Guaranteed Annual Income: A Policy to Address the Social Determinants of Health

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Executive Summary

Addressing the social determinants of health (SDOH) with a health in all policies approach is critical to improving population health and social outcomes and ensuring the sustainability of the Canadian healthcare system. Poverty is the single largest determinant of health and is the root cause of many widespread societal problems, so policies that target poverty reduction are needed. A guaranteed annual income (GAI) is a promising policy solution to achieve this through its influences on the SDOH. Essentially, GAI establishes an income floor by ensuring that every citizen has an income above the poverty line so that they have enough money to meet their basic needs.

A GAI would have positive influences on four key SDOH; income and social status, employment and working conditions, education, and early childhood development. Since the minimum income level would be set above the poverty line, it has the potential to virtually eliminate income poverty, providing enough money to every citizen to afford enough food to eat and adequate housing to live in. The financial security and freedom that a GAI provides will allow people to escape jobs with poor working conditions for better employment, pursue entrepreneurial and business ventures, pursue education or other meaningful activities, perform caregiving responsibilities for children and the elderly, and allow children to escape the poverty cycle and reach their full potential as well-adjusted, productive, and healthy adults.

For all of these reasons, GAI has the potential to improve the health and well-being of Canadians, but should be complemented with additional public and social programs. Implementing this policy will require widespread political will and rigorously evaluated pilot projects to determine the details of the design and how to best implement it across Canada.

Introduction

Social class disparities in the prevalence of disease and mortality are persistent despite living in a nation that provides universal access to health care services, indicating that these services are insufficient in themselves in achieving health equity. In order to ensure the sustainability of Canada's universal healthcare system, the Government must strongly consider the implications of policy from other sectors on health. Since the Lalonde Report in 1974 (Health and Welfare Canada, 1974), there has been growing emphasis on addressing the social determinants of health (SDOH) in the healthcare sector because health disparities exist on a socio-economic gradient (Marmot, 2002, Pickett & Wilkinson, 2015). Yet, the healthcare system in Canada largely focuses on the downstream treatment of illness; more focus is needed on the upstream prevention of illness with a health in all policies approach to addressing the SDOH (Kershaw, 2018).

In a world where the richest eight individuals possess more wealth than half of the global population (Oxfam International, 2017), it is imperative that we are proactive in creating a poverty free society where everyone has a decent standard of living. Poverty is a socially constructed problem that results from the inherent income inequality in our capitalist society that creates large gaps between the rich and the poor. A reformative policy that shows huge promise in addressing income inequality and poverty is the Guaranteed Annual Income (GAI). GAI has been supported for decades by economists, welfare theorists, and politicians on both the left and the right because of its potential to eradicate poverty by providing every citizen with enough money to meet their basic needs (Roos & Forget, 2015).

About 1 in 7 Canadians live in poverty (Citizens for Public Justice, 2017), a quarter of whom are children (Statistics Canada, 2017), which indicates that our current social assistance systems are insufficient to eradicate poverty. The poor health and social consequences associated with poverty costs everyone in Canada through additional costs to the healthcare system, social assistance, the criminal justice system and lost productivity (Canada Without Poverty, 2013). In fact, lower socio-economic status groups are consistently more likely to be high-cost users of healthcare, and are part of the small percentage of the population who account for a disproportionately large amount of healthcare costs and utilization (Lemstra et al, 2009, Canadian Institute for Health Information, 2014; Fitzpatrick et al., 2015; Rosella et al., 2014). The differences in health by income level were estimated to cost Canada's healthcare system at least $6.2 billion annually, or over 14% of total expenditures on acute care inpatient hospitalizations, prescription medication and physician consultations (Public Health Agency of Canada, 2016). The total costs of poverty have been estimated at $72-$84 billion annually in Canada (Canada Without Poverty, 2016).

GAI appears to one of the most promising alternative policy options to solve poverty, and healthcare leaders should be advocating for it because investments in social programs have a stronger influence on population health than spending within health ministries (Dutton et al, 2018). The remainder of this essay explains how a GAI may work and discusses how its implementation could have profound positive impacts on the health and well-being of Canadians through its effects on the SDOH.

Guaranteed Annual Income

Although a GAI could be designed in numerous ways, the model advocated for in this essay is the Negative Income Tax (NIT) model. This model of GAI is implemented through the income tax system and is designed so that if someone's income from all sources falls below an income threshold that is deemed necessary to meet their basic needs, they would receive an income supplement topping them up to that threshold. At an income level equal to the threshold, people would not receive a supplement but also would not pay any taxes. Above the threshold, the progressive income tax system would kick in. This threshold would create an income floor that no citizen should fall below, and since it would be set above the poverty line, it has the potential to virtually eliminate poverty (Martin, 2017).

The income supplement would be adjusted for household size, accounting for the variations in the cost of living per adult and child. It would also account for regional variations in the costs of living and be indexed to inflation to effectively reduce poverty over the long-term. Although the details of the GAI could be designed in various ways, these basic features remain the same. The last major GAI experiment in Canada was conducted during the 1970's in Manitoba, called the MINCOME experiment (Forget, 2011). The effects on healthcare showed an astonishing 8.5% reduction in hospitalization rates with the largest drops in admissions due to accidents and injuries and mental health, and significant decreases in family doctor visits for mental health. This study is held up as the shining example of evidence for GAI in Canada.

GAI is a policy based on the principle that every human being has the right to a decent standard of living no matter their individual circumstance or socio-environmental realities. The focus of current social assistance systems on excluding "un-deserving recipients" obscures the

structural barriers associated with the social determinants of health that create obstacles for vulnerable people (McNeill, 2010). The GAI would be universal to every eligible citizen, considering these barriers and paying everyone without a means test or work requirement, meaning that the only condition would be their income when they file their income tax return.

Since the GAI would be implemented through the tax system, it would eliminate the high bureaucratic costs and administrative burden existent in current social assistance systems. It would also allow for objectivity in assessing eligibility, administrative simplicity, and financial efficiency through targeted payments to low-income individuals (Martin, 2011). The simplified structure would also reduce the stress and anxiety of obtaining benefits for a population that is already under a lot of stress and, if designed correctly, would incur a cost that is comparable to current social assistance systems. However, as outlined next, there are also many benefits that a GAI would have through its influences on the SDOH.

Income and Social Status

The SDOH are all interrelated and interact in complex ways, often piling up on top of one another to produce poor health outcomes. However, Dr. Danielle Martin put it best when she said, "Income is the determinant of the determinants of health," and argued that if we had to choose only one social determinant to focus on, it should be poverty because it the single largest determinant of health (Martin, 2017, WHO, 2018). Addressing income poverty would improve health by influencing the ability to purchase the things necessary to survive such as food and housing, and by influencing one's social participation and ability to control life circumstances (Government of Canada, 2013). Reducing poverty would also help to mitigate

the toxic stress and allostatic load created by living in conditions of income insecurity where one's ability to access essential resources is constantly in a precarious state.

GAI would be an improvement over existing social assistance systems because even the best programs provide an income below the low-income cut-off (LICO), the unofficial poverty line (Tweddle, Battle & Torjman, 2017). This forces people on social assistance to choose between shelter or food, resulting in 8% of Canadians experiencing food insecurity and 12.5% not living in acceptable housing because they cannot afford it (Government of Canada, 2016). Setting the minimum income threshold at a level above the poverty line will ensure that every Canadian can afford the essentials of a decent standard of living such as nutritious food and acceptable shelter.

Reducing poverty and rising income inequality is necessary to maintain peace and social trust, but it will require a strategy of wealth redistribution that keeps the free market intact. A GAI is a fair redistribution strategy that will provide enough income to the impoverished to increase their self-perceived social status and perhaps their faith in society. Everyone benefits when those at the bottom do better, and that is why GAI is a rising tide to lift all ships.

Employment and Working Conditions

A major concern about GAI is that it will lead to reduced work effort as people will just sit at home collecting their benefits and not contribute to the economy. This is a real concern, but quite frankly the evidence on GAI experiments in Canada and the United States do not bear this out. While there were modest decreases in work effort, these decreases were much less likely than expected before experimentation (Martin, 2011). The only reduction in work during MINCOME were for married women, who used the GAI to look after their young children, and

for young, unattached males, who used it to continue their education (Hum & Simpson, 2001).

However, the reduction in hours worked was significantly higher in the American studies, which

ranged from 1% to 8% for husbands and 3% to 33% for wives (Hum & Simpson, 1993). Since

these studies are more than 20 years old, it is important to study this aspect of the GAI further.

These modest reductions in work effort could be offset by the societal benefits of what

people do with their time instead of paid work. Without the absolute necessity of work just to

make ends meet, people are free to escape jobs with poor working conditions to pursue higher

quality or more meaningful employment, pursue entrepreneurial and business ventures,

continue education and perform caregiving responsibilities for children and elderly relatives.

17% of women and 11% of men report spending 20 hours or more per week providing care,

with about 1 in 7 of all employed caregivers having to reduce their paid work by an average of

about 10 hours per week (Vanier Institute, 2017). All of this unpaid work is saving money

through decreased health and child care utilization and should be subsidized with a GAI.

It appears that our economy can afford a modest reduction in labour supply given that

current labour market trends are becoming increasingly characterized by underemployment,

precarious work, and low, stagnant wages as a consequence of corporatocracy, innovation, and

the increasing automatization of jobs. The reduction of well-paying, full-time jobs is shifting the

labour market distribution into an hour glass shape, squeezing out the middle class, and leading

to further inequality and poverty (Toronto Workforce Innovation Group, 2010). This poses

many questions about how Canadians working at the bottom of the hourglass distribution will

be able to achieve an acceptable standard of living as the wealth becomes more concentrated

at the top and quality job opportunities decline. The realities of the labour market make it

imperative that we consider a new social contract about wealth redistribution in society that benefits everyone.

The current social assistance systems deter people from working because the claw back of benefits as income is earned traps people behind a "welfare wall," which institutionalizes poverty rather than fighting it (Martin, 2017). GAI will maintain work incentive because as earned income increases the benefit declines, but less than proportionately, ensuring that people who work are always better off than they would be if they did not. The current systems also leave behind the roughly 750,000 Canadians who are living in a household headed by someone who meets the definition of the "working poor," which means that despite working over 910 hours per year, they fall below the LICO (Government of Canada, 2016). If someone is working this much, they deserve to earn enough money to support their family and have access to income assistance if needed. The universality of GAI will ensure that every Canadian has a social safety net, even if they are employed.

Education

Education is connected to health through a number of pathways. Higher educational attainment leads to better employment opportunities, especially with the labour market switch to more knowledge jobs that require a post-secondary education. It also leads to better working conditions, more work-related resources, and higher social standing (Braveman & Gottleib, 2014, Zimmerman, Woolf & Haley, 2014). Additionally, education increases knowledge, skills health literacy, which facilitates informed health decisions and healthier behaviors (Zimmerman, Woolf & Haley, 2014).

Getting an education is often someone's best chance at getting out of poverty, but people in poverty are the least likely to have the financial ability to pursue an education. Unlike the current social assistance systems, which takes away support when one applies for a student loan, the GAI will not dis-incentivize education. Also, the financial security and freedom that a GAI provides will allow many more people to stay in school longer. This is supported by the MINCOME evidence, which saw high school enrolment rates in Dauphin, Manitoba exceed 100% during the GAI experiment as previous dropouts returned to high school to graduate (Forget, 2011). After MINCOME, enrolment rates dropped back down to previous levels consistent with the rest of rural Manitoba. Additionally, when Brazil implemented its GAI program, school dropout rates lowered to zero after two years (Suplicy, 2010). When people are not compelled to work just to survive and support their family, they can use the opportunity as a springboard to build a better life through education, leading to better health, increased productivity and long-term economic gains.

Early Childhood Development

Early childhood development is another SDOH that would benefit from a GAI. In 1989, the House of Commons voted to end childhood poverty by 2000, but in 2015 childhood poverty rates were over 17%, leaving about 1.2 million children in poverty (Campaign 2000, 2017). The rates are even worse for children in single-parent families, racialized children, and First Nations children. Families with children are also more likely to live in a household experiencing food insecurity and inadequate core housing needs (Government of Canada, 2016). The allostatic load resulting from living in chronic social and environmental stress during childhood development places children at risk of direct health consequences, and earliest years of life are

the most sensitive (Shonkoff et al, 2010). Therefore, early experiences of poverty and poor

living conditions in early life have been associated with increased vulnerability to a range of

adolescent and adulthood diseases. Not only are impoverished children more susceptible to

poor health outcomes as adults, they are also less likely to reach their full potential and

contribute to the economy, and more likely to repeat the cycle of poverty. Early investments in

children will lead to significant long-term societal benefits with better educated, well-adjusted

and more productive adults.

Canada already has a basic income policy in place for children called the Canada Child

Benefit (CCB), which is a major stride in eradicating child poverty. Since its implementation in

2016, welfare incomes for families with children increased dramatically (Tweddle, Battle &

Torjman, 2017). It is estimated that without government transfers such as the CCB, about 28%

of children would live in poverty (Campaign 2000, 2017). While this more than 10% decrease in

child poverty is important, improvements are still needed in income security programs to

eradicate it, and the integration of the CCB with the GAI is a potential solution to fill this gap.

Conclusions and Moving Forward

In summary, the GAI would reduce income inequality and poverty by providing every

Canadian with sufficient income to meet their basic needs, respond to the current labour

market realities and support better employment, provide the financial security to pursue

education or other meaningful activities, and put children in a better position to reach their full

potential. Not only does the GAI have the potential to significantly improve the health and well-

being of Canadians through its influence on the SDOH, it has the potential to decrease stigma

and enhance the dignity of those requiring income assistance. However, GAI is not a poverty

panacea, and should be complemented with strong public and social programs such as

increased minimum wages, affordable housing options, employment support programs, early

childhood education and care programs, and others to confront the multiple dimensions of

poverty.

In addition to the CCB, the Guaranteed Income Supplement (GIS) and Old Age Security

(OAS) for seniors already provide a form of basic income to about a third of Canadians (Martin,

2017). When OAS was introduced in 1975, poverty rates in seniors dropped from 35% to 3% in

three years, marking one of the most successful poverty reduction policies in Canadian history

(Segal, 2014). The logical next step is to integrate these programs with a GAI to provide a basic

income to every Canadian no matter their age.

Canada has the opportunity to show leadership in the developed world and take a huge

step forward in reducing poverty and income inequality by implementing a GAI. As citizens, we

must do the right thing by demanding leadership from our political leaders in order to create

the political will necessary for the implementation of a policy of such grand magnitude.

However, it has been a long time since the MINCOME experiment first showed supporting

evidence for implementing GAI in Canada, so further investigation is required to determine how

to maximize improvements to health and social outcomes in today's society. A 3-year pilot

project is currently ongoing in Ontario (Government of Ontario, 2017), but additional pilot

projects representative of diverse Canadian populations are needed in order to inform future

implementation. Further investigation into the specifics of the design are needed to determine

the income thresholds, benefit claw back rates, financing, inter-face with provincial and

territorial programs and other unintended consequences of GAI. Rigorous examinations of the

health and social outcomes resulting from GAI are also needed, including a full health impact

assessment.

Many people say that a GAI is such a radical idea that it cannot be done. However, many

said the same about universal health care before it was implemented, and now it is regarded as

a source of national pride. It is based on the same basic premise as Canadian healthcare; that

we all pay in, hope that we never have to use it, but when push comes to shove we all have the

sense of security knowing that it is there to catch us when we fall. I believe that once

implemented, a GAI has the potential to drastically improve the health and well-being of

Canadian society, and people will look back on its implementation as a defining moment in

shaping what it means to be Canadian.

References:

Braveman, P., & Gottlieb, L. (2014). The Social Determinants of Health: It's Time to Consider the Causes of the Causes. *Public Health Reports*, *129*(1_suppl2), 19–31. https://doi.org/10.1177/00333549141291S206

Campaign 2000. (2017). A Poverty-Free Canada Requires Federal Leadership: 2017 Report Card on Child and Family Poverty in Canada. Retrieved April 4, 2018, from https://campaign2000.ca/wpcontent/uploads/2017/11/EnglishNationalC2000ReportNov212017.pdf

Canadian Institute for Health Information. (2014). Pan-Canadian Forum on High Users of Health Care, 1–25. Retrieved March 30, 2018, from https://secure.cihi.ca/free_products/highusers_summary_report_revised_EN_web.pdf

Canada Without Poverty. (2013). The Cost of Poverty. Retrieved March 10, 2018, from http://www.cwp-csp.ca/poverty/the-cost-of-poverty/

Canada Without Poverty. (2016). Canada Without Poverty Annual Report 2016-2017. Retrieved April 4, 2018 from http://www.cwp-csp.ca/wp-content/uploads/2017/06/Annual-Report-2016-2017.pdf

Citizens for Public Justice. (2017). Poverty Trends Report 2017. Ottawa, Ontario. https://www.cpj.ca/sites/default/files/docs/files/PovertyTrendsReport2017.pdf

Dutton, D., Forest, P.G., Kneebone, R.D., Zwicker, J.D. (2018). Effect of provincial spending on social services and health care on health outcomes in Canada: an observational longitudinal study. Canadian Medical Association Journal, 190(3): E66-71. doi: 10.1503/cmaj.170132

Fitzpatrick, T., Rosella, L. C., Calzavara, A., Petch, J., Pinto, A. D., Manson, H., … Wodchis, W. P. (2015). Looking beyond Income and Education: Socioeconomic Status Gradients among Future High-Cost Users of Health Care. *American Journal of Preventive Medicine*, *49*(2), 161–171. https://doi.org/10.1016/j.amepre.2015.02.018

Forget, E. L. (2011). The Town with No Poverty: The Health Effects of a Canadian Guranteed Annual Income Field Experiment. *Canadian Public Policy*, *37*(3), 283–305. https://doi.org/10.3138/cpp.37.3.283

Government of Canada. (2013, January). *What Makes Canadians Healthy or Unhealthy?* Retrieved April 4, 2018, from https://www.canada.ca/en/public-health/services/health-promotion/population-health/what-determines-health/what-makes-canadians-healthy-unhealthy.html#status

Government of Canada. (2016, October). *A backgrounder on poverty in Canada*. Retrieved April
    4, 2018, from https://www.canada.ca/en/employment-social-
    development/programs/poverty-reduction/backgrounder.html#h2.7-h3.2

Government of Ontario. (2017, April). *Ontario Basic Income Pilot, Studying the impact of a basic
    income*. Retrieved March 10, 2018, from
    https://files.ontario.ca/170508_bi_brochure_eng_pg_by_pg_proof.pdf

Health and Welfare Canada (1974). A new perspective on the health of Canadians: the Lalonde
    report. Ottawa, ON: Health and Welfare Canada.

Hum, D & Simpson, W. (1993). Economic response to a guaranteed annual income:
    experience from Canada and the United States. *Journal of Labour Economics*, 11(1).

Hum, D & Simpson, W. (2001). A guaranteed annual income? From Mincome
    to the millennium. *Policy Options*; Mulvale.

Kershaw, P. (2018). The need for health in all policies in Canada. *Canadian Medical Association
    Journal*, *190*(3), E64-5. doi: 10.1503/cmaj.171530

Lemstra, M., Mackenbach, J., Neudorf, C., & Nannapaneni, U. (2009). High health care
    utilization and costs associated with lower socio-economic status: results from a linked
    dataset. *Canadian Journal of Public Health*, 100(3), 180–183. Retrieved from
    http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=emed9&NEWS=N&AN=
    19507718

McNeill T. (2010). Family as a social determinant of health: implications for governments and
    institutions to promote the health and well-being of families. *Healthcare Quarterly*,
    14(Sp), 60-67. doi:10.12927/hcq.2010.21984

Marmot, M. (2002). The influence of income on health: views of an epidemiologist. *Health Aff
    (Millwood), 21*(2), 31-46.

Martin, D. (2017). Better Now: Six Big Ideas to Improve Health Care for All Canadians. Penguin
    Canada.

Martin M. (2011). International perspectives on Guaranteed Annual Income Programs. *Queen's
    Policy Review*, 2(1).

Oxfam International. (2017, January 16). Just 8 men own same wealth as half the world.
    Retrieved March 06, 2018, from
    https://www.oxfam.org/en/pressroom/pressreleases/2017-01-16/just-8-men-own-
    same-wealth-half-world

Pickett KE, & Wilkinson RG. (2015). Income inequality and health: A causal review. *Social Science & Medicine*, (128), 316-326. https://doi.org/10.1016/j.socscimed.2014.12.031

Public Health Agency of Canada. (2016). The Direct Economic Burden of Socioeconomic Health Inequalities in Canada: An analysis of health care cost by income levels.

Roos N, Forget E. (2015). The time for a guaranteed annual income might finally have come. *The Globe and Mail*. Retrieved April 4, 2018, from https://www.theglobeandmail.com/report-on-business/rob-commentary/the-time-for-a-guaranteed-annual-income-might-finally-have-come/article25819266/

Rosella, L. C., Fitzpatrick, T., Wodchis, W. P., Calzavara, A., Manson, H., & Goel, V. (2014). High-cost health care users in Ontario, Canada: Demographic, socio-economic, and health status characteristics. *BMC Health Services Research*, *14*(1). https://doi.org/10.1186/s12913-014-0532-2

Segal, H. (2014). Senator speaks about guaranteed annual income. Toronto: Anglican Church of Canada. Retrieved March 30, 2018, from www.toronto.anglican.ca/2014/05/26/senator-speaks-about-guaranteed-annual-income-at-church

Shonkoff, J. P. (2010). The Foundations of Lifelong Health Are Built in Early Childhood. *Harvard University Center on the Developing Child*, 1–32. https://doi.org/papers://3A1C84B7-1D09-4494-9751-18F2A4917626/Paper/p6389

Statistics Canada. (2017). Children living in low-income households. Statistics Canada Census in Brief. Catalogue no. 98-200-X2016012

Suplicy, EM. (2007). Basic income and employment in Brazil. *An International Journal of Basic Income Research*, *2*(1). Retrieved April 4, 2018, from http://www.bepress.com/cgi/viewcontent.cgi?article=1067&context=bis

Toronto Workforce Innovation Group (2010). An Economy Out of Shape: Changing the Hourglass. Toronto: Author.

Tweddle A, Battle K, & Torjman S. (2017). Canada Social Report: Welfare in Canada, 2016. *The Caledon Institute of Social Policy*. Ottawa, On. November 2017.

Vanier Institute. (2017). Women, caregiving and work in Canada. *Vanier Institute of the Family*. Retrieved on April 6, 2018 from file:///Users/mac/Downloads/Women-Caregiving-and-Work-in-Canada_Infographic-1.pdf

World Health Organization. (2018). Poverty and social determinants. Retrieved April 8, 2018 from http://www.euro.who.int/en/health-topics/environment-and-health/urban-health/activities/poverty-and-social-determinants

Zimmerman E, Woolf SH, & Haley A. (2014). Understanding the relationship between education and health. Discussion Paper. Washington, DC: Institute of Medicine.