health care, children's education, and parents' work (Riccio et al., 2013; Miller et al., 2016).

Empirical evidence

There is little empirical evidence on the effects of social obligations attached to main welfare benefits or other payments in high-income countries.

Evidence from **Australia** is mixed. The immunisation initiatives introduced in the 1990s appear to have been successful in increasing immunisation, based on a 'methodologically unsophisticated but favourable evaluation' (OECD, 2009 p177). They were also generally seen as acceptable, partly because they were attached to 'bonuses' that could be received on top of existing benefits, and partly because of provision for exemption in cases of conscientious objection or medical contraindication.

It is less clear that the SEAM trial led to the intended behaviour change (Taylor et al., 2016). An evaluation found a number of difficulties with implementation, and uneven impacts across groups of schools. For some groups of schools, positive effects were estimated. For others *"the observed SEAM effect was not sustained throughout the trial. Qualitative information suggests that families were receptive to the trial and schools were encouraged by the reaction at the initial stage of the trial. Practical difficulties and challenges arising from the implementation of the SEAM trial, however, had limited its effectiveness over time. It was noted that the threat had not been backed up by prompt responses and implications such as suspension in payments and thus the behavioural change was not sustained."* The evaluation found the provision of social work contact was one of the critical and most positive elements for the SEAM trial. Support required by families typically proved to be intensive and on-going (Former Department of Education, Employment and Workplace Relations, 2014 pIX-X).

A recent review of the **US** welfare reform provided no evidence examining the distinct impact of varying application of social obligations within the **US** welfare system post-welfare reform (Ziliak, 2016).

Overall, the empirical evidence on **CCT's in middle- and low-income countries** indicates that they have been effective in achieving their goal of ensuring that services are used and alleviating poverty in the short-term (OECD, 2009; Watts & Fitzpatrick, 2018).

However, there is debate about whether it is the 'conditional' part of CCT's that makes them effective, or if simply giving families unconditional cash transfers (UCTs) would produce similar benefits. In other words, perhaps CCTs have been effective not because they are conditional, but because they provide frequent payments to families in need. The evidence on whether CCTs or UCTs are more effective in achieving the policies goals is mixed. Some studies find that while both achieve the programmes' short-term aims, CCTs have had a greater effect (Fiszbein & Schady, 2009). However, one of the latest reviews by Kidd (2016) makes the case that some studies that favour CCTs over UCTs are flawed and overall, there is no robust evidence that suggests CCTs are any better than UCTs.

There is little evidence to date on the long term effects CCTs have on people in poverty and their children, and a call for additional attention to be placed on the quality of services (OECD, 2009, p176).

The **US Family Rewards** CCT demonstration studies were evaluated in randomised controlled trials (RCTs). Results were mixed.

In the first Family Rewards demonstration study, families were offered 22 cash rewards for activities and outcomes in three domains. Over $8,700 in cash rewards was transferred to families over three years, on average.

Family Rewards succeeded in reducing current poverty and material hardship (its main short-term goal), but effects weakened after the cash transfers ended.

The RCT showed positive effects on some human capital outcomes, but many important outcomes were unchanged. The programme:

- did not improve school outcomes for elementary or middle school students
- had few effects on school outcomes for high school students overall, however, it substantially increased graduation rates and other outcomes for students who were already stronger readers
- did not increase families' use of preventive medical care, which was already high, and it had few effects on health outcomes
- produced large increases in families' use of dental care services.

The authors concluded that the model had not demonstrated its value sufficiently to scale it up in its original form, but that because it had some successes continuing to experiment with a CCT approach in the United States had merit (Riccio et al., 2013).

In the subsequent 'Family Rewards 2.0' demonstration study, families were offered fewer rewards (8 rather than 22), education rewards were only offered in respect of high school students, and rewards were made more timely by paying them each month. The biggest change to the model was the addition of guidance from staff members, who actively helped families develop strategies to earn rewards. Over $6,200, on average, was transferred to each participating family.

The guidance component became more intensive over time, although the amount of interaction between staff and participants was less than planned. The addition of this component was seen as a positive step, leading to a good understanding of the programme and higher rates of receipt of available rewards.

After four years, as with the first model, Family Rewards 2.0 had produced some positive effects on some outcomes, but left many other outcomes unchanged. RCT results showed the programme:

- increased income and reduced poverty during the program period, and led to improvements in parents' reports of life satisfaction and happiness
- did not affect students' school progress, either for the full sample of students or for the subgroup of academically proficient students
- increased preventive dental visits, with some evidence that it also improved adults' self-reported health status, particularly for those in poorer health at study entry.

Family Rewards 2.0, while replicating many of the results from the first model, did not prove to be more effective. The lack of effects on educational outcomes in the second study may have been partly due to the lower total value of the cash transfers (Miller et al., 2016).

Conclusion

A general premise of social obligations attached to welfare benefits and CCTs is that people make decisions in the short term that are not consistent with the longer-term interests of their children or wider societal goals (Riccio et al., 2013). The aim of conditionality is often to increase use of a free service that is not fully taken up by all, and to bring private behaviour closer to the social optimum (OECD, 2009).

There is little empirical evidence on the effectiveness of conditionality that involves social obligations backed by sanctions in achieving this aim.

Considerations for policy makers when reviewing use of social obligations include the following.

- Whether conditionality will effectively address the underlying causes of non-take up of services. For example, if a family undervalues the future benefits of education then CCT's might successfully increase school attendance, but if a family decides not to send their child to school because the quality of education is poor, then a CCT might only financially harm the family (Fiszbein et al., 2009); when people experience scarcity, this can hinder ability to think about the future, resist temptations and focus (Shafir and Mullainathan, 2013), and if this drives a parent's decision making, conditionality that triggers sanctions or means they miss out on cash transfers may fail to address or compound the problem.
- Whether conditionality is the most effective approach relative to alternative ways of influencing behaviour, eg using behavioural insights to make options which are beneficial in the long-term attractive and easy options in the short-term (Richburg-Hayes et al., 2017). Examples of studies that have applied behavioural insights include one that shows that sending letters that target key misbeliefs held by parents of at-risk students can increase school attendance (Rogers & Feller, 2015; Behavioural Insights Team, 2018).
- Whether, if conditionality is to be used, conditionality reinforced by sanctions is the most effective approach, relative to conditionality reinforced by rewards (eg CCTs) (Taylor, 2016).
- Whether, if conditionality reinforced by sanctions is to be used, this results in some highly vulnerable families disengaging from the system, and whether it results in stigmatisation (Taylor, 2016; Watts & Fitzpatrick, 2018). An identified risk with an increasingly punitive approach to the application of immunisation-related conditionality in Australia over time is that those experiencing social and economic disadvantage are least able to meet the conditions and the most likely to be penalised (Taylor et al., 2016).
- The critical role of case managers and education, health and caring professionals and administrative complexity in determining whether conditionality is applied in practice (Taylor, 2016; Former Department of Education, Employment and Workplace Relations, 2014).

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