World Health Organization
REGIONAL OFFICE FOR Europe

Universal basic income policies and their potential for addressing health inequities

Transformative approaches to a healthy, prosperous life for all

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Abbreviations

GDP	gross domestic product
HESR	Health Equity Status Report
HESRi	HESR initiative
HIV	human immunodeficiency virus
IMF	International Monetary Fund
MIHL	minimum income for healthy living
MIS	minimum income standards
NIT	negative income tax
OECD	Organisation for Economic Co-operation and Development
UBI	universal basic income
WHO	World Health Organization

Executive summary

Over recent years, universal basic income (UBI) has become an important reference point when discussing innovative basic income policies as promising alternatives to address shortcomings resulting from the changing nature of traditional employment patterns and work. Related to this is the notion of new insecurities that have arisen, which existing welfare state arrangements are not in a position to adequately tackle.

These aspects also resonate with the debate on health and well-being, emphasizing the role of income security – either through employment or social protection measures – in playing a key role in achieving more equitable health. More recently, this debate has gained momentum, as global and domestic factors are forcing a rethink of income security design, to generate conditions in which income support systems effectively counteract insecurity.

Changing employment and income patterns, the impacts of technological change, austerity, and structural trends in providing and reforming income security have rendered increasingly insecure the provision of income security through employment and social protection mechanisms. The rise in non-standard employment as a consequence of increasing globalization and liberalization of trade makes it increasingly difficult to obtain income security through work. Automation is compounding these effects, in particular for low-income population groups and those with lower levels of education. At the same time, non-standard employment patterns increasingly limit access to welfare state provisions, which in turn is linked to a large extent to the capacity of workers to contribute.

Austerity measures since 2008 have led to increased use of targeted approaches, which further limit access to basic social welfare schemes. The economic crisis has reinforced the use of behaviour conditionalities as a punitive approach aiming to promote labour market participation; it has also increased the application of sanctions regimes in response to failure to comply with requirements relating to work searches and employment offers.

Health consequences are substantial. The generally poor job quality – including a range of measures of "low worker control" – is considered an important dimension of public health risk. In particular, the adverse mental health impacts of unstable in-work patterns are increasingly recognized. The rise in inequality and poverty across Europe has also increased the public financial costs of poverty. There is ample evidence across countries that insecurity surrounding income support status has adverse effects on people's physical and mental health. Conditionalities that cast benefit status into doubt tend to reinforce these effects further.

In this context, UBI policies, that is, the first steps towards a UBI, are increasingly perceived as one set of measures that may insulate subsistence guarantees from increased economic pressure; increase the impact of other welfare policies, such as education and health; as well as re-incentivize employment and savings.

Recently, several countries and cities within Europe and North America have embarked on basic income experiments in order to test some of these assumptions. The rationales behind the experiments are fourfold: (1) anti-poverty and health-linked rationales, which are very prominent in countries with mid-sized welfare states and higher levels of poverty (and their associated health inequalities) (e.g. Canada and Scotland); (2) a self-motivation and socio-psychological rationale, focusing on positive motivational impacts of controlling resources in relation to labour market participation, which has

been strong in countries with high income dependency (e.g. Denmark, Finland and the Netherlands); (3) administrative efficiency, which has played a role in particular within welfare states with strong income behaviour control systems; and (4) concerns about labour market change (automation and increasing non-standard employment) and preparing for a new model of social protection to better fit the modern labour market have also been mentioned among stakeholders.

While these basic income experiments mimic only some features of UBI, in particular un-conditionality, they mark a significant turning point in moving the emphasis away from disqualifications and sanction-based regimes to self-motivation. This is particularly significant from a health equity perspective and the massive negative mental health impacts that have been observed in this regard. At the same time, the experiments in most countries are taking place in complete isolation from other ongoing debates on inequality, including those about health.

Local government and municipalities play a key role in initiating and carrying out these experiments. On the one hand, this is the result of the traditional role of local government in delivering social assistance; on the other hand, local governments are also usually the first to notice the effects of austerity and cut-backs in public services, including in terms of the administrative and financial burden of increased demand and casework.

The UBI experiments have heralded a new way of thinking around the close interconnectivity between basic social services and basic income security, which have become increasingly disconnected in the context of austerity and fiscal constraints, being juxtaposed against each other in reference to fiscal trade-offs and value-for-money alternatives. However, it is only in their complementarity that they may realize their respective full potential.

The UBI debate covers a range of different design options, in view of the broad variety of existing welfare state typologies, institutional and legal challenges, as well as fiscal space across countries and regions. This report focuses on a foundation model put forward by Louise Haagh and by the Council of Europe, proposing an additional third basic income tier in addition to the traditional two-tier welfare state model (detailed in Chapter 4). The proposal involves both targeted income support schemes and contributory schemes, which it argues appears to be the most comprehensive approach, also allowing for other income security mechanisms to develop or remain in place.

As part of a tiered model, UBI – in close complementarity with universal services – can help support the building of welfare systems based on the principle of proportionate universalism, providing basic income stability that is both crises-preventative and health-constitutive. This is in line with WHO's proportionate universalism approach, providing universal policies that act across the whole gradient but are implemented at a level and intensity that is proportionate to need.

Adopting a universal income scheme would imply a profound transition in how social welfare systems are currently set up. Hence, UBI is best thought about as a long-term goal and as part of a basket of measures, which gives room for adopting differently staged transitions and models across countries, in view of differential institutional and fiscal capacity and political contexts. The type and scale of challenges involved will vary by country and across the WHO European Region.

An understanding of UBI as a long-term objective should not prevent policy-makers from undertaking first steps towards this goal. UBI experiments have shown that even small changes to the current known welfare logic can have huge impact, such as lifting conditionalities and sanctioning regimes. Other potential short-term measures towards UBI as a long-term goal include the universalization of access to specific benefits, such as child allowance or disability benefits.

UBI policies are but one measure in a policy basket to improve systems of economic security and health. While a UBI can help support work incentives, the overall impact of it on the labour market and health will depend on a wider range of factors; labour market policies, such as better control over working life or more stable contracts may be equally important for people to experience better health. Wider macroeconomic dimensions, such as (among others) disinvestments in the productive sphere, and innovative solutions for creating fiscal space are key to creating a more stable economic environment that allows for inclusive growth. This, in turn, may create feedback effects on financing social protection measures.

In many countries across the WHO European Region, the health sector has only recently started to respond to these developments. One of the reasons for this seems to be that the health sphere largely lacks the vision and narrative in order to engage in the institutional and political debate around economic security and health. Herein, WHO may have an important role to play to support Member States in doing just that.

In particular, this involves supporting Member States in developing a health (equity) narrative that moves away from health as a lifestyle issue towards health as a social justice agenda, as well as emphasizing the key role of implementing income security as part of a set of preventative health measures. Understanding health as a common good would imply a stronger engagement of the health sector with other sectors, in particular in the debates around much-needed universal income policies, in close interconnectivity with universal health care services.

As a regional knowledge broker and facilitator, WHO could play an important role in creating communities of interest by uniting different stakeholders engaged at various levels in health, social services and income protection. As such, it could be a centre of excellence that collects and provides evidence on health inequities across countries, policy sectors and different government tiers, providing guidance on methodological issues in collecting evidence, as well as identifying priorities for building datasets on health equity at country level to support such efforts. This would include the promotion and further development of tools for data collection (e.g. health impact assessment for health equity purposes, or the recent WHO European Health Sector Social and Economic Footprint Initiative), as well as supporting countries in feasibility research, modelling and micro-simulation of different UBI models.

Chapter 1. Introduction

The debate on UBI, a "periodic cash payment unconditionally delivered to all on an individual basis, without means-test or work requirement" (BIEN, 2019) has experienced a remarkable renaissance over recent years, attracting the attention of policy-makers and decision-makers alike (OECD, 2017a; Council of Europe, 2013, 2018; ILO, 2018). Most policy options discussed do not resemble a full UBI. However, in the context of increasingly volatile economic conditions and constrained social spending, UBI has become an important point of reference to discuss basic income policies that represent promising alternatives to address shortcomings resulting from the changing nature of traditional employment patterns and work and, related to this, new insecurities that existing welfare state arrangements are not in a position to adequately tackle (Handler, 2006; Jordan, 2008; Haagh, 2006, 2017a, 2017b). In reference to its universal and unconditional character, UBI is perceived as having a positive impact on what are known as the "underlying drivers of equity", including empowerment, participation, democratization and equal opportunities for all through fairer redistribution of resources, and social justice (Patemann, 2004; Wright, 2006; Haagh, 2011a, 2017b; Goodhart et al., 2012; Sloman, 2017; Ruckert, Huynh & Labonté, 2018).

These aspects also resonate with the debate on well-being and health equity, emphasizing the role of income security – either through employment or social protection measures – as playing a key role for health and well-being (Lundberg et al., 2010; Reeves et al., 2016; Haagh, 2011a, 2011b, 2019b, 2019c; Forget, 2011; Samuels & Stavropoulos, 2016). The role of wider policies and governance mechanisms in addressing pathways to better health by taking action on social, economic, environmental and commercial determinants also lies at the heart of the new WHO European health policy framework Health 2020, adopted in 2012, emphasizing an integrated and multisectoral approach to achieving better health and well-being (WHO Regional Office for Europe, 2013b).[1] The determinants of health equity are represented in many – if not all – of the 17 Sustainable Development Goals (SDGs) of the 2030 Agenda for Sustainable Development (United Nations, 2015) and resonate in the European Pillar of Social Rights (EC, 2017), emphasizing the role of social rights in the creation of efficient employment and better social outcomes, and an inclusive and fair growth model (WHO Regional Office for Europe, 2017).

The implementation of Health 2020 is progressing significantly in all WHO European Region Member States. Despite progress being made, the regional situation remains mixed, in particular with regards to gaps in health between countries; significant gaps persist in mortality and amenable morbidity, well-being and self-reported health between countries with similar economies, cultures and health systems. Within-country inequities in health remain high, and in some cases have increased since the mid-2000s (WHO Regional Office for Europe, 2012, 2013a, 2013b). Constrained fiscal spending on public policies, including on health and social protection, along with reinforcement of conditionalities on these policies, have further increased the risk for many of falling into poor health and have exacerbated the situation for those already experiencing poor health and well-being. As a consequence, health sector representatives within countries are increasingly urged to respond to and act upon health challenges that lie beyond their own sectoral boundaries. For this, they look to WHO for guidance.

[1] Health 2020 aims to support action across government and society to "significantly improve the health and well-being of populations, reduce health inequalities, strengthen public health and ensure people-centred health systems that are universal, equitable, sustainable and of high quality" (WHO Regional Office for Europe, 2013b:11).

Based on a series of requests from Member States, the WHO European Health Equity Status Report Initiative (HESRi)[2] has commissioned this policy paper on UBI policies, which is part of a new series of discussion papers on innovative approaches to implementing a healthy, prosperous life for all. The aim is to contribute to a more structured debate on social and economic policies that may in turn contribute to accelerating progress to reduce inequities in health within the diverse context of the WHO European Region. This exploratory discussion paper aims to provide a more hands-on debate, contributing to a formal dialogue informing the WHO European HESRi's position on policies discussed in the context of UBI, and their potential role in reducing health inequities. The paper does not seek to promote a specific type of UBI. Rather, it takes as its starting point a view of UBI as one potential option that, alongside and as part of a basket of other, complementary proportionate UBI policies and services, may contribute together, in such a way as has proven effective elsewhere, to reducing health inequities.

1.1. Approach

The discussion paper is based on a broad literature review, including academic literature, policy documents, impact evaluations from UBI pilot approaches, and other, similar programmes currently being implemented (with a specific focus on the WHO European Region and North America), along with media clippings and relevant websites discussing UBI. The conceptual debate on UBI is underpinned by primary data collected though qualitative interviews[3] with public health practitioners, health experts and policy-makers involved in the implementation of experiments and trials testing one or more features of UBI; in particular, unconditionality. Several countries, regions and cities across the WHO European Region and beyond have recently embarked on social welfare experiments testing two or three features of UBI, in particular applying no or alternative forms of conditionality.[4] While in the public debate they are commonly termed UBI experiments, they can at best be considered partial UBI trials, partially mimicking some of the features. The aim of the interviews was to get a better understanding of how people from within and outside the health sector perceive UBI as a potential mechanism for addressing health inequities and to provide a more structured overview of the major emerging issues around UBI, in particular in view of the relatively minor role of health in the UBI debate so far.[5]

[2] See Annex 1 for a short description of the HESRi, a forthcoming suite of tools being developed to promote and support policy action for health equity and well-being in the WHO European Region.

[3] In total, six in-depth interviews were carried out, based on a structured interview guideline (see Annex 2). Questions revolved around income security and pathways to health, resulting health inequities, the potential role of UBI in reducing health equity, the role of health and well-being in current UBI experiments, the public debate around UBI (in particular with regard to moral and social justice arguments), as well as related perceived design and implementation challenges. The interviews were either conducted over the phone or using Skype and were recorded, transcribed and analysed using ATLAS.ti software.

[4] These countries and regions include the Canadian region of Ontario, the city of Barcelona in Spain, along with Denmark, Finland, and five Dutch cities (Groningen, Nijmegen, Tilburg, Utrecht and Wageningen). In several other countries (e.g. Italy, Scotland, and the United Kingdom), intense debates and planning for trials are ongoing.

[5] Morris et al. (2007) and Davis et al. (2012) developed minimum standards for a healthy living in the British context, sparked by the conspicuous absence of health needs from the minimum income requirements. The minimum income for healthy living (MIHL) and the minimum income standards (MIS) both define health needs as being more than food, clothes and shelter. They also consider resources needed for physical activity, as well as for psycho-social integration and participation in society, including costs for (among other things) telephone and television (Marmot et al., 2010). Historical evidence on the positive role of UBI policies for health and well-being exists, for example from the 1970s Manitoba negative income tax (NIT) trial (Forget, 2011). However, the more substantial debate around UBI as a potentially powerful mechanism to tackle structural barriers and inequalities to health and well-being is only just beginning to evolve (see, for example, Ruckert, Huynh & Labonté, 2018; Haagh, 2011b, 2019c; Painter, 2016; Prochazka, 2017; NHS Health Scotland, 2017a, 2017b; Richardson et al., 2018; Forget, 2017).

Chapter 2. Context factors shaping the case and conditions for basic income reform

The debate about UBI relates to major social, economic, institutional and political shifts that have affected the way welfare schemes are able to provide income security at a broad level. This also has major impacts on health and well-being, in particular health inequalities. The pathways through which income security impacts health are complex,[6] but a central factor relevant to the discussion about UBI is the role of certainty around basic income flows and legal rights to protection. This means that the design of income security systems has both direct and indirect implications for health outcomes and policies.

This chapter reviews the sources of new challenges to income security systems, in response to which basic income can be viewed as a central pillar within a basket of measures to strengthen the effectiveness of health systems and policies. It is important to separate general reasons why UBI is viewed as an anchor within welfare state development, on the one hand (**internal factors**), and the specific problems surrounding development policy, employment, and social contribution systems, which generate contextual challenges, on the other hand (**external factors**). More recently, several contextual factors that compound health risks and health equity concerns have become more central to the case for UBI, in response to both a challenging external environment, and changes in government responses to income security risks. While poverty and inequality have increased in the WHO European Region in response to labour market reforms, economic crises and austerity, public sector cuts to social provision also have further limited access to social support. This coincidence of global and domestic factors has forced a rethink of income security design, in order to generate conditions in which income support systems counteract insecurity effectively.

2.1. Explaining UBI

UBI is generally known to have three basic features: universality, individuality, and unconditionality (BIEN, 2019). In addition, most UBI experts consider uniformity and regularity (Van Parijs, 1995), payment in cash (Torry, 2013), and lifelong coverage (permanence) (Haagh, 2019b) to be equally important features. For example, UBI as a cash payment is viewed as a corollary of unconditionality: UBI is distinct from payments or subsidies in kind (Torry, 2013). Permanence is regarded as a basis for the psychological impact of basic income, linked with the anticipation of rights-based and lifelong status security (Haagh, 2019b).[7,8]

[6] The pathways between health and income security are usually described as being a three-way relationship, including direct consumption effects leading to material exclusion, psycho-social effects of exclusion, and a mix of both (Lundberg et al., 2010). Beyond individual-level differences, Wilkinson & Pickett (2008), along with Mackenbach (2006) argue that socioeconomic differences in health also tend to be influenced by the structural differences in society or overall levels of societal inequality.

[7] Non-withdrawability (Torry, 2019), non-mortgageability (Haagh, 2019d), and state-backed legality (De Wispelaere & Morales, 2016; Haagh, 2019c) of UBI payments have also been emphasized as relevant factors when considering basic income as an effective source of income protection. Legal stability of basic income is viewed by many as central to insulating subsistence guarantees from the economic cycle, and to the potential for UBI to support and extend the impact of other welfare policies, such as education and health (Haagh, 2007, 2012; Forget, 2017; Jordan, 2008), as well as incentivizing employment and savings (Haagh, 2017b). The feasibility and efficacy of UBI is connected with a broader challenge involving consolidating the fiscal basis for welfare policy and supporting the effectiveness of individual interventions by improving the architecture of welfare provision as a whole (see Annex 3).

[8] In the literature that is concerned with using basic income to improve the welfare state, basic income is thought to extend the well-known social, health and political benefits of institutions such as the basic citizen pension and universal child grants (Haagh, 2007, 2011a, 2012, 2017b; Jordan, 2008; Downes & Lansley, 2018).

For most UBI experts the key aim is to ensure a lifelong structure of security that cannot be withdrawn, in the assumption that support in this form of individuals' basic sense of security also positively impacts other government functions and society at large (Haagh, 2017a, 2019b). These assumed features of UBI play a salient role in present-day debates about how to improve income security and welfare systems in European countries in response to changing conditions.

2.2. Shifts in welfare state development

During the 2010s in Europe a pattern of long-term problems in income security design emerged, intensified by increasing tensions in the context of what are known as workfare policies, existing since the 1990s and sandwiched between rising insecurity and income benefit reform (Bambra, 2011). This involved states having reduced capacity to adapt proactively within the constraints of the European budgetary framework (Radice, 2014). Before examining how conditions generated by structural change have pushed the case for UBI to the forefront, it is apt to examine flaws in the design of post-war income security systems, which lay the groundwork for the policy menus through which countries have responded to global trends.

2.3. Structural context factors in the case for UBI reform

Four long-term structural shifts have accentuated failings in modern income security provision systems, based on means testing as the lowest tier of income security. The same trends also generate new challenges for countries seeking to build formal income security systems for the first time.

2.3.1 Employment and income trends

Global marketization of development, comprising trade and finance liberalization, privatization and labour market deregulation, along with fiscal pressures on countries, have all contributed to changes in production structures, wage compression, income insecurity, and poverty. Since the 1990s, Organisation for Economic Co-operation and Development (OECD) guidelines have promoted financial and labour market deregulation as an instrument to achieve growth (OECD, 2012). A number of studies find that deregulatory reform contributed to financial imbalances and reduced welfare, in particular but not only for lower-income households (Bertola & Lo Prete, 2015; IMF, 2015; OECD, 2018).[9]

For example, looking at England, interregional health inequalities relating to unemployment fell approaching the 2008 crisis (Buck & Maguire, 2015). However, between 2006 and 2016 in the United Kingdom, the number of employees on precarious contracts – defined as being in jobs linked with status insecurity – rose from 5.3 to 7.1 million, to around 20% of the labour force, leading to both new levels of health equity and general public health risks (Booth, 2016). Part-time, temporary work, and self-employment have also substantially increased disproportionately during the crisis at European level, affecting workers with fixed-term contracts. On average 14% of dependent employment is temporary,

[9] A 2015 International Monetary Fund (IMF) World Economic Output report found no evidence of a positive link between deregulation and countries' potential for economic growth (IMF, 2015). The OECD Employment Outlook edition for 2018 recognizes that rising employment was overshadowed by unprecedented wage stagnation. In addition, while low inflation and productivity growth have a part to play, the dynamics of low-paying jobs and the wages associated to them also play a significant, but understudied, role (OECD, 2018).

with high variations across countries.[10] Similarly, there was rapid growth in part-time employment during the crisis, increasing from 14.6% in 2007 to 16.5% in 2015 across the EU (COPE, 2017). The crisis has also accelerated informal employment. Whereas comparable data over time do not allow clear regional trends to be identified, country-level data indicate either a reverse trend towards increased informalization in some countries, including Serbia and the Russian Federation (ILO, 2017), or a high level of informal employment in a number of eastern European countries and the Russian Federation (ILO, 2018). In particular, the share of informally employed people among women who are employees is greater in high-income countries, which highlights the particular threat of informalization of formal work for women in Europe (ILO, 2018), along with the associated vulnerability in benefit systems that follows. This means that the negative health impacts associated with contemporary punitive benefit systems – affecting those in precarious employment – are likely to be most acute in the gendered dimensions of health inequality (Etherington & Daguerre, 2015; Haagh, 2019b).

According to European data on working conditions, the period 2010–2015 saw no improvement in subjective impacts of precariousness, albeit with fixed-term contract work, marginal part-time employees, and agency workers most at risk (Eichhorst & Tobsch, 2017). Consequently, while the negative health impacts of unemployment (Voss et al., 2004) and in particular **involuntary** unemployment (Gallo et al., 2004) are well-known (BMA Board of Science, 2016; Bramley et al., 2016), today generalized poor job quality – including a range of "low worker control" measures – is considered an important dimension of public health risk (Eurofound, 2014). In particular, the adverse mental health impacts of unstable in-work patterns of working are increasingly recognized (BMA Board of Science, 2016; Marmot et al., 2010).

Such development not only leads to a widening of the inequality gap to the detriment of those who are at the lower end; while the link between labour deregulation, employment growth, reduced work quality, and rising inequality is well-established (Bertola, 2008; European Comission, 2010), in a deregulatory context a fall in the quality of employment at the lower end contributes over time to a corroding of standards across the board.[11] This explains how a "levelling down" effect can highlight an equalization of outcomes along some dimensions of disadvantage, followed over time by a generalization of poor outcomes for all (Rubery & Piasna, 2016).

A consequence is to make economic stability a general health equity and social justice concern. A call for re-regulation – to achieve a more inclusive labour market – is emerging within the European agenda (EC, 2017), which entails levelling up instead of the aforementioned levelling down, as was seen at the core of the deregulation agenda of the 2000s.

2.3.2 Impacts of technological change

Rapid changes in the structure of work and impacts of new technologies in work organization have led to new forms of displacement that are beyond individuals' control. While a lot has been written about prospective job losses caused by automation (e.g. Acemoglu & Restrepo, 2017),[12] also significant in

[10] In 2015, over 20% of the jobs in Poland, Portugal and Spain were temporary; in the United Kingdom the figure was 6%, and around 35% in Estonia (COPE, 2017).

[11] Hence, the general state of social opportunity (conveyed by general employment and welfare standards) ultimately affects the standards enjoyed by those with the least opportunities. Conversely, where the standards for those with least opportunity are lowered, as typically occurs at the beginning of a trajectory of deregulatory reform, over time the effect of low-wage, low-skill competition degenerates the average social standard for all (Pagano, 1991; Haagh, 1999, 2002, 2012).

[12] The speed and level of displacement are hard to predict, with certain job markets (such as in the United States) that rely more heavily on services and global outsourcing facing greater disruption.

the case of basic income are the effects of technology on work processes and lifestyle patterns, which generate a need to support in new ways economic autonomy and systems of access to lifelong learning, respectively.

The impact of changes in work organization is complex and unpredictable in ways that contribute to different forms of psychological stress. For example, according to a study commissioned by the United Kingdom's Advisory, Conciliation and Arbitration Service (Briône & IPA, 2017) the nature and pace of technological change carries significant mental health risk, linked with disruptive effects of rapid change, a loss of boundary between work and private life, and reduced worker autonomy. Key factors in the negative mental health impacts of technology are loss of control and lack of voice. The United Kingdom Workplace Employment Relations Survey (2011) showed that about half of workplaces consulted with staff about technological change, and a much smaller number engaged in formal negotiation (cited in Briône & IPA, 2017: 39). "While workers are in principle welcoming of technology, their concerns about management intentions and potential control over it might be the bigger source of concern." (Ibid.: 36)

An independently guaranteed income in this context would also have a positive impact on improving people's voice in the labour market and within employment, while simultaneously facilitating other public policies targeted towards developing systems of lifelong learning. The effect of technological change is one of the key factors in the promotion of lifelong learning systems within the education segment of the United Nations 2030 SDG framework (Education 2030) (UNESCO, 2016). In this context, the existing income security division around unemployment in countries is increasingly out of date. Systems of individual responsibility for unemployment and employment failure – built into current income security systems, including active labour market policies – are no longer realistic.

There also is growing evidence that economic security structures need to be rebuilt to support individuals in work and equity in care roles (Lawrence, Roberts & King, 2017), partly because women are more likely to adjust time schedules to fit work around family roles (Parker, 2015).

2.3.3 Austerity

Given the rise in inequality that typically follows a financial crisis and ensuing recession, combined with the poorer segments of society's greater reliance on services, it can be predicted that austerity in response to economic crises will exacerbate inequality across a number of different dimensions. Within European countries, negative health impacts of sanction-based policies in income security provision are widely documented (Quaglio et al., 2013; Karanikolos et al., 2013; van Gool & Pearson, 2014).[13]

Three factors are important in shaping the impact of austerity programmes: the overall scale of cut-backs against the existing level of public provision; the distribution of cuts; and these factors set against the structure of provision already in place. The scale of the social embedding of public finance within societal institutions, along with public laws put in place to protect (which distinguish different varieties of capitalist economy (Haagh, 2012, 2015)), served to cushion the impacts of austerity on vulnerable groups, which are recognized as presenting health risks (Haagh, 2019b, 2019c). Faced with a more direct financial shock, Iceland chose to insulate the effects on welfare spending and the structure of social provision. Research by Stuckler and Basu (2013) also found that governments that have responded to financial crises by increasing public sector spending have seen faster economic recoveries and better health outcomes.

[13] There is evidence that austerity contributes to homelessness, and that homelessness is a serious health risk (Burki, 2010).

In contrast, cuts to health care spending in Greece following the start of the recession led to a decline in public health standards (including malaria outbreaks and rising HIV rates). Other countries, such as the United Kingdom, pursued an overall programme of deep cuts to public provision. In England, a health inequalities strategy (in effect between 1997 and 2010) – aiming to decrease the disparity between those living in the bottom fifth of the most deprived local authorities and the rest of the population – succeeded in decreasing the health gap between these groups; however, after 2010, during the period of austerity, this trend was reversed (Forster, 2017; cited in BMA Board of Science, 2016: 6). Data from the United Kingdom show geographical health inequalities rose in England in particular, in response to austerity measures implemented under an already decentralized approach to budget responsibility (Barr, Higgerson & Whitehead, 2017). In Scotland, mental health inequalities between regions widened in the period between 2008–2009 and 2012–2013 (Kellock, 2015). In OECD countries, where austerity was a more marked response to the 2007–2008 crisis and consequently public finances were hit particularly hard, adverse mental health trends were more pronounced, whereas other countries that were also subject to severe budgetary constraints saw rising mortality among the elderly, and rising food poverty (Stuckler et al., 2017).

In this context, moving the welfare and income security systems as a whole towards greater targeting of services risks reducing capacity for comprehensive coverage, inducing a negative downward spiral in funding and capacity for social provision. Comparative studies suggest that the propensity to cut public services is greater where provision is targeted (Rothstein, 1998; Haagh, 2012; Hills, 2015). According to the British Medical Association (BMA), spending cuts have more severe impacts in welfare states in which social spending predominantly targets the poorest households (BMA Board of Science, 2016). An important case for UBI in this context is a wider need to rebuild comprehensive income security and services systems, defined as covering the whole population, while also servicing particular areas of need.

2.3.4 Structural trends in income security provision and reform: reinforcing sanctions and increasing targeted approaches

In OECD countries the response to austerity has entailed a narrowing, rather than a broadening of social provision. Across these countries, austerity in response to the 2007–2008 crisis reinforced the use of behaviour conditionalities, connected with income benefit reforms (which had been under way since the 1990s), with differential health impacts, filtered by variation in the institutional form of the public administration of benefits (see Haag, 2019a: Annex A).[14] Pressures on countries, combined with new ideological approaches to welfare state provision linked with neoclassical models of work behaviour introduced in the 1990s, meant that the range of solutions to the poverty traps of the 1970s and 1980s that emerged focused on punitive approaches to promote labour market participation.

Across mature European welfare states, public sector reforms and the intention to cut benefit dependence formed the background for a policy of increased sanctions on benefit claimants in response to failure to comply with requirements surrounding work searches and employment offers (Adler, 2016; Haagh, 2019c, 2019e). Sanctions systems in many European countries have become more indiscriminate as a result of being more simply applied in relation to labour market objectives, despite the rise in precarious employment. Sanctions are increasingly applied on single parents, as well as long-term sick and disabled people, exacerbating the adverse social effects of economic transformations, particularly in relation to poverty, health inequalities, and patterns of social exclusion.

[14] The design of the initiatives taken in many cases exacerbated existing labour market insecurities, while generating new insecurities surrounding income support status, with different effects in different European states.

2.4. Effects of changing income security transfer systems on poverty, health and social cohesion in Europe

A rise in inequality and poverty across Europe has placed families at risk, while increasing the public financial cost of poverty. In the case of the United Kingdom, a Joseph Rowntree Foundation study found that 25% of health care costs could be attributed directly to poverty (Bramley et al., 2016).[15] The adverse impacts on mental health resulting from instability of and uncertainty about employment and benefit status have already been mentioned (Watts et al., 2014). These are compounded by increasing uncertainties regarding entitlement to benefits and legal redress. Over 40% of appealed cases have been found to be faulty in both the United Kingdom and Denmark (Adler, 2016; Haagh, 2019c), showing a high degree of error and uncertainty surrounding the sanctions regime. A common theme that emerges across different jurisdictions in terms of sanctions administration involves the adverse health effects of anticipating status assessment. This has been reported in Norway (Barr et al., 2016), Denmark (Haagh, 2019d), and the United Kingdom (Johnson, 2018), despite different systems of application. The application of benefit design policies which generate uncertainty about subsistence status was cited as the key factor in the rise of cases of children underperforming at school, in a recent survey of teachers in England (Adams, 2018). Many studies have found the employment effects of sanctions are short term, and sanctions sustain higher rates of crime (Griggs & Evans, 2010; Watts et al., 2014; Loopstra et al., 2015a). Other studies have found that sanctions have the effect of pushing disabled groups away from the labour market (Reeves, 2017). Predictably, a rise in unemployment has been linked with a rise in the use of food banks (Loopstra et al., 2015a). In the United Kingdom a growing number of clinicians act as referral points for food banks (27 000 front-line care professionals in 2013–2014), and a link has been found between higher rates of benefit sanctions and use of food banks, in a comparison of different areas (Loopstra et al., 2015b). Adverse effects of benefit reforms have been recognized in a number of public enquiries (APPG, 2016) and cross-country studies into the physical and mental health impacts of insecurity surrounding income support status in European countries (Karanikolos et al., 2016). Insecurities about the terms of employment along with conditionalities that cast doubt over benefit status have been found to contribute to income poverty, stress, ill health, and social exclusion (Reeves et al., 2016; Griggs & Evans, 2010).

Other studies show a strong association across local authorities between the implementation of work capability assessment and adverse mental health problems (suicide, reported mental health problems, and antidepressant prescribing) (Barr, et al., 2012; Reeves, 2017). Welfare reforms linked with caseload reduction targets have exacerbated the impact of structural trends that drive social determinants of ill health. Intensification of sanctions facing carers of young children has deepened child poverty (BMA Board of Science, 2016). In a letter to *The Guardian* in 2015 (also cited by the BMA (2016: 12)), 442 psychotherapists, counsellors and academics highlighted the adverse psychological effects of austerity, and emphasized the role of a lack of control over housing and benefit status (The Guardian, 2015).

While a number of studies exist on the positive long-term employment impacts of more sustained income security (Tatsiramos, 2006), sanctions have been linked with a lower probability of long-term employment integration (Arni, Lalive & van Ours, 2009). In addition, there is strong evidence that sanctions lead to social exclusion, meaning people become disassociated from formal benefit systems (Haagh, 2019c; Loopstra et al., 2015a). Such effects are kerbed in welfare states in which cuts to benefits

[15] The Joseph Rowntree Foundation assessed the financial side of the public health costs of poverty, counting, for example, additional hospital beds and primary care costs (Bramley et al., 2016). The methodology is based on studies from the United States (Holzer et al., 2007), which found that the health, crime and output/productivity costs of poverty each accounted for 1.3% of lost gross domestic product (GDP) (overall therefore nearly 4% of GDP).

have been more limited and in which public administrators avoid sanctioning the most vulnerable groups from a health perspective (Haagh, 2019b, 2019c, 2019d).

In all, owing to new economic pressures, basic income is viewed by many as being key to insulating subsistence guarantees from the economic cycle, and as an important instrument to expand the impact of other welfare policies, such as those involving education and health (Haagh, 2007, 2012, 2019b; Forget, 2017; Jordan, 2008), as well as to re-incentivize employment and savings (Haagh, 2017b). The feasibility and efficacy of UBI policies is closely connected with the broader challenge of consolidating the fiscal basis for welfare policy and supporting the effectiveness of individual interventions by improving the architecture of welfare provision as a whole (see Annex 3).

Chapter 3. Why UBI?

3.1. Rationales for UBI

Support for UBI within European populations is growing. According to the European Social Survey, support for UBI averaged around 50% across the European countries surveyed. More in-depth analysis of trends in support across several countries is still pending; however, looking at the United Kingdom, which has an average level of support for UBI, it is very clear that dissatisfaction among the electorate with existing benefit systems is a key driver. A recent Populus poll showed that only 19% of respondents felt the existing system of income security functioned well and no changes were needed (Populus, 2018). Although the poll shows that support for UBI is paradoxically lower in relatively wealthy states and/or countries with more comprehensive welfare systems (e.g. Switzerland and Sweden), in countries with high levels of equality, in which partial basic income trials have been taking place, support is higher.

In all, there are four main identifiable forms of rationale for UBI, which are to varying degrees present in the case for UBI made by stakeholders involved in various experiments.

1. An **anti-poverty** and **health-linked** rationale has been very prominent in experiments in countries with mid-sized welfare states, higher levels of poverty and associated health inequalities, for example Canada and Scotland.
2. A **self-motivation** and **socio-psychological** rationale – focused on positive motivational impacts of controlling resources in relation to labour market participation – has been more dominant in experiments in countries with more established welfare states, less poverty and associated health inequities, but high rates of income dependence, for example Denmark, Finland, and the Netherlands.
3. **Administrative efficiency** within income security behaviour control systems has been an associated rationale, particularly in more established welfare states that spend more on administration, for example Denmark, Finland and the Netherlands.
4. **Concerns about labour market change** (e.g. automation, increases in non-standard employment) and preparing for a new model of social protection to better fit the modern labour market have also been mentioned among stakeholders. However, this tends to be somewhat of a secondary concern.

Some country experiments represent hybrids in terms of their motivational rationale; for example, the Spanish experiment is heavily dominated by an anti-poverty and economic inequality focus, but at the same time also includes strong motivational factors.

The political debate around UBI policies in the experimenting countries reflects this field of unresolved tensions between fiscal constraints, rising poverty rates and the pressure involved in delivering more cost-effective and responsive income security. While they are closely connected and difficult to disentangle, countries vary as to which aspect they emphasize or prioritize. In more mature and comprehensive welfare states, such as Finland and the Netherlands, the efficiency aspect appears to play an important role. The over-bureaucratization of welfare, the high opportunity costs of conditionalities, and active labour market policies all have a part to play. They are also the key objectives of these interventions, and form the basis of the hypotheses to be tested in the impact evaluations. This search for efficiency is also captured to a certain extent in the nature of the interventions being considered for experiments

or trials (as opposed to pilots), with a strong emphasis on testing and evidence-based policy. In some countries they are just one of a bundle of experiments, or simulations running in parallel, in order to look for the most efficient new welfare model.

In other countries, the administrative dimension is related to a notion of effectiveness. This is especially so where welfare state administrations are highly centralized, as is the case, for example, in Scotland and Spain. While it renders access to services challenging, in particular for people with low incomes – who tend to have more difficulties than others in navigating these welfare complexities – it also creates gaps in the welfare systems, especially where central and local services overlap and weak legal regulations lead to exclusionary mechanisms. In most countries, fiscal constraints are a major driver to engage in innovative ways that will allow a response to rising needs but with unchanging resources. In the context of fiscal decentralization, these structures tend to result in conflict between central and local government levels, especially where welfare states are highly decentralized, and where rising demand is not matched with additional resources (e.g. in the Netherlands). In such situations, the local level has a strong interest in testing innovative solutions to deal with the rising demand or caseload, but this is also at the cost of going against centralized labour market policies.

Economic inequality is rising in all the case countries and represents a constant undercurrent in the debate around innovative welfare solutions, coupled with automation and changes in the employment and economic sphere of the post-industrial era. Where the degree of economic inequality is high and effective welfare state structures are not in place that may (even inadequately) respond to it, open political pressure to react is created; this is the case in Barcelona, where the sharp increase in poverty and economic inequality after the crisis built up significant public and political pressure to act.[16]

3.2. Normative and moral challenges

Public norms have led to conditioning, historically, to regard social contribution as directly linked with employment, or much specified status exceptions. This is one of the principal motives for basic income experiments which have tended to focus strongly on identifying impacts on the work ethic. However, four other factors also contribute to explaining the concern with disproving negative effects of income guarantees on the work ethic. (1) First, a key factor that has contributed to UBI experiments focusing on testing work behaviour is the long-standing influence of neoclassical economics on public policy; that is, the so-called leisure–work trade-off assumption. (2) Second, the notion that has been put forward in some libertarian arguments for basic income – that social democracy is coercive and paternalistic because it emphasizes social transformative goals – has caused concern about basic income among the social democratic-leaning public and trade unions. This has also contributed to the need to prove the link between income security and work behaviour through UBI experiments, even though there is already good evidence of this link from existing studies. (3) Third, public concerns about reciprocity emanate from the tendency to associate income with market contributions, and services with rights. (4) A fourth factor in experimentation can be considered inertial and is linked with public administration itself. Public managers of local income security administration, who have experimented with giving income grants without conditions, are concerned about social integration and the willingness of different populations to contribute to society. In welfare states that provide more generous social protection, such as some Nordic countries, the expectation of contributory obligations, as administered through public benefit offices and social work, is very strong. A challenge in this context is to emphasize the role of basic income security in enabling not only a range of non-market social contributions, such as social

[16] Qualitative data gathered from a selection of interviews carried out by the author team.

and charitable activities, staying longer in education or care, but also social insurance and other failing shared insurance systems. In countries with stronger contributory institutions, new mechanisms are needed to reverse the effects of slow decline.

3.3. Challenge of complementarity within UBI

Despite the many influences that shape the discussion and varying designs of UBI experiments in European government and municipal-led trials, the strongest impetus to undertake the experiments is practical. The main concern for policy-makers in all cases has been to improve the effectiveness of the public administration of income security in general, and in relation to the labour market in particular. The circumstances are slightly different depending on the case (see Annex 4 and Annex 5 for more details).

Current UBI experiments in Europe are characterized by adopting primarily **one** feature of **UBI**: unconditionality.[17] Notwithstanding, there are good reasons why these experiments should be considered related to UBI, despite mimicking only some features and doing so partially (for example, in the case of low-value grants in Finland). First, given the **current context**, which is one of intensified use of conditionalities, disqualifications and sanctions regimes (which threaten to exclude groups from access to social assistance), the experiments mark a significant turning point in emphasis. From a health equity perspective, the switch from emphasizing sanctions to focusing on self-motivation is significant, given the evidence cited concerning the negative mental health impacts of sanctions.

So far the evidence from the Danish experiments is mainly qualitative, concerning the experience of social workers, select beneficiaries, and sets of beneficiaries in terms of the areas of spending prioritized in self-budgeting plans (Haagh, 2019c). The most outstanding finding, according to both the director of the programme in Aarhus, and social workers involved in the experiment in Kalundborg, related to the sense of reported self-control. Beneficiaries' attitude to their own condition and to social workers changed in a positive direction. The phrase "can we decide, *ourselves*?" was reportedly common, according to Vibeke Jensen of the Aarhus council (Thougård Pedersen, 2016). Beneficiaries were so used to being told what they should and could do that they were shocked to find that some independent decision-making was possible in finding their way into the labour market. Other senior social workers interviewed (Haagh, 2019b, 2019c) noted that some social workers had resisted the experiment at first, but came to value the changed relationship with citizens. In the case of Kalundborg, social workers running coffee mornings with unemployed people who were given the option to lead their own integration plans said the relationship with citizens changed, stating "we got teased a lot – that was new." Citizens in these experiments reported a feeling of freedom in being able to "say no" to employment offers they did not think suited them (Haagh, 2019b, 2019c).

Anecdotal evidence from qualitative interviews carried out in Spain shows that, despite health not being mentioned in the interview questions, it features strongly as a core area in which beneficiaries have seen positive programme impacts on health and well-being. This is also the main finding of the experiment on the effects of lifting conditionalities on the receipt of the major share of income benefits

[17] Some also adopt individuality. In some experiments the payment is uniform (e.g. in Denmark and Finland – although in Denmark some municipalities also give development grants). In the Netherlands, different amounts are experimented with, and – apart from grants given without any conditons – different types of conditionalities (see Annex 4 and Annex 5 for descriptions of the experiments). Different types of conditions, inlcuding unconditionality, are also part of the Barcelona trial. In Denmark, the amounts are related to assistance benefit levels, plus in one municipality there are added benefits. In Finland, the amounts are below the subsistence level. However, all experiments retain means tests, and they are of limited duration.

among 2000 unemployed recipients of income security in Finland (Kangas et al., 2019). The fact that the main employment-related effects of the experiment were motivational rather than behavioural substantiates the well-being effects of economic security found in other economic security surveys, with the implication emerging that motivational effects are greater in the context of stable employment opportunities (Haagh, 2011b).

A second reason for considering these experiments to be linked to UBI is that they tend to emphasize individuality of status and personhood. Although this is not the same as a guarantee of status independence, as basic income supporters highlight, the emphasis on the right to self-control of basic resources is a step in that direction. Third, the UBI experiments herald a new way of thinking about social assistance bureaucracy, delivery mechanisms and positively connecting income security regimes with wider social goals. In Europe, the connection between basic services – such as health and education, and income security systems – has been taken for granted, and the growing disconnect between health and education services and income security has been allowed to deepen without acknowledgment.

Bringing into view the close interconnection and positive mutual impact of basic income security and services can be considered an important challenge. Debates which have been more prominent in the United Kingdom concerning the choice or trade-off between **universal basic services** and **UBI** (Social Prosperity Network, 2017) can be considered as prematurely discounting the important complementarities between the two approaches. The debate about the two approaches has been presented in terms of fiscal trade-offs and value-for-money alternatives. This, however, overlooks how positive complementarities between social services and basic income security for human development outcomes are stronger in systems in which different social groups benefit from a range of income transfers **and** shared services (Haagh, 2012, 2019b). This is also acknowledged by the BMA (BMA Board of Science, 2016): where a high level of social spending enables provision of shared services, along with additional support for specific risks and vulnerabilities, a form of proportionate universalism is possible that protects vulnerable groups without sacrificing universalism.[18] Austerity and the processes of narrowing, targeting and undercutting shared provision involved undermining this logic, juxtaposing basic services against basic income.

As with partial services, the partial form of so-called UBI trials raises a concern in this context. One risk of partial UBI in countries that are experiencing high or/and rising inequality is that UBI becomes an anchor in the development of a reduced-value welfare state, or gets "stuck" in a partial form, which weakens its impact and stability. While UBI is tested in partial ways, it is only in its entirety of **individuality**, **universality**, **unconditionality**, **permanency** and **constancy** that it is able to deliver on all the problems listed.[19]

However, UBI is not a silver bullet. It is therefore important to distinguish between short-term observable impacts of experiments and the longer-term changes that can be foreseen from the provision of a stable basis of basic income security. An important indicative finding from the Aarhus experiments in Denmark is the extent of exclusion and deprivation affecting claimants, and the likely slow progress of impacts from income security regimes that undergo changes. A particular concern is having too-

[18] An analysis of the effects of taxes and benefits on United Kingdom household income for the finanical year 2017 shows that the poorest quintile of households received relatively larger amounts of both cash benefits and benefits in kind, while richer households, on the other hand, paid higher amounts in taxes. Benefits in kind and in cash had the largest impact on reducing inequalities, while the role of tax benefits was negligible: the ratio of disposable income of the richest quintile to the poorest quintile in the financial year 2017 was 5:1. The ratio increased to 6:1 on a post-tax income basis (disposable income minus indirect taxes), but fell to less than 4:1 on a final income basis (post-tax income plus benefits in kind) (ONS, 2018). For details, see Fig. A6.1 in Annex 6.

[19] For why all five elements are considered important, see Haagh (2019b).

high expectations linked with labour market integration of beneficiaries, given their vulnerability, low capabilities, and the depressed nature of labour markets.[20] This suggests the sustained integration of beneficiaries would also depend on other measures, including education, health or housing and broader economic and labour market policies that transcend national boundaries.

[20] The spending plans of the Aarhus experiment beneficiaries revealed a preference for self-development or capability spend, glasses, a driving licence, a bicycle, a computer, a sewing machine, a delivery van, and so on (Haagh, 2019b, 2019c, 2019e).

Chapter 4. UBI: how to make it work for health equity

In response to global transformations, there is growing recognition of economic stability as a matter of social justice, well-being and policy efficacy (Haagh, 2012; Goodhart et al., 2012), and as a preventative health intervention (Reeves et al., 2016). Economic stability is distinct from economic security as a policy concept. The former comprises the state(s) of enjoying permanent security. This chapter aims to link the debate on UBI back to health equity by discussing some of the major controversies and challenges around UBI as concrete policy measures, discussing different models and design options, legal and institutional challenges and fiscal space, in the light of competing policies between income support and services. Against this background, an argument exists for an embedded three-tier UBI model, which may also best respond to health inequities issues (Haagh, 2012, 2019b). Annex 7 summarizes the debate, distilling the success factors required.

4.1. Design

In the debate around UBI, various models are distinguished: (1) a full basic income model (full UBI), whereby everybody in society receives the same amount, irrespective of income and situation, replacing means-tested benefits; (2) NIT; (3) other models of income support, testing different conditionalities and forms of delivery, which are sometimes also subsumed under basic income policies; and (4) a basic income model as one tier and in addition to certain social security and social insurance or earnings-related benefits (Kela FPA, 2016; Forget, 2017).

4.1.1. Full UBI

A full UBI model is usually understood as an approach that would replace a large part of social security benefits (both contributory and non-contributory). In financial terms, this would mean that the UBI would certainly need to be higher than current social assistance benefits (Kela FPA, 2016). More importantly, the model could imply a more complete break between the notion of work and that of income, implying a radical transformation of welfare, but also of societal thinking as a whole (van der Veen & Van Parijs, 2006). From the literature reviewed and the interviews with policy-makers involved in current experiments, it appears that the debate about this model is largely settled. While attracting a lot of attention as an idea, it is considered largely unfeasible and even undesirable. However, new normative perspectives are emerging, which conceptualize basic income in terms of the values of welfare universalism, endorsing a low basic income as a baseline onto which other non-contributory and contributory transfers and services can build (Haagh, 2013, 2019b).

4.1.2. NIT

NIT, sometimes also termed a partial basic income model, is a tax-based classical social security measure based on means-tested income compensation by means of taxation once an individual's income falls below an agreed threshold. NIT differs substantially from the UBI model in terms of its underpinning philosophy, which aims to reduce the depth and breadth of poverty by targeting the (working) poor, with benefit levels varying according to income. Payment modes also differ. The models have similar end results, aiming to guarantee minimum income and increase incentives for work. A major difference

to the basic income models is that it is means-tested.[21] In the literature, NIT is discussed as one stepping-stone in a broader-based welfare context, where social assistance for specific social and economic risks – such as motherhood, illness, old age, studying, disability or unemployment – would continue to exist (often as a combined payment; see, for example, Forget (2017)). In some countries, the proposed NIT models are combined with active labour market policies in order to reduce disincentives to work.

One of the criticisms of NIT relates to its ex-post character. In order to provide real-time security, real-time periodic updates of income and salaries across society are needed. Without such updates, the NIT would become outdated, arbitrary and prone to mistakes (Kela FPA, 2016). Another critical aspect is to create the NIT in such a way as not to be regressive; that is, to avoid placing the burden on low-income groups.

However, adopting a long-term, welfare system perspective, it is not clear that means testing even the basic layer of income security is optimal in relation to poverty and health equity goals.[22] The expectation that income security will be clawed back when earnings increase does not fully resolve the status uncertainties linked with current systems, or the poverty trap and disincentives linked with reducing benefits; nor does it enable the transformative potential associated with giving individuals more control over their employment relationship and time for a range of productive activities (including care). Maintaining dependence on the labour market can have the effect of sustaining the underbelly of an informal, low-skilled, low-wage economy, which reinforces poverty and sustains the preference for targeted income security. [23]

4.1.3. Other models

Various other models exist that are being discussed or implemented in various countries across the WHO European Region, testing alternative forms of conditionalities that are discussed in the context of UBI because they suggest a type of contribution to society other than labour (see Atkinson (1996)). Participation income, or participatory social security links benefits with communal work, such as care work or work for nongovernmental organizations, with the aim of strengthening social cohesion and inclusion. The Dutch and the Spanish trials are currently testing these options: an additional participation income may be obtained as a top-up to the basic benefits, if beneficiaries participate in voluntary work. In other countries (such as Germany), this option is being discussed as a potential conditionality.

Critics state that while the content of the conditions would change, participation income would not change the basic problems and caveats of conditionality and access to basic income in general.[24] Contrary to common cost-saving arguments, the creation of participatory work that makes sense to

[21] Historically, several NIT-trials have been carried out in the United States and Canada in the 1960s and 1970s. In particular the B-Mincome Manitoba trial gained a lot of attention (Forget, 2011). The trial in Ontario is assessing a classical NIT model, which aims to provide income security for the working poor population, while at the same time incentivizing working through a stepwise threshold model; that is, the compensation is not withdrawn immediately, but progressively, as employment continues (for an overview, see Annex 4).

[22] Moreover, while immediate benefits from a very low baseline can be found, alternative designs might result in improved heath equity goals.

[23] Targeting is more likely to emerge, be sustained or reinforced in conditions of rising inequality or/and poverty. Low real wages, and unstable income from employment are likely causes of rising inequality and poverty, which tends to entail targeted grants that are set at a low level to retain incentives to work.

[24] This includes questions regarding what is considered participatory work, and how much of it would be necessary, in order to be eligible. Moreover, who should define such participatory work, or should individuals be allowed to choose their participatory contribution themselves, including raising children, taking care of elderly or undertaking further education (Kela FPA, 2016; De Wispelaere & Stirton, 2018)?

society may actually be quite costly, often including high administration and management costs.[25] Overall, critics also see the risk that participation income could replace paid work and eliminate the incentives to move into the open labour market (Kela FPA, 2016; De Wispelaere & Stirton, 2018).

Another alternative approach to addressing current welfare challenges is rolling a range of benefits into one to simplify and flatten income security whilst retaining conditionalities and targeting. Although only superficially connected to UBI, policy-makers and practitioners sometimes consider universal credit as a second-best alternative to UBI policies.[26] However, the only commonality between universal credit and universal income policies is semantic. The model currently being implemented in the United Kingdom combines elements of basic social assistance in one "universal" credit, which decreases as income increases. It is thus strongly means-tested and involves sanctions in case of non-compliance. The basic aim of this so-called active welfare model is to reduce poverty by eliminating disincentives to work and integrate as much people as possible in the labour market. The workfare focus, as opposed to a needs-based approach, can also be seen in the basic means-testing model, based on household rather than individual income. Simplifying the scheme through a unification of benefits for different social risks is also thought to render welfare more efficient and effective, both for providers and beneficiaries. However, evidence so far is mixed. While participation in the labour market has increased, this often concerns non-standardized, highly insecure jobs. Contrary to expectations, the change has increased the complexity of application and delivery processes, increasing exclusionary mechanisms and leading to major delays in the delivery of benefits. Sanctions create a lot of mental stress, while the household-based calculation model is considered a major intrusion in peoples' lives, as it would substantially influence the way people live, which goes beyond welfare ethics. Universal credit has also engendered a change in payment modalities, which causes a lot of distress, especially among people with low incomes who have difficult expenditure decisions to make. While, previously, housing allowance was paid directly to housing associations, the merging of the housing allowance into universal credit has put many people at the risk of eviction, as they can no longer manage to pay their rent (NAO, 2018).[27]

4.1.4. Putting UBI into a broader welfare context: a three-tier model as a long-term goal

Looking at UBI policies through a health equity lens, two aspects deserve specific attention: first, the relationship between health and income security. While pathways between the two are complex and context specific, more income does not necessarily translate into more health for all, but needs to be looked at against the social gradient and the extent of poverty, emphasizing the need to address health equity simultaneously across the gradient and at its lower, poorest end (Lundberg et al., 2010, 2014; Marmot et al., 2010). Second, considering the institutional aspect is just as important; namely, how social policies to address health equity would need to be designed in order to provide incentives and address (health) needs, including generosity, coverage, and the way they are linked and complement other policies. Focusing on the poorest in society, the NIT might be perceived as the best approach, having a strong impact on the lower end of the gradient, but it would probably have limited impact across the gradient, and the other models seem to be rather unspecific in terms of their impact on health

[25] In this context it is worthwhile looking at the controversial debates around public works and guaranteed employment programmes (McCord, 2010). One reason for the Dutch partial income trial was that the creation of communal works as prescribed in the active labour market guidelines was so costly for communities that they decided to experiment with unconditional programme designs and invest the money in more "useful" projects, such as building a communal library (according to qualitative data from an interview carried out by the author team).

[26] Qualitative data gathered from interviews with health practitioners and social policy experts involved in the trials.

[27] Qualitative data gathered from an interview carried out by the author team.

or, in the case of universal credit, actually work against it; that is, increasing poverty and exclusionary practices, with considerable negative health impacts.

Adopting a three-tier model of income security with basic income as a foundation (Haagh, 2013, 2019b) provides a supportive structure within which other needs-based policies and contributory, savings-based schemes can be built and sustained.[28] This foundation model of UBI sits within a broader income security structure. The three-tier model separates UBI from needs-tested schemes (second tier) and contributory schemes and occupational incentives (third tier). This system retains the central features of UBI, which contribute to generating basic income stability for individuals; universality, unconditionality, individuality, as well as permanence. At the same time, it allows flexibility in terms of how UBI is combined with other needs-based and contributory systems. Basic income therefore acts as a structure that supports other systems, and avoids over-simplification of welfare policies by rolling too many policy functions into a single transfer. The level of UBI can vary with the fiscal capacity of individual countries, and with the existence of other contributory and needs-based institutions, depending on political preferences. Within this system, UBI acts as an independent basic foundation for other needs-based and contributory systems, but entitlement is guaranteed and separated from entitlements under the other systems. In this sense it has the advantages of two-tier models that already exist in Scandinavian countries (Haagh, 2007), including the ability of wage earners to retain a higher level of cover for a period of time, before turning to basic income assistance, thereby generating a deeper sense of security. The two-tier system also generates social contributions, thus alleviating fiscal pressures and enabling a broader sense of having a shared stake in mutual insurance across societal classes, as state subsidy allows lower earners to benefit from this system as well. In the case of Denmark, studies have shown how tax subsidy avoids an outcome whereby otherwise premiums would have the effect of excluding people with lower incomes (Bjørn & Høj, 2014; Haagh, 2013).[29] Overall, this makes it possible to provide the sense of basic stability in subsistence entitlement that has been lacking in Europe, with the health benefits that have been documented, while preserving needs-based systems (around maternity, and disability, among others), as well as contributory and occupational affiliations systems and policies.

The thinking behind the three-tier system is that basic income as a foundation will strengthen capabilities and incentives to contribute and save, which therefore replaces the need for compulsion mechanisms linked with subsistence support. As such, it also avoids the poverty traps associated with means-tested basic assistance. This can help address the documented negative health impacts of conditional and benefits sanctions approaches. Sanctions and conditions can be relevant in contributory systems with defined access rules, but in this case without putting claimants' basic security status at risk.

Such an approach may also be useful in dealing with poverty in older individuals, the necessity of which is expected to increase further as a result of precarious employment trajectories. A basic income grant understood as being a baseline, in addition to existing ones, would provide important basic security for this group, as well as for people who – for one reason or another – are not able to find employment. A three-tier model could also help to close the gaps in existing social protection mechanisms (which lose their protective capacity as a result of changing labour market and employment conditions), such as access to unemployment insurance for young people who (depending on temporary jobs) may not be able to contribute sufficiently (Eurofound, 2017; COPE, 2017). It would also fit well with overall health equity concerns and the identified pathways in tackling them, in particular proportionate universalism

[28] This concerns in particular people with special needs, such as (among others) people with disabilities and social or health care services involvement, drugs prescription, or child care services (Zon, 2016, 2017; Forget, 2017).

[29] For a single person aged over 25 years, coverage was about DKK 7800 per month (after tax) in 2013, compared with the equivalent of about DKK 2756 in the United Kingdom (not counting housing support in either case) (Haagh, 2019b).

(Marmot et al., 2010; Pillas et al., 2014). At the same time as providing a basic income security for all, the model would encompass targeted policies in order to strengthen health and well-being of specifically vulnerable groups across the gradient, but in particular at the lower end.

This presupposes that well-being and health equity are considered key concerns and objectives in this process. Where this is not the case, UBI policy reforms may miss the opportunity to impact on health equity dimensions in a more purposeful way. In ongoing trials, health equity concerns play no or only a marginal role (with the notable exceptions of Canada and Scotland). This is not to say that health equity concerns are not a public concern. On the contrary, the debate around unequal health outcomes for specifically vulnerable population groups linked to unequal access to public services and related reforms is quite high on the political agenda.[30] However, both debates are taking place in complete isolation. While evaluation and monitoring frameworks of all trials include a series of health indicators, the number and quality vary widely and tend to be rather unspecific. Generally, health is considered a secondary outcome,[31] with the main interest focusing on testing impacts on work/workfare/employability in the context of changing labour markets and bureaucratic welfare state arrangements. Poverty and income inequality play a role, but they are not central to the debate.

4.2. Administrative, legal and institutional dimensions

Ongoing trials faced considerable legal, administrative and institutional challenges during implementation; notably, the need for a separate legal framework to enable a temporary exemption of participants from active labour market policies, taxation and social insurance contributions. This was compounded by fiscal concerns in some countries, leading to intense conflicts between the central and local levels, with the latter fearing substantial curtailments to their local tax basis.[32]

These experiences would clearly speak to a transition to full coverage, rather than proceeding through isolated experiments creating major legal and moral problems. This is not to deny that implementing UBI effectively is a long-term challenge and would imply profound administrative, legal and institutional changes to the current system, notably a reorganization and redefinition of the links between the various tiers, in particular with regards to insurance mechanisms. Furthermore, the question of the central State and its responsibility in adequately financing social policies would also need re-opening.[33] However, what is evident from all the experiments is that a UBI cannot be implemented in isolation,

[30] In Finland, the debate on health inequities is centred on unequal access to health care services that is strongly related to socioeconomic differences, including employment, education and gender, resulting in large differences in mortality rates (Kangas & Blomgren, 2014; and qualitative data gathered from an interview carried out by the author team). A broad-based primary health care reform is currently being discussed, in particular linked to health insurance schemes. In Barcelona there is great concern about the large gaps in life expectancy between the richest and the poorest areas; these have substantially increased since the onset of the financial crisis. At the same time, Barcelona is facing huge demographic changes, with an increasingly old population, which increases the pressure on public services in terms of care services and social integration. In the Netherlands a major political concern in terms of health inequalities centres on the differences in life expectancy between so-called blue-collar workers with low education levels, and those with higher educational backgrounds. Currently, a change in the pension system is envisaged, allowing workers with a long career in blue-collar jobs to retire earlier, so as to regain a few years in life expectancy.

[31] In some countries the inclusion of basic health indicators in the evaluation frameworks is the result of the professional interest of researchers involved, rather than the ministries, municipal departments or insurance institutions commissioning the experiments.

[32] Qualitative data gathered from an interview carried out by the author team.

[33] In a number of trial countries, design and implementation of the experiments led to intense conflicts between central and local government levels in terms of financial responsibilities, with the latter fearing potential cuts in their tax base, as well as in terms of legal issues related to the exemption from centralized conditional labour market policies.

but would need to be implemented on an incremental basis and simultaneously to complementary adjustments and modifications of existing welfare arrangements.

4.3. Financing

An important dimension of the UBI debate is how to finance it. Various models exist dealing with how to calculate the costs of UBI.[34] Here, some general points should be raised. First, a major criticism of UBI is that financing aspects are not critically discussed and advocates tend to turn a blind eye to the economic realities, in particular the deregulatory tendencies in global economic development. The divestment of finance institutions from the productive sector, by concentrating its investments on the speculative sphere, some authors argue will have an enormous impact on the real economy, as interest on loans may increase substantially over the following years and lead to a major increase in debt problems (Lavinas, 2018; Haagh, 2019c). In a recent paper, Flassbeck (2016) critically questions the fact that calculations on costs for a UBI systematically tend to exclude the political dimension that is invariably linked to such proposals, such as an increase in VAT or taxing financial transactions – often against the interests of entrepreneurs, big companies and rich people. At the same time it is worth noting that global financial institutions (IMF, 2017) are advocating the need to rebuild fiscal capacity, especially in relation to progressive taxation, and have considered UBI as being relevant in some country scenarios.

In the case countries, broader financial implications have not been discussed, as most trials are clearly limited in time and are termed "experiments" and not "pilots", which would suggest an expansion into the future. However, one important aspect that transpires from all the interviews is to consider the costs of not implementing any intervention at all; that is, the financial, economic and social costs of neglecting rising economic inequalities and, for that matter, health inequities too: "while UBI inspired reform policies may mean an increase in costs, so will costs increase if we stick to the current system"[35] (see Cecchini & Martínez, 2012; Bonilla Garcia & Gruat, 2003).[36]

Since countries also face pressures to increase spending on services, the likelihood is that public policy debate will become politicized and focus on the choice between income and services as means of human development. It is difficult to avoid this trap in the short term and it is therefore important to create awareness of its conditions and impacts, and in particular of the necessity to strengthen both basic services and income security in order to achieve intended outcomes (see Section 3.3 on the challenge of complementarity within UBI). Engaging this challenge productively requires political will, long-term planning, effective political communication, and making human development an overall goal and a public priority guiding fiscal reforms. See Annex 7 for a more detailed insight.

[34] Estimates vary widely, clearly also depending on the design and proposed benefit level. Various financing models and calculations have been carried out by various institutions and researchers (Kela FPA, 2016; Arcarons, Raventos & Torrens, 2014; OECD, 2017b; Widerquist & Lewis, 2005; Richardson et al., 2018; Citizen's Basic Income Trust, 2018). Different financing modalities are being discussed, ranging from traditional means of increasing income, property tax or VAT to more innovative solutions of additional taxes on natural resources, or on air pollution (Goldhill, 2016). An aspect which dominates the financing debate is whether UBI would actually cost more than existing schemes, or whether UBI could be largely financed by merging existing schemes, in addition to proposed efficiency gains through leaner administration and bureaucratization.

[35] Qualitative data gathered from an interview carried out by the author team.

[36] Evidence from Latin America suggests that the most important drivers for narrow targeting as the model of choice in income security were flawed, represented by the theory that poverty is temporary and represents an individual responsibility, and the theory that insecurity of income or status is conducive to motivation and effort. This has important implications for countries in Europe with less-developed income security systems, highlighting the importance of adopting a road map for income security coverage that is motivated by long-term social development goals, rather than short-term costs or political trade-offs.

4.4. The role of local government

Local government plays a key role in the reform context of social protection and UBI policies in particular, being one of the main drivers behind UBI experiments and wider social policies in many countries. This is on the one hand related to the traditional role of local government in delivering social assistance, which in many countries is also linked to a certain degree of autonomy in setting transfer levels or deciding conditionalities – often in addition to national programmes; on the other hand, the local level is the most decentralized government level, whereby effects of austerity and cut-backs in public services have more immediate impacts (also in terms of administrative and financial burden), through increased demand and casework.[37] It is thus not surprising that local government has a strong interest in basic income policies, as any shift in changing living conditions and/or demand in services are registered more directly and sooner than at other government levels. A basic income policy funded and extended at national level could give a much-needed boost to local government services, by making policies that target needs and employment policies at this level more effective.

UBI design is not only about creating the most technically sound and most efficient and effective model, but also a politically palpable one. This may imply some trade-offs in the short and medium term, within an overall long-term perspective. In this respect, the debate on UBI also needs to be understood as an important platform and catalyst to discuss and propose a broad range of ideas and policy alternatives, including with regards to wider economic and public policies; for example, in the debate around tax justice for social justice, which in the long run may lead to the implementation of UBI policies (Richardson et al., 2018).

[37] The Netherlands, which has a highly decentralized social protection system (including in terms of financing), or the municipality of Barcelona, which suffers from a total mismatch and parallelism between national and local-level social assistance schemes, are two such examples.

Chapter 5. Discussion and recommendations

An unconditional UBI involves building a universal tier of income security that is unconditional and not means-tested. The presence of such a system allows other supplementary income transfers to be built in a way that can minimize the problems of stigma, the poverty trap and work disincentives associated with post-war means-tested systems. A UBI system can support economic adjustments and work incentives by allowing individuals to take greater control over their lives when affected by changes in the economy. In doing so, it also addresses health inequalities and well-being. This concerns in particular the documented negative health impacts of contemporary income security systems, which involve uncertainties about subsistence status. As part of a tiered model, UBI – in close complementarity with universal services – can help support the building of welfare systems based on the principle of proportionate universalism, providing basic income stability that is both crises preventative and health constitutive. Being based on a basic income fall-back net for the whole population, linked into targeted policies aimed at specifically vulnerable groups, specific needs and demands can be addressed. This is in line with WHO's approach and the concept of proportionate universalism – providing universal policies that act across the whole gradient but are implemented at a level and with intensity that is proportionate to need; that is, addressing specifically the needs of people at the bottom of the social gradient and the people who are most vulnerable (WHO Regional Office for Europe, 2014; Marmot et al., 2010), without sacrificing universal inclusion.

Adopting a universal income scheme would imply a profound transition in terms of how social welfare systems are currently set up, which – contrary to the profound transitions taking place in economics and employment – appear to face much stronger resistance in terms of acceptance. This is the case politically, financially and socially. This paper's proposal is therefore to view UBI as a long-term goal and as part of a basket of measures, which gives room for adopting differently staged transitions and models across countries in view of differential institutional and fiscal capacity and political contexts. The type and scale of challenges involved will vary by country and across the WHO European Region.

Some countries with strong fiscal systems can envisage a relatively short transition to UBI.[38] In such cases, reform may involve converting tax-free allowances and the lower tier of comprehensive income security systems that are already in place. Other countries with less comprehensive minimum income security systems and fiscal provision may consider a transition via an NIT model, which involves means testing but in a form that is not directly connected with labour market conditionalities, and thus avoids some of the key features of current sanctions-based systems, which lead to non-uptake and social exclusions (see Richardson et al., 2018). In countries with weak income security systems in place and middle-income countries, the long-term goal of UBI can help avoid some of the problems of conditional cash transfer schemes, including time delimitation and other access barriers affecting the poor. In those countries, the basic income tier may actually provide the foundation and primary intervention on which to build and expand the higher-level tiers.

Building a system of universal support steadily, by first ensuring effective coverage of the lowest-income quintiles and gradually implementing a comprehensive basic income system can also be used as a way to support formalization and transparency in tax-benefit systems, and to build or rebuild contributory systems. The foundation or three-tier model of UBI discussed in Chapter 4 is an adaptable structure that can be built on over time and in accordance with differing existing levels of fiscal and institutional

[38] It can be noted that in countries deemed able to fund a UBI, combined with existing universal services and other contributory systems the share of tax in GDP is about 50% (Colombino et al., 2010).

capability across countries. Recommendations concerning basic income as a foundation for other contributory systems (Haagh, 2019b) are very similar to those made by global organizations concerning three-tier pensions. In this case, UBI guarantees security – with the health benefits that security is known to have – but does not exhaust possibilities for added income security protection. Focusing on the lowest income quintile first would also strengthen the effectiveness of health interventions to address health inequalities, in particular for those at the lower end of the gradient.

The perspective on UBI policies as a long-term goal should not prevent policy-makers from undertaking first steps towards this goal. The UBI experiments reviewed in this paper have shown that – despite mimicking only limited features of UBI – even small changes to the commonly known welfare–workfare logic have a huge impact, such as lifting conditionalities and sanctioning regimes. Other potential short-term measures towards implementing UBI as a long-term goal include the universalization of access to specific benefits, such as child allowance or disability benefits (see, for example, Matkovic, 2017; WHO Regional Office for Europe, 2014; Marmot et al., 2010).[39] Implementing such shifts on a large-scale basis would allow important pilot experiences to be generated, which may have a much stronger weight in future policy discussions than small, complex, short-term experiments.

At the same time, it is evident that the scope and legitimacy of three-tier systems (involving lifelong basic security, means-tested top-ups, and voluntary or compulsory contributions and voluntary savings elements) depend on the future of work and employment. UBI policies are only one measure in a policy basket to ensure sustainable and inclusive growth and development. Countries with more stable and better distributed employment opportunities will be better able to sustain three-tier systems. The more deregulated the labour market, the greater the pressures will be to raise the level of UBI and/or means-tested transfers, because contributory systems will be less realistic. Reforms to the current labour market, wide-ranging fiscal reforms as well as appropriate economic and trade policies are equally important in order to sustainably reduce inequities and prevent gaps from widening.

This is also in line with the 2030 Agenda, with its focus on health and well-being for all and at all ages, as a key condition for economic development to which WHO has committed. Equally, it aligns with the European Pillar of Social Rights, in particular with regards to the creation of efficient employment and better social outcomes.

Further investigation of the potential for UBI to improve systems of income security and health should take account of broader factors in the economic and regulatory environment. Insecurities within the labour market are not directly resolved by a UBI; while a UBI can help support work incentives, the overall impact of UBI on the labour market and health will depend on a wider range of factors (Haagh, 2019b). Labour market policies, such as better control over working life or more stable contracts may be equally important for people to experience better health (Haagh, 2011b). Wider macroeconomic dimensions, such as (among others) disinvestments in the productive sphere, and innovative solutions for creating fiscal space are key for creating a more stable economic environment that allows for inclusive growth. This, in turn, may create feedback effects on financing social protection measures.

[39] For an example of the effects of child allowances in reducing child poverty, see Fig. A8.1 in Annex 8.

5.1. What role for WHO?

The debate around UBI has a clear link to Health in All Policies (HiAP) as a policy approach and an understanding of health as being influenced by factors other than health policies and conditions, which are both firmly anchored in Health 2020. Notwithstanding, the health sectors at country level appear largely to lack vision and a narrative linking to the debate around basic income policies and their role for health inequalities, creating a political and institutional stake. This appears to be worse in countries where (health) inequalities are only beginning to widen and debates around universal policies are largely taking place without the involvement of the health sector.

WHO thus has an important task to perform in supporting countries to explore further the health implications of universal and stable income security, considering impacts on individuals, society, and health delivery institutions in particular.

- **Health should be promoted as a common good.** Supporting Member States in developing a health (equity) narrative that moves away from health as a lifestyle issue towards health as a social justice agenda is essential, emphasizing the key role of income security as a preventative health measure (Reeves & Loopstra, 2017) and the need for the health sector to engage with other sectors (in particular in the debate around much-needed universal income policies, in close interconnectivity with universal health care services) (Haagh, 2019b). A range of important policy frameworks exist on which to build, including Health in All Policies, wide-ranging work on the social determinants of health, the European Pillar of Social Rights and the SDGs. Herein, WHO could play a key role in facilitating the exchange of experiences across countries on how to create and influence policy processes in this direction, including the development of advocacy and communication tools that support partner countries to better communicate across government, enabling them to create consensus and "win-win" situations for health.
- **WHO has a role as a regional knowledge broker and facilitator.** It is important to create communities of interest by uniting different stakeholders engaged in health, social services and income protection, as well as across different government tiers.
- **WHO should provide guidance and evidence.** Evidence on health inequities across policy sectors and across different tiers of government should be collected and provided. As a regional body, WHO would be in an ideal position to host such evidence, providing guidance on methodological issues involved in collecting evidence, as well as identifying priorities for building datasets on health equity at country level; this also includes the promotion and further development of health impact assessment as a tool to be systematically applied by governments and health actors to assess the impact of wider economic and social policies, in order to elevate health considerations to the same plane as other outcomes of concern (APHA, 2012; Wismar et al., 2007). WHO Regional Office for Europe's Footprint Initiative, aiming to measure economic and social impacts of health systems at local, regional and national levels, may provide an additional tool in this regard (Boyce & Brown, 2019). Such a role for WHO would also include supporting countries in feasibility research, modelling and micro-simulation of different UBI models, and promoting and developing further tools to be provided to Member States in cooperation with countries and regions that have already moved ahead in this field (e.g. Scotland's Triple I; see Annex 4).

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Annex 1. The WHO European Health Equity Status Report Initiative (HESRi)

The WHO HESRi has three core objectives. It intends to:

1. set a baseline for monitoring health equity status and health equity policy progress within countries of the WHO European Region **(Accountability, and Priority for Health Equity)**;
2. set an agenda for scaling up action to increase equity in health within countries and across communities of practice in the Region **(Action for Health Equity)**;
3. create a strong voice for political advocacy for health equity in the Region **(Advocacy, Dialogue and Constituency-building for Health Equity)**.

A key purpose of the HESRi is to capture what is already working to reduce health inequities and to bring forward for discussion promising approaches, with the potential to: (a) create the conditions for all people to prosper and flourish, in health and in life; and (b) remove barriers that are holding people back by from being able to live a healthy life and achieve their potential.

Often efforts to reduce health inequities depended on single policy measures (e.g. education) and at times, the impact of these policies has been overestimated. Scaling up action on health equity and enabling the conditions necessary to lead healthy and prosperous lives therefore require a combination of policies and interventions.

The HESRi is based on five interrelated action areas in which policies can be strengthened and progress monitored (See Fig. A1.1).

Fig. A1.1 Action areas to increase equity in health and well-being within countries

These action areas are closely interlinked, producing the key conditions needed to be able to live a healthy life. They include: (1) health services; (2) income security and social protection, including universal health care; (3) living conditions; (4) social and human capital, including community capacities; and (5) employment and working conditions.

Evidence clearly suggests that a coherent basket of interventions (policies, services and programmes) across all five of these interrelated areas may work best to level up health opportunities and outcomes across the population (WHO Regional Office for Europe, 2014).

In addition to policy coherence, the HESRi highlights the need to tackle the underlying causes of inequity, including participation, empowerment and accountability for health equity, with the aim of reducing stigma, removing barriers to participating in social, economic and cultural life, as well as increasing individual and community resilience and control over destiny.

Annex 2. Structured interview guideline

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR EUROPE

WELTGESUNDHEITSORGANISATION
REGIONALBÜRO FÜR EUROPA

ORGANISATION MONDIALE DE LA SANTÉ
BUREAU RÉGIONAL DE L'EUROPE

ВСЕМИРНАЯ ОРГАНИЗАЦИЯ ЗДРАВООХРАНЕНИЯ
ЕВРОПЕЙСКОЕ РЕГИОНАЛЬНОЕ БЮРО

The WHO European Health Equity Status Report initiative (HESRi)

Discussion paper on how universal basic income (UBI) policies can contribute to accelerating progress to reduce inequities in health within the diverse context of the WHO European Region

Guidance for interviews contributing to the WHO discussion paper

Introduction and purpose of the discussion paper
Progress to reduce health inequities across countries of the WHO European Region in the last 10 years has been mixed. For example: in more than half of Member States inequities in limiting illness and poor self-reported health by quintile groups have remained the same or have increased between 2008 and 2015; infant mortality continues to follow a social gradient in transition economies; and there are worrying trends in falling life expectancy by gender and socioeconomic status in some high-income countries. Against this backdrop, health policy-makers and practitioners are looking for innovative solutions and mechanisms that may help to address the structural factors or pathways to health, in order to reduce health inequities and improve well-being for all.

The WHO HESRi is taking up this challenge, with the aim to:

1. **set a baseline for monitoring health equity status and health equity policy progress within WHO European Region Member States;**
2. **set an agenda for scaling-up action to increase equity in health within countries and across communities of practice in the WHO European Region;**
3. **create a strong voice for political advocacy for health equity in the Region.**

The HESRi is being led by Chris Brown and the team at the WHO European Office for Investment for Health and Development, based in Venice, Italy. Core to the work of the HESRi is capturing what is already working to reduce health inequities and bringing forward for discussion promising approaches, with the potential to:

- create the conditions for all people to prosper and flourish, in health and in life;
- remove barriers that are holding people back from being able to live a healthy life and achieving their potential.

Purpose of the interviews
Within this context, the aim of this policy research is to review the extent to which UBI policies can contribute to accelerating progress to reduce inequities in health within the diverse context of the WHO European Region.

The specific request of the WHO HESRi is to take a closer look at the current debate and role of UBI for health equity as being taken up by Member States. It also relates to wider policy processes, making specific reference to: the WHO European health policy framework Health 2020; the 2030 Agenda for Sustainable Development and its core objective of leaving no one behind; and the European Pillar of Social Rights (2017), which emphasizes the role of social rights for the creation of efficient employment and better social outcomes, along with an inclusive and fair growth model.

As part of this research, the WHO HESRi, based at the Venice Office, is carrying out qualitative interviews with health practitioners, experts working in the field of health inequities, and policy-makers concerned with inclusion and well-being, who are all engaged in the debate around UBI and its potential for reducing health inequities and/or are involved in UBI pilots and experiments already under way. The aim of the interviews is to get a better insight into the debate around health inequities and UBI in your country/region/city, including the major drivers behind the debate, stakeholders involved, the perceived potential of UBI for health inequities and the perceived challenges, as well as the wider political and societal debates that are ongoing.

Interview style

- The interview is based on a structured interview guideline and should last around 45 minutes.
- To aid a smooth process and analysis, with your permission we would like to record the interview.
- The interview will be partly transcribed and analysed and will constitute a major source for informing the discussion paper; however, the information obtained will remain strictly confidential and will be anonymized.
- Any consented recording of the interviews will be destroyed after transcription.

Interview questions

1. Before discussing UBI, please could you tell us more about health equity in your country. What are the major issues around health equity/ inequity? How is it currently "positioned" within the priorities of government and wider society? Are any specific goals and approaches being pursued? Who/what is the motivation or drivers behind the priorities/goals and approaches?
2. How did UBI get onto the political agenda in your country/region/city?
3. What are the drivers behind the debate on UBI? What are the major issues that have nurtured the debate on UBI?[40]
4. Does health in general, and health equity/reducing inequities specifically feature in the debate around UBI? If yes, in what ways? If not, what do you think are the reasons for this?
5. Who is driving the UBI process in your country and what do you consider to be the underlying interests, motivations and goals?[41]
6. Looking at people's health and well-being, evidence suggests that the classical welfare approaches that have dominated the post-war period – being based on a specific employment and labour market model – are no longer in the position to address existing health inequities. Do you agree with this statement, or not? Please tell us more about this. If you agree, in your opinion what are

[40] Suggestion: probe for wider debates in society and politics that touch upon issues of well-being, social justice and sustainable development.

[41] This could include stakeholders, groups and institutions that play a key role in moving these issues forward.

the major challenges/reasons why things are not working out?

7. UBI has three core features that are all important, and should be set together: individuality of the benefit; no conditions applied to the basic benefit, such as work tests on health or education/training measures; and no means testing.[42] There is also the issue of the size of the benefit, as people should be allowed to make a decent living. Compared to current social and health policies, what advantages would you see with the introduction of a UBI for tackling pathways to health? What are your expectations for UBI in terms of improving health equity? What does it offer/what role can UBI play in tackling health inequities?
8. WHO's position is not to substitute other policies for UBI; it is understood as a package of several policies that create the conditions for good health and well-being for all, used to tackle multiple inequities which hold people back in health and in life. What is the debate in your country? What kind of UBI is debated and what role does it play in relation to other policies and services?[43]
9. How does this match your perspective/position on UBI from a health equity perspective?
10. There is a lot of debate around UBI at political and societal levels, but only a few countries/regions have started to implement pilots. From the health point of view, what would you consider the most important challenges with regards to implementing UBI approaches?
11. We have talked a lot about UBI, which is currently receiving much attention and is widely debated. What could be alternative approaches/measures, if any?
12. What role could WHO HESRi play to support countries, with respect to:
    - UBI in particular;
    - promoting equity in health, generally;
    - supporting policy-makers with common challenges and interests? Specifically, this means encouraging them to implement, share and innovate in best practices (in terms of both policies and approaches) to increase equity in health and well-being as part of their broader development agendas and plans.
13. Additional comments/reflections/information are welcome.

[42] For probing/clarification: not setting a means test is argued for in order to avoid stigma and work disincentives that arise if benefits are clawed back with earnings. Individuality is argued for as it protects rights; for example, those of women in households. Finally, having no work tests is argued for to encourage individuals to search for jobs they are motivated to do and keep.

[43] For probing/clarification: there are four basic approaches to basic income security which involve all, some or none of the components of UBI. For example, some people argue that a partial UBI is best, combined with other means-tested and contributory policies, as a "top-up" for groups that need or have paid into insurances to attain additional support. This means keeping many existing benefits, but making a basic benefit floor that is universal to all, to avoid stigma, etc. A second approach entails UBI replacing most means-tested benefits. Finally, a third (and fourth) approach involves no universal benefit – no UBI – but retains the current approach of tailoring benefits only to need. Within this there are two options (constituting the fourth approach): assessing only need but not setting behaviour conditions; or, assessing need and setting behaviour conditions. From a health and a practical perspective, which do you think would work best?

Annex 3. The equality paradox: public finance conditions for human development and a health-effective basic income reform

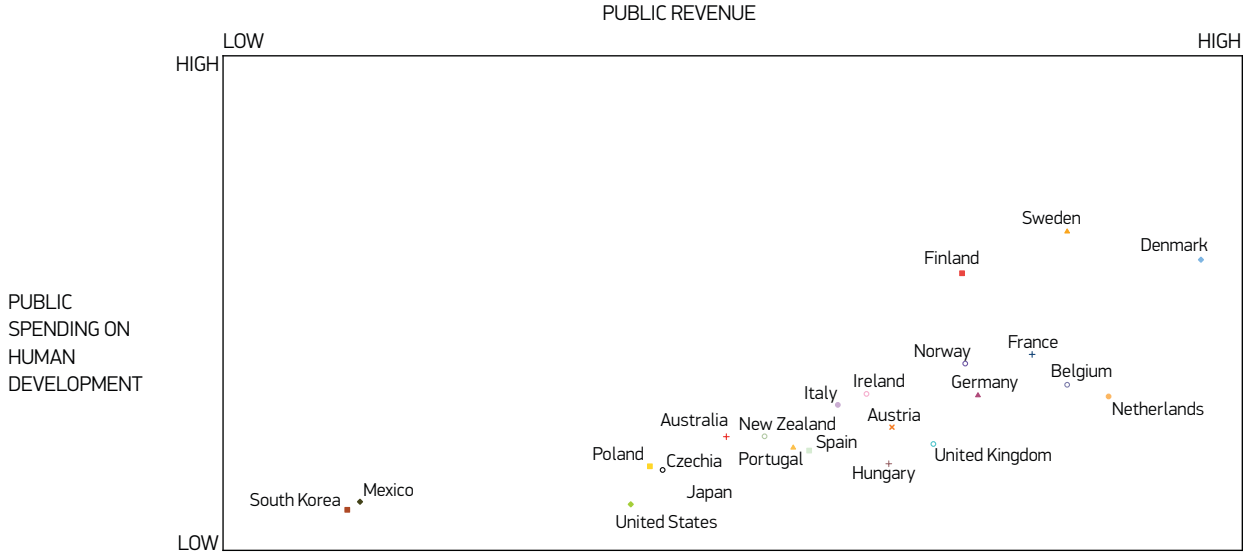
It is broadly recognized that various conditions shape the positive health benefits of basic income reform. Several welfare scholars have linked effective welfare policies to the scale effect, with both the level of public finance and the reach of services across populations playing a role (Hills, 2015; Rothstein, 1998; Korpi & Palme, 1998; Haagh, 2002, 2012; Kangas & Blomgren, 2014). This is highly relevant for basic income because it is wide-reaching by definition. On the other hand, the depth of this reach – for example, whether it extends beyond mere subsistence to generate conditions for active inclusion – depends on other human development-sustaining policies, and ultimately on the reach and scale of the whole system of public finance (Haagh, 2012, 2015). In this context, although interviews with stakeholders highlight concerns about the connection between basic income and contributive systems, a positive case can be made for how basic income supports a rebuilding of contributory and employment systems in the context of a more active welfare state (Haagh, 2019b).

Fig. A3.1 and Fig. A3.2, derived from Haagh (2019b, 2019d[44]), set the level of inclusiveness of public finance systems against the level of public investment in select core human development-promoting policies; in particular, education, support for employment training, and care/family benefits. A propensity to support higher levels of human development investment in inclusive tax states with correspondingly high levels of economic formalization of employment reaffirms a core hypothesis elaborated by Korpi & Palme (1998), to the effect that redistributive (targeted) welfare policies tend to coincide with low levels of welfare financing, and vice versa. Comparing tax systems and human development spending pre- and post-austerity, the illustrations show a propensity to sustain human development investments, despite a tendency towards erosion of the level and inclusiveness of tax systems during the period of austerity, especially within European countries. This presents a challenging policy scenario, which explains the tendency to favour caseload reduction within income security provision in the period after the onset of the financial crisis in 2007. However, a policy to promote deregistration from public income security support systems is counterproductive in a context of rising job insecurity. Paradoxically, basic income may seem less urgent in countries in which basic income is fiscally feasible (known as the equality paradox, as discussed in Haagh (2019c)). However, it is important to think beyond short-term fiscal constraints to consider how the design of income security institutions can be improved. The role of universal basic income (UBI) reform in this context is pivotal because, even as countries recover fiscal capacity, an inclusive design of income security institutions will be crucial in order to derive the best return to investment in other areas of social provision (such as education and health) and to build capability for effective employment promotion.[45]

[44] More in-depth understanding of the data can be gained from the online appendix to Haagh (2019b) (http://politybooks.com/bookdetail/?isbn=9781509522958&subject_id=4).

[45] Research which looks at long-term employment effects of alternative income security designs shows better sustained employment outcomes under systems with more stable (long-term) income security provision (Tatsiramos, 2006; Griggs & Evans, 2010). Even cases of so-called moral hazard, e.g. where recipients of unemployment insurance remain covered after taking employment, suggest external sources of income security act as a springboard for employment integration (Chahad, 2004; Haagh, 2011b).

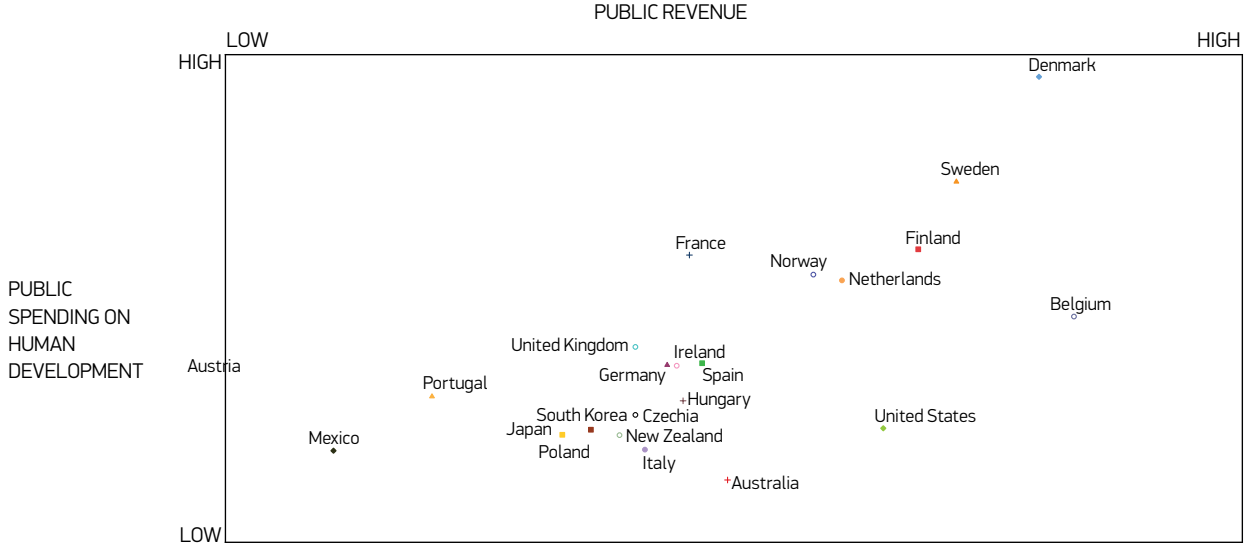
Fig. A3.1 Trends in fiscal capacity and human development spending, 2000 (plus available data trends)



Notes. Available data trends range from 1975 to 2015. The diagram is intended to give a representation of welfare state structure by setting different measures together, presenting an overall picture of the level of and trends in public fiscal capacity (tax on various types of revenue), on the one hand, and human development spending on child care, education and training (social spending in GDP, share of social expenditure, etc.), on the other hand. Details of the data points and measures can be found in Haagh (2019b), in the online appendix.

Source: adapted from Appendix tables A.1 and A.2 in Haagh (2019b).

Fig. A3.2 Trends in fiscal capacity and human development spending, 2015 (various years) (plus available data trends)

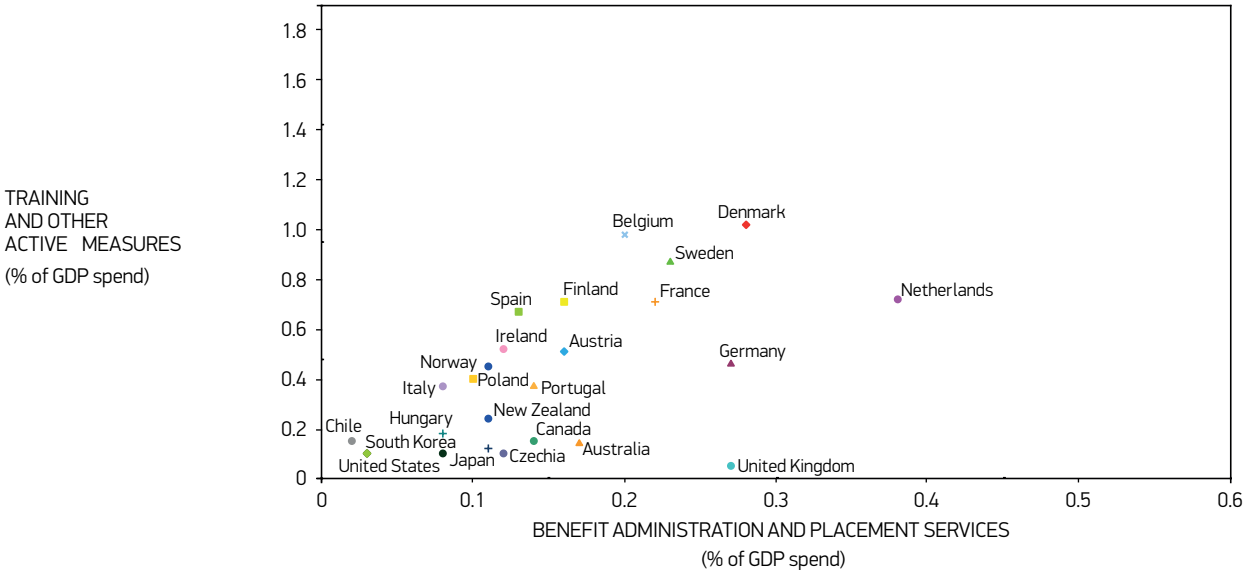


Notes. Available data trends range from 1990 to 2016. The diagram is intended to give a representation of welfare state structure by setting different measures together, presenting an overall picture of the level of and trends in public fiscal capacity (tax on various types of revenue), on the one hand, and human development spending on child care, education and training (social spending in GDP, share of social expenditure, etc.), on the other hand. Details of the data points and measures can be found in Haagh (2019b), in the online appendix.

Source: adapted from Appendix tables A.1 and A.2 in Haagh (2019b).

Fig. A3.3, A3.4 and Fig. A3.5 (based on Haagh, 2019a, 2019c) show countries' administration and training expenditure during pre- and post-austerity employment transitions. Although policies emphasizing benefits sanctions became more common before the 2008 crisis, this event deepened the use of benefits sanctions and caseload reduction targets to implement fiscal retrenchment goals. The illustrations show rising investment in benefits administration, but without a uniform level of response in spending on education and training in employment transitions. This suggests countries with a similar level of sanctions within benefits systems (such as the United Kingdom and Denmark) administer employment transitions and sanctions very differently (Haagh, 2019a, 2019c). Negative health outcomes of sanctions are a direct result not of the level of state investment in benefits administration, but rather of the level of marketization of the labour market and the effects this has on both the application and effect of sanctions on social exclusion and health outcomes (Haagh, 2019a, 2019c). For example, in Denmark negative health impacts of sanctions policies are cushioned by protective legislation and education investments.

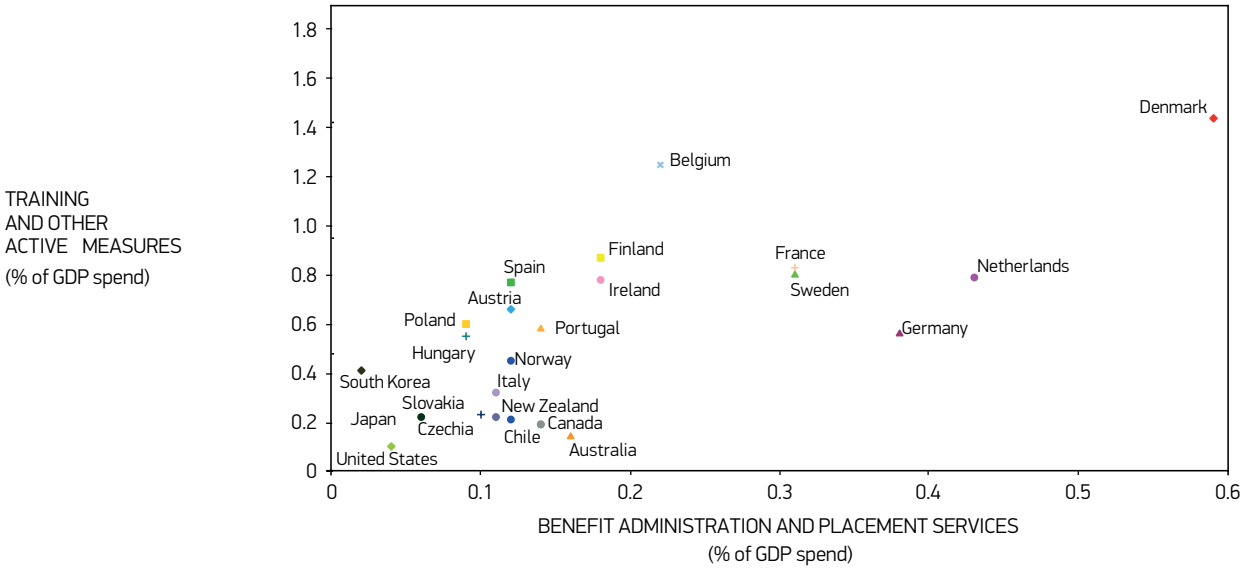
Fig. A3.3 Public support for employment transitions, 2007



Notes. Other active measures include: employment incentives, supported employment and rehabilitation, direct job creation, and start-up incentives. Details of the data points and measures can be found in Haagh (2019b), in the online appendix.

Sources: adapted from Haagh, 2019b; data elaborated from Organisation for Economic Development (OECD) Employment Outlook 2010 (OECD, 2010).

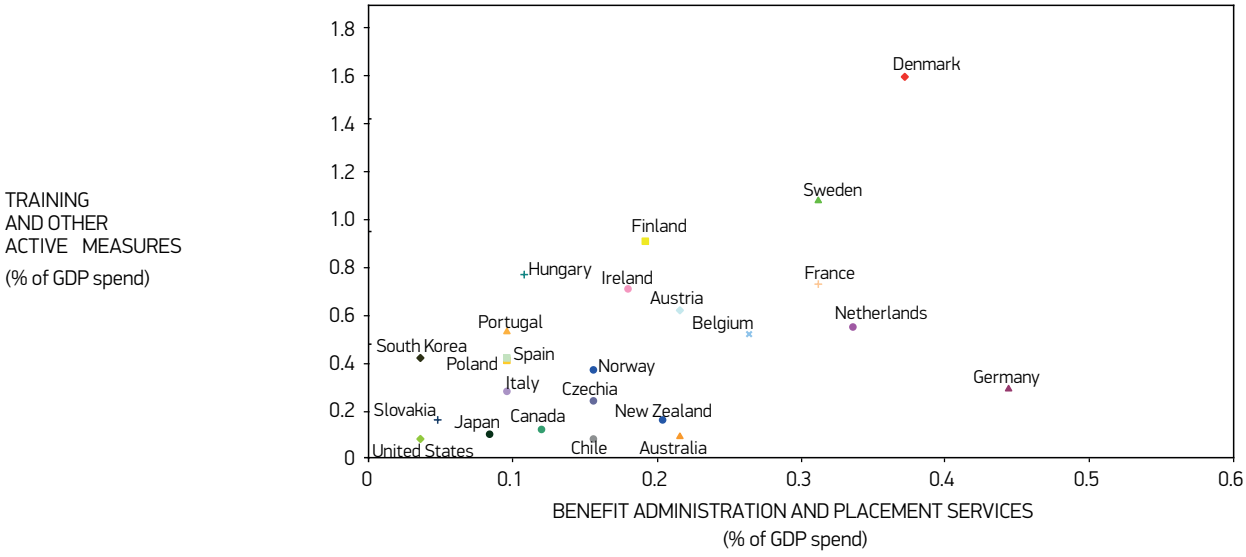
Fig. A3.4 Public support for employment transitions, 2010



Notes. Other active measures include: employment incentives, supported employment and rehabilitation, direct job creation, and start-up incentives. Details of the data points and measures can be found in Haagh (2019b), in the online appendix.

Sources: adapted from Haagh, 2019b; data elaborated from OECD Employment Outlook 2013 (OECD, 2013).

Fig. A3.5 Public support for employment transitions, 2014



Notes. Other active measures include: employment incentives, supported employment and rehabilitation, direct job creation, and start-up incentives. Details of the data points and measures can be found in Haagh (2019b), in the online appendix.

Sources: adapted from Haagh, 2019b; data elaborated from OECD Employment Outlook 2016 (OECD, 2016).

Annex 4. UBI initiatives in Europe and Canada

Country	Name	Size	Aims and objectives	Research design	Effects measured
Canada	Ontario's basic income trial (stopped due to change of government in July 2018)	6000 people Randomly selected from among the eligible population: • aged between 18 and 64 years • resident in one of the locations for more than 12 months • living on a low income	The pilot will test whether a basic income can better support vulnerable workers, improve health and education outcomes for people on low incomes and help to ensure that everyone shares in Ontario's economic growth.	4 000 people will receive will receive: • up to $16 989 per year for a single person, less 50% of any earned income; • up to $24 027 per year for a couple, less 50% of any earned income; • up to $6 000 additionally for a person with a disability. Randomly selected control group of 2000 eligible people who will not get the transfer. The basic income will be decreased by 0.50 cents for every dollar earned through work. People who receive money from employment insurance or a pension plan will have a reduced basic income. All the other benefits will be exempted.	• Food security • Stress and anxiety • Mental health and health care usage • Housing stability • Education and training • Employment and labour market participation *Source:* Government of Ontario, 2017.

Country	Name	Size	Aims and objectives	Research design	Effects measured
Finland	The Basic Income Experiment (trial) 1 January 2017 – 31 December 2018	2000 participants randomly selected from recipients of unemployment benefits.	The basic income is intended to: (a) reduce the amount of work involved in seeking financial assistance; (b) free up time and resources for other activities, such as working or seeking employment. The aim of the pilot is to: (a) evaluate whether a basic income could help to simplify the social security system; and (b) associate it with stronger work incentives.	Target group was residents of Finland aged between 25 and 58 years who were on paid basic unemployment allowance or other labour market subsidy as of November 2016. Size of transfer: 560 Euro/ month The basic income is paid unconditionally and without means testing. Recipients get it automatically once a month.	How could the social security system be redesigned to address the changing nature of work? Can the social security system be reshaped in a way that promotes active participation and gives people a stronger incentive to work? Can bureaucracy be reduced and the complicated benefits system simplified? *Source:* Kela FPA, 2016.

Country	Name	Size	Aims and objectives	Research design	Effects measured
Netherlands	Research project: Weten wat werkt/ What works	900 participants (randomized trial) June 2018 – October 2019	Research project with the City of Utrecht and the University of Utrecht, studying the effects of fewer rules in social assistance. The current rules in social assistance under the Participation Act (Participatiewet) are complex and strict. The City of Utrecht wants to know whether social assistance can be administered differently.	Four groups were considered. "Self-activiation" (unconditional transfer): no obligation to apply for a certain number of jobs per week or other reintegration activities. "Supported activation" (psycho-social support): participants receive extra help and guidance from the municipality. "Work pays off", in that beneficiaries who work alongside their benefits may keep more of the money they earn (up to 50%, or a maximum of €202/month). "Measuring what works" (comparison group): beneficiaries continue to receive their benefits under the current Participation Act.	Assessing: 1. whether people find work more quickly and/ or participate in society more actively (e.g. through volunteer work); 2. the effect on participants' health; 3. the financial situation; 4. the satisfaction of welfare recipients with their own situation. *Sources:* City of Utrecht, 2018; Hoeijmakers, 2016.

Country	Name	Size	Aims and objectives	Research design	Effects measured
Spain	Pilot: B-MINCOME project (started September 2017) Accompanying research project that measures effects and efficiency	1000 households randomly selected from eligible households. Eligibility criteria: • residents of the Besòs Axis; • rent below the minimum to guarantee having a member aged between 25 and 60 years. Amount: 100 € (minimum) and 1.676 € (maximum, double the poverty line in Catalonia), depending on household composition and income.	The project aims to directly invest in people through a guaranteed minimum income (IMS – inclusion municipal support), while seeking to improve their immediate surroundings, their neighbourhoods and districts by engaging people in active social and workplace inclusion policies. Together with IMS, the objectives included testing a range of active policies incentivizing training, sharing and creating cooperative economies, mutual support, public participation at neighbourhood level and (last but not least), the creation of a local currency.	Four beneficiary groups were considered. With conditions Receiving aid is conditional upon mandatory participation in one of the four active inclusion policies (training and employment, social economy, help in renting out rooms, and fostering community participation). Unconditional Benefits are granted unconditionally (no participation in active labour market policies). Limited Benefit levels will vary with the variation in the computable income of the household (with a limit). Unlimited The income that is generated by the household will only partially reduce the aid (without a limit). Overall condition: 25% of the transfer is paid in social currency to promote proximity commerce.	Qualitative community impact assessment on active social policy measures (beneficiaries and non-beneficiaries). Programme evaluation (operations, finances, administration). Impact on beneficiaries and impact on co-creation of solutions. Impact on happiness and subjective well-being, including analysis of factors such as: age, sex, civil and labour status, state of physical and mental health, educational achievement, income and income fluctuation, emotional stability, social capital and trust, community relationships (sharing), entrepreneurship, consumption and community/ policy participation practices. *Sources:* Colini, 2017; The Young Foundation, 2017.

Country	Name	Size	Aims and objectives	Research design	Effects measured
Scotland	Informing Interventions to reduce health Inequalities (Triple I)	Triple I provides national and local decision-makers with practical tools and interpreted research findings about investing in interventions to reduce health inequalities in Scotland (e.g. taxation policies, benefits policies, various forms of UBI, minimum wage, negative income tax (NIT), and increasing benefits uptake through psycho-social support.	The aim is to model the potential impact of different interventions and policies on overall population health and health inequalities.	The tools can be used to produce detailed results for different geographical entities: • Scotland • Council areas • health boards • city regions • integrated joint boards.	Three outcomes are measured: • premature mortality • years of life lost • hospital stays. *Source:* ScotPHO, 2018.

Annex 5. Case countries

A5.1. Finland

In the Finnish case, a move to simplify the benefit systems at their foundation has been progressing for some time; it is not dissimilar to the developments accompanying the move to universal credit in the United Kingdom. The main difference is that in the United Kingdom, administration of universal credit has remained linked with testing of work conditionalities; greater market administration of benefits in line with labour market fluctuations is in evidence in the use of in-work conditionality regimes, which entail adjusting benefits with job changes, as well as asking beneficiaries to change jobs to satisfy requirements relating to working hours. In Finland, potential public savings from streamlining administration by easing conditionalities – along with the potential for bringing an end to poverty traps by allowing claimants to retain their income grants when working – have entered into experiment design. The aim to retain fiscal neutrality led to a partial version of basic income, below the subsistence level. The aim of general system simplification can be seen in the national-level administration of the experiment. The general political debate in Finland, however, has remained tied to reinforcing employment participation, including with the increased use of conditionalities. Hence, the Finnish experiment represents a contribution within a more complex debate about the direction of income security systems.

It should be noted that in terms of health, the experiment does not relate directly to the health sector, despite the ongoing broad health equity debate in the country.[46] Evaluation and monitoring frameworks include health indicators, the number and nature of which vary widely and tend to be rather unspecific. Health is also considered a secondary outcome, sometimes more driven by research than policy interest, which tends to centre on work/workfare/employability in the context of changing economies and labour markets, as well as cost-efficiency of welfare states.

A5.2. Denmark

In the Danish case, local experimentation in lifting conditions on unemployed groups' receipt of assistance has been occurring in response to various developments, including government initiative, and with the support of private foundations. Practical failings in sanctions systems that were identified in a series of public reports contributed to the impetus for experimenting with lifting conditions on claimants. As was the case in Finland, an important driver was testing a different model to motivate the social integration of excluded groups, in particular the long-term unemployed population. Support in the form of education and development grants has featured in the experiments. Emphasis on the autonomy of beneficiaries has been strong and built into the design and the form of social support for beneficiaries during the experiments. The Danish experiments are very small in scale, but significantly different from other ongoing experiments. They involved self-direction in allocating time for job searches, and voluntary workshops among social workers and unemployed people, along with obligations for those without work and, in Aarhus, a self-budgeting arrangement (Haagh, 2019b, 2019d,

[46] Increasing inequalities in accessing health care services are currently being broadly discussed in Finnish politics. Evidence suggests that this is likely the result of socioeconomic differences, including in employment, education and gender, resulting in large differences in mortality rates (Kangas & Blomgren, 2014; and qualitative data from an interview carried out by the author). As a response, broad-based reforms of the primary health care sector and in particular health insurance schemes are being discussed.

2019e). In the latter case, the experiment was supported by a private foundation, which allowed the council to "go further than would [otherwise] be possible in law" (essentially to spend more money). The unemployed individuals selected for the experiment were given their usual benefits and allowed to spend up to 50 000 kroner or (about €5000) according to their own self-designed support plan. This plan involved assistance and monitoring, but was based on self-selection of needs.

A5.3. Netherlands

As in Finland and Denmark, experiments in the Netherlands have been driven by interest in testing models of delivering income security that are driven by motivation rather than demanding social contributions, underpinned by threat of sanctions. In contrast with Denmark, the experiments in the Netherlands were under discussion for a long time before proceeding, and have been motivated to a much greater degree by experimental design. The concern has been to compare exactly how beneficiaries would behave under different motivational conditions, and faced with different financial incentives. Participation grants, namely a top-up transfer for voluntary participation in community-oriented work, are one such incentive. These experiments are highly localized. The background to this is on the one hand the highly decentralized structure of the Dutch welfare state, coupled with extensive fiscal decentralization. Faced with rising caseloads under stable resources, local communities had a strong incentive to look for innovative solutions. The decentralized character of welfare policy in the country enabled communities to do this within the established legal framework.[47] Similarly to Finland, health specifically does not play a significant role, except where a correlation can be drawn with motivational effects, such as stress related to economic scarcity.

A5.4. Canada

In contrast to Finland, Denmark and the Netherlands, the experiment in Canada was driven by a strong anti-poverty agenda, which was closely linked to a debate on health inequities. While motivational issues played a role, there was a strong focus on the (working) poor population, which also determined the design of the UBI trial, being based on an NIT model (see Section 4.1). Under the common agenda of social justice, the political pressure for the income grant was essentially a bottom-up movement firmly rooted at the local level and based on a broad-based coalition, including civil society, the public health sector and local government. Health as a poverty trap at the individual level, but also at a broader social, economic and fiscal level was a core dimension of the campaign, which was also favoured by the positive political climate of a liberal government. The recent change in government has put a quick end to the only recently started programme.

A5.5. Scotland

The Scottish experiment stands out from the others because it does not involve field experiments, but is essentially a broad-based feasibility study to test different income policies with regard to their impact on health outcomes, in particular premature mortality, years of life lost, and hospital stays. A micro-simulation tool, which includes a variety of design options (taxation policies, benefits policies, various forms of UBI, a minimum wage approach, NIT, and an increase in benefit uptake through psycho-social support) allows different stakeholders and government levels to model potential health impacts.

[47] Qualitative data gathered from an interview carried out by the author.

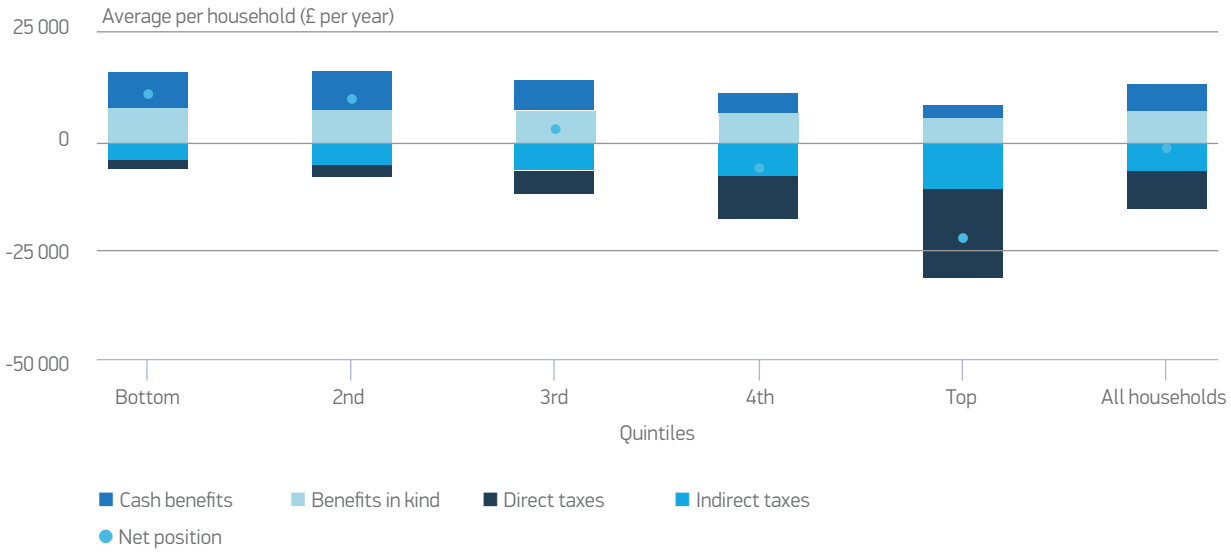
Similarly to Canada, in the Scottish debate poverty and health take centre stage as social justice issues. The initiative is firmly rooted at the local level and is based on a strong coalition of the public health sector and local government, pressurizing government to explore innovative solutions in the face of rising inequality that is resulting in increased poverty and social exclusion, with negative outcomes for health and well-being. Concerns about administrative effectiveness with regards to accessing welfare services are another key aspect, in particular in light of the scaling up of universal credit, which – against its core objectives – appears to foster exclusionary processes.

A5.6. Spain

Similarly to the Netherlands, Denmark and Scotland, the Spanish model is firmly rooted at the local administrative level and has been initiated as a reaction to rising local demand and an inadequate response by central welfare schemes. Rising economic inequality is a key political aspect of the Spanish experiment, while core objectives encompass the motivational aspect, participation grants, as well as strengthening employability by supporting beneficiaries in creating local employment opportunities. The programme thus has a broader focus oriented towards poverty reduction – while testing different motivational aspects – which is unique to the project. Health is not expressly considered, except where it factors in as an inherent poverty issue.

Annex 6. Example of the effects of taxes and benefits

Fig. A6.1 Summary of the effects of taxes and benefits on all households by quintile groups, United Kingdom, financial year ending 2017



Source: ONS, 2018.

Annex 7. How to make it work for health equity – success factors

Several aspects emerge from the case studies and the debates with health practitioners and policy-makers involved in the UBI experiments, which seem to be crucial for establishing UBI as a health equity issue.

- The health sector needs to **make health inequities a priority theme**, and to take action; not only within its own sectoral boundaries, but also beyond them, by persuading other sectors and stakeholders to take action on social determinants that influence health inequities, in particular income security measures.
- Closely related to this argument is the importance of **developing a narrative on health equity as a social justice issue**, which should be broadened beyond health impacts and outcomes. It is important to show the pathways between income security and health, but it is equally important to develop a narrative on the role of health in strengthening and maximizing other sectors' outcomes (such as employment through sustained productivity), as well as broader societal objectives, goals and values (such as social justice, inclusive growth, reducing poverty and leaving no one behind). In order to gain credibility and create consensus, the health sector has to take the health debate forward and out of purely the health domain.
- **Consensus** needs to be built around health equity as a social justice issue. This **whole-of-government approach** involves both horizontal and vertical dimensions. The local level of government seems to play a key role in pushing for reform processes, laying the groundwork for a bottom-up reform process for social justice. This has been seen in Canada, where the health sector and poverty-focused civil society coalitions came together to promote basic income ideas. In Scotland, too, the role of local government was essential for bringing to the fore the health equity debate, pushing central government to recognize and take action on health as a social justice issue (Box A7.1).
- **Political will** cannot be engineered. A complex mix of various stakeholders' interests and specific overall political, social and economic conditions (policy windows) make government take action. However, some things may help: for example, in Canada and Scotland empirical evidence that underpinned the pathways between health and poverty was central to **creating awareness about the link between poverty and health and well-being**. What was even more important – including in winning over the various tiers of government – was to show through disaggregated data the **impact of poverty on health** at the local level. International and regional debates about the role of social determinants of health for health equity (led by international or regional organizations, such as WHO Regional Office for Europe) provided an important additional input and support for national health sectors to act and increase the pressure on their respective governments.
- These processes are not happening overnight, but need time, and **change will be necessary in the mindset of many politicians and practitioners**. A stable political environment supporting the case for health equity as a policy priority lasting beyond one legislative period only seems to be conducive.
- Finally, as with almost all reform endeavours, policy champions play a critical role, lending a voice to the cause, which in turn can provide an important contribution to improving public and political acceptance.

Box A7.1: From health as a lifestyle issue to health as a life circumstance issue – the case of Scotland

The debate on health inequalities in Scotland is very much framed as a health equity and social justice issue. However, this was not always the case and it took around 20 years to change it. In 1999 a White Paper was produced in Scotland (entitled *Towards a healthier Scotland* (The Scottish Government, 1999)) that for the first time framed health as part of a life circumstance agenda, whereas before it had been very much framed as a lifestyle issue (as was the traditional approach). The language therefore also changed, focusing less on health disparities and moving towards a discourse on issues of equity.

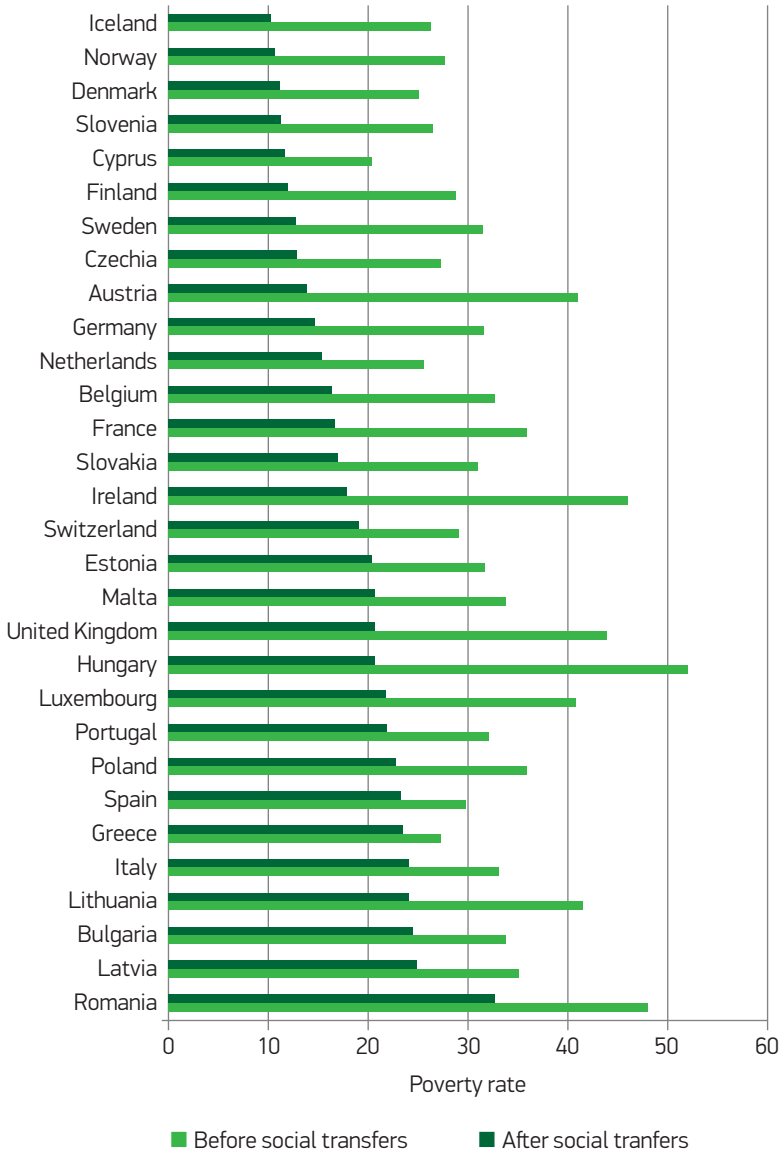
In 2007 a Ministerial Task Force on Health Inequalities was established in Scotland. The Task Force's published report, entitled *Equally well* (The Scottish Government, 2008), looked into the root causes of health inequalities. It marked a turning point in the debate on health inequalities, as it started for the first time delve into the health equity issue, looking at the root causes and, in this way, moving the agenda away from purely lifestyle factors to take into account life circumstances and examine social justice issues.

Initially it was mainly the health directorate that promoted the issue, albeit referring to the role of other sectors in dealing with the problems: it did refer to the life circumstances element, such as early years and employment, along with social justice issues, such as drugs, alcohol, violence and environment/transport. However, it was still seen mainly as an agenda, and did not penetrate throughout government. Some local authorities understood the significance of this subtle change, identifying the issues as being cross-sectorally important, which allowed the health sector to move them forward out of the health domain, changing the direction and fostering appreciation for the issue among other sectors.

Reducing health inequalities is a government priority and has become iconic on the Scottish Government's agenda. The coalition with the local government level was important initially, to initiate moving the issue out of only the health domain. The Government now publishes monitoring reports on the reduction of health inequalities twice yearly (The Scottish Government, 2017), assessing progress in tackling health inequalities by monitoring not only health policies, but also policies in other sectors. This really facilitates the promotion of health inequalities as a social justice issue that concerns all sectors.

Annex 8. Example of the effect of social transfers on child poverty rates

Fig. A8.1 Child poverty rates before and after social transfers, 2009



Note. Child poverty rates are based on <60% median income.

Source: WHO Regional Office for Europe, 2014.

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