Treating causes not symptoms

Basic Income as a public health measure

Elliott Johnson, Howard Reed, Daniel Nettle, Graham Stark, Joe Chrisp, Neil Howard, Grace Gregory, Cleo Goodman, Matthew Smith, Jonathan Coates, Ian Robson, Fiorella Parra-Mujica, Kate E. Pickett and Matthew Johnson

Basic Income Conversation

Autonomy

Compass

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About the Authors:

Elliott A. Johnson, Senior Research Fellow in Public Policy, Northumbria University: https://orcid.org/0000-0002-0937-6894

Howard Reed, Senior Research Fellow in Public Policy, Northumbria University: https://orcid.org/0000-0003-4577-1178

Daniel Nettle, Professor of Community Wellbeing, Northumbria University, and Directeur de recherche, Institut Jean Nicod: https://orcid.org/0000-0001-9089-2599

Graham Stark, Senior Research Fellow in Public Policy, Northumbria University: https://orcid.org/0000-0002-4740-8711

Joe Chrisp, Research Associate, Institute for Policy Research, University of Bath: https://orcid.org/0000-0002-6980-7537

Neil Howard, Lecturer in International Development, University of Bath: https://orcid.org/0000-0003-2328-8230

Grace Gregory, Research Assistant, University of Bath, https://orcid.org/0009-0008-9607-1060

Cleo Goodman, Co-Founder of Basic Income Conversation and Basic Income Lead, Autonomy: https://www.basicincomeconversation.org/

Matthew Smith, Professor of Health History, University of Strathclyde, https://orcid.org/0000-0002-9267-2124

Jonathan Coates, NIHR In-Practice Fellow, Durham University and GP in the North East: https://orcid.org/0000-0003-0013-9267

Ian Robson, Associate Professor, Department of Social Work, Education and Community Wellbeing, Northumbria University: https://orcid.org/0000-0003-3477-8710

Fiorella Parra-Mujica, PhD Candidate, Erasmus Universiteit Rotterdam: https://orcid.org/0000-0002-0974-7528

Kate E. Pickett, Professor of Epidemiology, University of York: https://orcid.org/0000-0002-8066-8507

Matthew T. Johnson, Professor of Politics, Northumbria University: https://orcid.org/0000-0002-9987-7050

About the Basic Income Conversation
The Basic Income Conversation is an initiative to promote the idea of a universal basic income in the UK. We work with people across civil society to understand the opportunities, questions and concerns around basic income. We help organisations decide if they should add basic income to their policy toolkit and look at how it fits alongside other big policy reforms. We work with researchers to ensure the basic income debate is informed by research. We help coordinate a growing network of cross-party politicians and activists to put basic income at the top of the political agenda.

Up until May of 2023, we were powered by Compass. Our host organisation is now Autonomy, a think tank dedicated to the future of work. This paper is the last in a series of three papers exploring the impact of basic income on public health, on poverty and inequality, and the popularity of the idea with voters that Compass is the publishing partner for. This paper ends the series, and future papers will be published by Autonomy.

About Compass
Compass is the pressure group for a good society, a world that is much more equal, sustainable and democratic. We build alliances of ideas, parties and movements to help make systemic political change happen. One strategic focus is on policy ideas that are rooted in real needs now but which have transformative potential. Introducing a universal basic income is one such policy and speaks to every element of the good society we want to create by providing more freedom, independence, time security and sense of citizenship. This is our third report in this series on basic income and shows the public health impact of implementing a basic income. The next stage is to build a national coalition in support of a basic income.

About this project

This work was funded by the National Institute for Health Research (NIHR) as part of a project entitled 'Understanding the prospective public health impact and social feasibility of Universal Basic Income schemes in the UK'.

The project commenced in December 2022 and has led to a number of articles currently under review. This publication serves as the final project report. All publications will be collated on the project website, available here, or in the project archive, available here.

Please address all correspondence to the project's lead, Prof Matthew Johnson at matthew7.johnson@northumbria.ac.uk.

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Foreword

We are living in potentially transformational times, when it is surely quite evident that millions of people are suffering from chronic insecurity in a context of gross inequalities, partially concealed by an unprecedented level of tax evasion and concealed forms of income and wealth among the plutocracy and elite.

And yet as social policy is dismally failing, evidenced by a growing plethora of food banks, hygiene banks, rising morbidity and a reversal of the long historical trend to rising life expectancy, mainstream politicians on the so-called left and right are reacting like zombies. In neither Keir Starmer's five missions nor Rishi Sunak's comparable list of objectives did providing the citizenry with basic economic security figure.

They simply do not have a strategy for dealing with the scourge of our time, which is chronic uncertainty. The paternalistic left offer the prospect of faster GDP growth and vague talk of 'universal basic services', which would do very little to deal with the crisis. Of course, in Britain after 13 years of regressive austerity, there is a desperate need for better public services. But that would not deal with uncertainty or its severe consequences for the health of individuals, families, local communities and the whole society.

William Beveridge, whose famous 1942 Report shaped the post-war 'welfare state' recognised that once peace had been restored the main sources of insecurity in what was an industrial economy based on stable full-time jobs for men were what economists call 'contingency risks', that is risks for which one could estimate the probability of an adverse event and thus develop a social insurance scheme that matched contributions with expected benefits. It was sexist and had other failings, but it provided ex post compensation that offered a majority in society sufficient security. But those days are long since gone.

Today, most people feel and are vulnerable to shocks and hazards that are unpredictable in their severity, in their timing and in their incidence. Most feel they cannot predict if they will be hit or whether they will be able to cope or recover. Uncertainty is pervasive. Already there have been six pandemics in the 21st century, Covid being the most recent.

Few epidemiologists believe there will not be more coming. And there will be more natural disasters linked to global warming and ecological decay. There will also be more financial market meltdowns unless the economy is transformed. All those trends are occurring at a time of gross inequalities of income, wealth, health and, most relevantly for this report, insecurity and stress.

The only sensible way to combat chronic uncertainty and the associated health problems is to provide ex ante basic security, not more uncertainty linked to the use of means-testing and behavioural conditionality, as is done with the wretched and punitive Universal Credit. This is why basic income has surged from the margin of public political debate to the centre of all discussion of desired revivals of social protection.

A basic income as an economic right is justifiable on ethical grounds, rather than instrumental. It is a matter of common justice and ecological justice, it gives meaning to freedom and it offers basic security, which is a human need and a public good.[1,2] However, what is good about the numerous pilots and experiments of recent years is that they have refuted what should be called low-hanging fruit prejudices. Providing people with basic income does not reduce work; it energises, improving mental and physical health. Basic income does not push women into the home; it improves their bargaining position and is emancipatory, helping many to move out of abusive relationships. Basic income does not harm the economy; it induces more people to spend more time on caring for those they love and on voluntary community work. And it is affordable. I believe the best way of paying for it is by building a Commons Capital Fund. But this report shows that related fiscal policies could pay for it as well.

What is great about this report, and why it is a pleasure to urge sceptics as well as advocates to read it, is that it emphasises the hugely beneficial effects for health at a time when Britain's cherished National Health Service has been viciously and deliberately run down during more than a decade of so-called austerity. Basic income is a health policy.

- Guy Standing, Co-founder, Basic Income Earth Network

1. Introduction

In 2022, we published a report[3] that described the UK, indeed the world, as being "in an age of crisis". The drivers of this were financial insecurity, poverty and inequality following the global financial crisis, austerity politics, Brexit, the COVID-19 pandemic and the cost-of-living crisis due, in part, to the war in Ukraine. We described a position in which institutions, services and individuals were under unprecedented pressure. This condition of crisis shows little sign of resolution, even where some of the initial drivers, such as extreme energy prices,[4] have begun to stabilise. If anything, we may be entering a phase in which the most crushing effects of these pressures begin to tell. The rate of inflation in May 2023 remained unsustainably high at 8.7%[5] and an ongoing response from the Bank of England to raise the base rate by 4900% from 0.1% on 15 December 2021 to 5% on 22 June 2023[6] is likely to set off what has been described as a 'timebomb' of mortgage unaffordability, with more than 14 million people's fixed-rate deals set to be renewed between the fourth quarters of 2022 and 2023. Indeed, the Institute for Fiscal Studies (IFS) estimates that should rates remain at their current level (6.01% in June 2023 for the average two-year fixed deal) compared with a counterfactual of rates persisting at the level in March 2022 (2.65%), adults in mortgage-holding households will be paying on average £280 per month more.[7] This equates to a fall in disposable income on average of 8.3%, with 1.4 million losing 20%. Indeed, the rate of home repossessions increased by 50% in the first quarter of 2023 compared with the last quarter of 2022.[8] Meanwhile, strikes, particularly among public servants, have returned at a sustained scale unseen since the 1980s.[9] NHS England services are struggling to meet the key cancer and elective care targets set as part of its three-year recovery programme,[10] while councils are beginning to declare effective bankruptcy.[11]

At the same time, population health and social care needs continue to grow and the true impact will only be fully known in years or decades to come, since today's pressures will contribute to increases in the number and complexity of short, medium and long-term health conditions.[12] This is creating a planning and budgeting crisis that will exacerbate challenges for population health over many years. But even in the present day, the costs are stark. Government healthcare expenditure in 2022 was estimated at £230 billion, even that representing a fall from the peak during the COVID-19 pandemic, with a further £52 billion through non-government healthcare schemes.[13] Meanwhile, total spending on adult social care in 2021/22 was estimated by the King's Fund to have reached £26.9 billion.[14] But there are other costs too. For example, a report published by the Mental Health Foundation and LSE estimated that mental health problems cost the UK economy a minimum of £117.9 billion each year, with most from losses in productivity.[15] Analysis from the

Institute for Public Policy Research estimated the personal cost of acquiring health conditions, with mental and physical health conditions associated with a drop in annual earnings of £1,700 in 2020–21, and even larger amounts in previous years, while long-term physical illness of another household member was associated with a fall of £1,224.[16] In 2021/22, stress, depression or anxiety accounted for 914,000 (51% of all) cases of self-reported work-related ill health, including 372,000 new cases, and a total of 17 million working days lost, higher than the pre-pandemic period.[17] This loss of productivity is a profound challenge to the economic growth that forms one of the Government's five key priorities for 2023.[18]

A stark reminder of the real impact of worsening population health can be seen in the proportion of the UK population with a long-standing illness, disability or impairment which causes substantial difficulty with day-to-day activities. This is estimated to have risen from 19% in 2011/12 to a record 24% in 2021/22, an increase of 3.9m people.[19] Indeed, the estimate increased from 14.1m in 2019/20 to 16m in 2021/22.[19] Interestingly, the proportion among state pension age adults has remained the same between 2011/12 and 2021/22 at 45%, while for working-age adults it has increased from 16% to 23%, while for children the figures are 6% to 11%. This does not indicate simply the effects of an ageing population.[19] There is something else going on.

In that context, it is essential that policymakers invest real thought in realising the Government's prevention agenda,[20] which was incorporated into the 2019 NHS England Long Term Plan.[21] Taking prevention seriously means addressing causes, not just symptoms and, over 40 years on from The Black Report (1980), there is good reason to tackle the social determinants of health. Existing approaches are proving inadequate means of achieving this.

While concern naturally focuses on those with the fewest resources, the challenges are actually far broader. Many of those exposed to poverty and the most extreme levels of insecurity are, in fact, those currently in full-time, insecure and low-paid employment or nominal "self-employment",[22] who receive little or no help from existing conditional benefits. However, it is not just those on low-paid work who are exposed: recent analysis from the University of York's Social Policy Research Unit suggests that the recent crises mean "some richer households also spend more than 20 per cent of their income on fuel and a quarter of households in fuel poverty are not income poor".[23] This is affecting large numbers of hardworking, productive and dynamic Britons, whose contribution is fundamental to the functioning of our society.

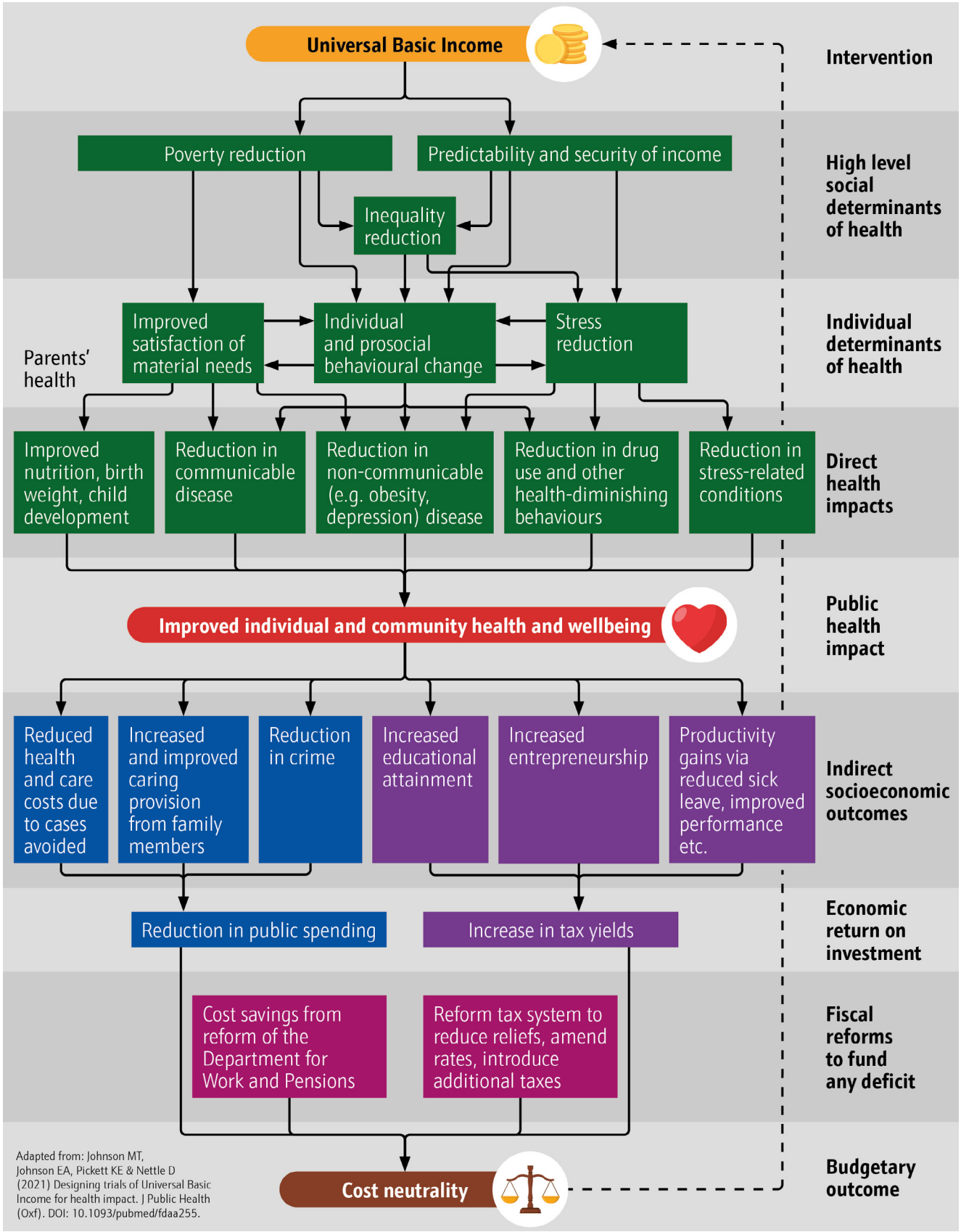
As such, it is crucial that cash-transfer interventions be considered as upstream interventions. Basic Income, also known as Universal Basic Income (UBI), describes a welfare system which includes regular, secure, guaranteed payments to every individual, regardless of their employment

status or means. It is a policy that has been proposed by figures from across the political spectrum and the National Institute for Health and Social Care's Research (NIHR) decision to invest in research on the topic indicates a sea change in the way in which government bodies view public health. Our Basic Income model of impact (Figure 1 below) suggests that schemes which provide regular, uninterrupted access to cash support have the capacity to improve outcomes by addressing poverty, stress and health diminishing behaviour.

There is a great deal of evidence to support the notion that income affects health. Cross-sectional and longitudinal associations between income disparities and health have been established in studies and reviews examining, for example: self-rated health[24-27]; mortality[24, 25]; biomarkers[27]; child health, wellbeing and educational outcomes[28]; mental health among children and young people[29-31]; and adult mental health.[32-34]
Supporting Pickett & Wilkinson's causal review,[29] Adeline and Delattre's[35] analysis endorsed both the Absolute Income Hypothesis (a positive and concave effect of income on health) and the Income Inequality Hypothesis (that income inequalities affect the health and wellbeing of nearly all members of a society). As such, evidence supports the notion of an increase in the quantity, security and predictability of income being the 'ultimate "multipurpose" policy instrument'.[36]

Systematic reviews of cash transfer schemes that resemble Basic Income, such as Gibson, Hearty and Craig's,[37] have indicated positive impacts on mental and physical health, hospital attendance and health related behaviour, such as alcohol and drug use. In contrast, conditional, means- and needs-based welfare systems in high-income countries are associated with below average health outcomes[38] and increased psychological distress prevalence.[39] We have suggested several explanations[40]: schemes are 'insufficient to offset the negative health consequences of severe socioeconomic disadvantage'[38]; conditionality and assessment inflicts stress[41] and creates perverse incentives for health-diminishing behaviour[40]; focusing on the poorest fails to mitigate broader determinants that affect society as a whole.[42]

Figure 1: Basic Income model of impact (38)



Since our last report, there have been key developments in relation to Basic Income. The Welsh Government has rolled out its Basic Income pilot for care leavers to its first cohort. Meanwhile, some of the authors of this report have published proposals[43] for micro-pilots in two areas in England: Jarrow, South Tyneside, and East Finchley, London. The aims of these pilots are modest but represent a step forward in examining the social feasibility of Basic Income in the UK, with the size and duration of payments designed to activate the pathways set out in the model of impact.

There are four aspects to this report that advance the evidence base on Basic Income as a public health measure. First, we examine the relationship between income and health in large longitudinal datasets and microsimulate the impact of three Basic Income schemes on health, NHS costs and distribution of resources. The groundbreaking findings, which are likely to be conservative underestimates, suggest considerable impact on public health. Second, we present the findings of conjoint experiments on British people's preferences in developing Basic Income schemes for health. The evidence suggests strong preferences for more generous schemes that reduce poverty and are funded through wealth, carbon and business taxes. We set out our Public Policy Preference Calculator (PPPC), which enables the general public to explore the likely impact of different scheme designs on public acceptability. Finally, we present findings on social feasibility, implementation concerns and prospective health impacts co-produced with residents of Jarrow, South Tyneside

Detailed key findings and recommendations are available at the end of this report, with a summary below. It should be noted that these findings have not yet undergone peer review. As such, they should be regarded as indicative. Peer-reviewed papers will be listed on the project website, available here, once they are published, with preprints available in our project archive, available here.

2. Key findings

1. **Radical transformative and effective policies have been instituted over centuries - Basic Income is a feasible policy for today.**

2. **Money affects health.**

Using a 'within-between' model, we found that increases in income and higher average income is associated with better mental and physical health. Correspondingly, a relationship between lower income and worse mental and physical health is also apparent.

3. **Basic Income would have a significant impact on poverty and inequality**

A fiscally neutral starter scheme would reduce child poverty to the lowest level since comparable records began in 1961 and achieve more at significantly less cost than the anti-poverty interventions of the New Labour governments.

Child and pensioner poverty would fall by at least 60% each, with working age poverty down by between 29% and 75% depending on the scheme.

Inequality would drop by 55% to the lowest in the world under the most ambitious scheme.

4. **Basic Income schemes are likely to have a very significant impact as a preventative health measure, with significant social and economic returns on investment.**

Between 125,000 and 1 million cases of depressive disorders and 120,000 and 1.04 million cases of clinically significant physical health symptoms could be prevented or postponed in 2023.

Between 130,000 and 655,000 quality-adjusted life years (QALYs) could be gained, valued at between £3.9 billion and £19.7 billion.

Based on depressive disorders alone, NHS and personal social services cost savings could be between £125 million and £1.03 billion assuming 50% of cases diagnosed and treated.

5. **Basic Income is popular, effects on poverty are particularly important and there are means of funding it that chime with public opinion.**

- People prefer systems that reduce poverty and ideally want a system that removes it altogether.
- People prefer more generous benefits to less.
- People value systems that improve health and reduce (compared to increasing) cases of anxiety and depression.
- They also value reductions in inequality itself.
- The desire for these other features was not as strong as the desire to see poverty reduce.
- They prefer lower income tax rates to higher, though with small increases of three percentage points in each rate deemed as preferable as the status quo. However, if poverty could be reduced, the positive value they would place on this would outweigh their lower preference for higher income tax rates.
- Other forms of funding the policy, notably a wealth tax, were popular.
- Respondents were swayed little by whether the system was an unconditional or a conditional one, whether there was any means testing or whether access was restricted to citizens.

6. **We can calculate which particular designs are likely to be preferred by the public based on the above findings.**

7. **Members of local communities understand best the issues and health effects that might emerge from policies such as Basic Income, with concerns for safety important in pilots and recognition of the increased positive community activity that might result from a full policy.**

3. Recommendations

1. Policymakers should commit to large trials of Basic Income, but not at the expense of pushing for its introduction as national policy.

2. Policymakers should examine the potential health and economic impacts of Basic Income and explain them to voters using narratives tailored specifically to people's circumstances.

3. Trials should be evaluated comprehensively and consistently, using measures that can be microsimulated to estimate long-term effects across the population.

4. Researchers and policymakers must engage in co-production with stakeholders to determine formulation of schemes and uphold concern for the interests of participants in pilots.

5. Policymakers should be confident that Basic Income is the right policy at the right time.

4. The historical context

In the past, governments have understood that, in order to prevent disease, upstream investments are required. The nature of these investments has varied from engineering projects and regulatory regimes to vaccination campaigns and public education. But governments have also demonstrated hesitance to invest in other disease prevention strategies, even when the evidence justifying such interventions has been strong. Such reticence is often rooted in ideological or political factors, rather than conflicting scientific evidence. Knowing why upstream investment in disease prevention has or has not occurred historically can inform current attempts to tackle the social determinants of health through progressive political action.

Perhaps the most emblematic, and literal, upstream investment in public health that occurred during the nineteenth century was the construction of the Loch Katrine Aqueduct in 1859.[44] Prior to its construction, Glaswegians had to either source their water from the River Clyde, which also absorbed the city's sewage and industrial waste, or purchase it from private providers.[45] While these water sellers relied on privately-owned wells, they also sourced their water from the polluted river at times. This unsanitary water source resulted in high levels of mortality and morbidity from water-borne diseases, such as cholera, dysentery and typhoid. [46, 47]

By the mid-1850s, however, evidence was gathering that such diseases were not being caused by bad air or miasma (the prevailing theory) or a vengeful God (another common explanation), but by unclean water.[48] Key here was John Snow's famous experiment in 1854, which linked cases of cholera in a London neighbourhood with the Broadstreet water pump.[49] The following year the Glasgow Corporation decided to build a pipeline from Loch Katrine, 35 miles to the north, to bring fresh water to the city. In 1859 this highly ambitious project was completed, bringing with it clean water and a reduction of waterborne disease. Many other cities soon followed suit across the world.

It is worth noting that the decision to build the pipeline was made only a year after Snow's famous experiment and thirty years before the bacterium responsible for cholera was discovered. One might argue, therefore, that the Glasgow Corporation was making a risky investment. But this would overlook the other benefits that would come with a readily accessible water supply. Water became a public good in Glasgow, one less thing for people to worry about. Numerous water-based industries also sprang up, diversifying the economy.[19] Glaswegians are still benefiting.

Many of the other upstream investments in disease prevention made during the nineteenth century were also rooted in engineering. This

included other water supply projects, such as Manchester's Thirlmere Aqueduct, and the London sewer system. Such projects were responsible for significant reduction in mortality and morbidity, especially of children.

As germ theory emerged as the explanation for infectious disease during the second half of the nineteenth century, governments found other ways to invest in disease prevention. Some of these initiatives, such as the Contagious Diseases Act (1864), which attempted to control venereal disease in British sailors and soldiers by subjecting prostitutes to invasive medical examinations, were wrong-headed.[50] But others initiatives, such as the compulsory vaccination programmes initiated in the early 1850s, resulted in huge reductions in the rates of the infectious diseases that had previously been endemic.

Investment in disease prevention is not always popular. The Anti-Vaccination League would form in London in 1853, the same year as the Vaccination Act which made it compulsory for children under three to be vaccinated against smallpox.[51] Protests against COVID-19 vaccination, therefore, has only been the most recent example of vaccine resistance. The point here, however, is that governments have and have continued to be willing to face up to such protests because they understand that the benefits of vaccination far outweigh the risks. Unfortunately, they have not been so willing to push for proactive disease prevention strategies that could address other diseases.

By 1945, a host of government-funded initiatives, including water and sewage systems, vaccination programmes, public housing schemes (which reduced overcrowding) and free school milk and meals – along with the development of effective antibiotics – all contributed to a decline in infectious disease.[52] But non-communicable diseases, such as cancer, heart diseases, autoimmune diseases (such as diabetes) and mental illness, were replacing them.[53] Unlike most infectious diseases, which are acute in nature, these diseases tended to be chronic, afflicting sufferers over long periods of time and requiring ongoing medical care. In other words, they were a greater burden on the public finances, especially after 1948 and the foundation of the NHS.

It made even more sense, therefore, for governments to invest in disease prevention. And, in some cases, progress was made. The link between cigarette smoking and cancer, for instance, spurred anti-smoking campaigns and eventually anti-smoking legislation (though no government has banned cigarettes outright).[54] But governments failed to go far enough overall.

Post-war epidemiological research also established the link between poor diet and a variety of chronic diseases.[55] While governments were happy to launch healthy eating campaigns and, more recently, impose taxes on certain foodstuffs, such as sugar, they have been unwilling to

make healthy foods, such as fruits and vegetables, more accessible and affordable to people living in so-called food deserts.

Similarly, governments have been unwilling to act upon longstanding epidemiological research on the social determinants of health. Although tacit knowledge about the devastating impact poverty, inequality and social disintegration on health has existed for centuries, academic research on the connection began in earnest approximately a century ago. Nobel Laureate John Boyd Orr's pioneering research on human nutrition (informed by his early experiences as a teacher during the 1900s) began in the 1920s.[56] Research on what we would call the social determinants of mental health, for instance, was central to the work of the Chicago School of Sociology in the 1920s and 1930s.[57] It would inspire the new field of social psychiatry, where social scientists and psychiatrists teamed up to investigate the causes of mental illness. Their research cemented the link between socioeconomic problems and poor mental health.[58]

Governments certainly took notice. The Beveridge Report (1942) inspired the foundation of the NHS and the development of the post-war welfare state in the UK.[59] The insights of social psychiatrists paved the way for the Community Mental Health Act of 1963, which resulted in the end of the asylum (initially, another example of government-funded investment in health) and the emergence of the community mental health centre, originally intended to be a driver of preventive psychiatry.[58]

As the costs of healthcare in developed countries rose steeply in line with increased demand and expectations for good healthcare, rising wages for health workers and new technologies (including new drugs, sophisticated surgical techniques and advanced imaging tools) during the 1970s, governments again considered what could be done to prevent disease. Canada's Lalonde Report, Britain's Black Report and the United States' Presidential Commission on Mental Health all emphasised the need for prevention through progressive policies to reduce poverty and inequality. But these investigations largely fell on deaf ears.[60–62]

Part of the problem was a political shift to the right resulted in a turn away from population health and towards individual responsibility for health.[63] It is also evident that, unlike during previous eras, physicians now had the tools to treat many diseases much more effectively. Because of this, health expenditure went primarily to funding treatment, rather than preventive initiatives. Underlying everything was the enduring nineteenth-century notion of deserving and undeserving poor, that is the idea that the poverty of some people was nobody's fault but their own.[64, 65] This idea undermined any suggestion that the poor should be afforded more material resources, even if it would result in lower healthcare expenditures in the long run.

The problem with such ideas is not only that they are incorrect, but also that they are preventing us from the upstream investment in disease prevention that is required to address the long list of health crises that are bedevilling the NHS and other healthcare systems. The evidence justifying the need to tackle the social determinants of health is clear. What is needed now is the political will to do so.

- Matthew Smith, Professor of Health History, University Strathclyde

5. Economic modelling

Full economic modelling based on three Basic Income schemes (starter, intermediate and full Minimum Income Standard) was provided in our last RSA report, available here, and in a Compass report focused specifically on the issue, available here. However, we have updated the findings based on the latest available data and provide a summary in this section.

The modelling has demonstrated that Basic Income schemes can be both affordable and effective. These 'static' economic modelling findings are conservative, as they do not take into account the additional returns on investment provided by, for example, improvements in health and economic growth and reduction in crime. Nor do they include the likely funding of schemes through, for example, wealth taxes and increased corporation tax on large businesses to fund larger schemes.

Even a fiscally neutral starter scheme would reduce child poverty to the lowest level since comparable records began in 1961 and achieve more at significantly less cost than the anti-poverty interventions of the New Labour governments:

- Child and pensioner poverty down by at least 60% each.
- Working age poverty down by between 29% and 75% depending on the scheme.
- Inequality down 55% to the lowest in the world under the most ambitious scheme.

> "We keep being told that the alleviation of today's heightened levels of poverty would be too complex and too expensive. This report shows that a Basic Income is within reach, would be affordable and feasible, and would be a clear route to building a better post-Covid society"
>
> - Howard Reed, Senior Research Fellow in Public Policy, Northumbria University

We used the Landman Economics tax-transfer model (TTM) to microsimulate the impacts of the three schemes, which were broadly designed to provide pathways towards attainment of the Minimum Income Standard (MIS).[66] MIS is the income needed by different types of households to reach a socially acceptable living standard, as determined

by members of the public with support from experts. Our calculations, conducted in late June and early July 2023, require the following caveats: the cost-of-living crisis is likely already to have raised the MIS level and the rate of inflation, still at 8.7%, means that data in this area is continuing to change rapidly.

Scheme 1 – Starter
£50 per child; £75 per adult over 18 and under 65; £205 per adult aged 65+. All payments are per week.

Scheme 1 is fiscally neutral in static terms and does not include savings and returns from investment elsewhere as a result of its introduction. It is affordable under any definition. No additional funding from the Exchequer and no net increase in taxation is required.

Scheme 2 – Intermediate
£75 per child; £185 per adult under 65; £205 per adult aged 65+. All payments are per week.

Scheme 2 is a mid-point between the lower and higher levels. It is not fiscally neutral, but can be funded by a range of means.

Scheme 3 – Meeting the Minimum Income Standard
£100 per child; £295 per adult under 65; £295 per adult aged 65+. All payments are per week.

Scheme 3 ensures that all families reach the MIS level. It has a significant up-front cost, but can be funded by a range of means.

The income for different household types associated with each scheme are shown in Table 1.

Table 1: Basic Income payments by household type for scheme 1, 2, and 3.

	Scheme 1		Scheme 2		Scheme 3	
Period	Weekly	Annual	Weekly	Annual	Weekly	Annual
Under 18	£50	£2,600	£75	£3,900	£100	£5,200
Single adult under 65	£75	£3,900	£185	£9,620	£295	£15,340
Single adult aged 65+	£205	£10,660	£205	£10,660	£295	£15,340
Couple under 65	£150	£7,800	£370	£19,240	£590	£30,680
Couple + 1 child	£200	£10,400	£445	£23,140	£690	£35,880
Couple + 2 children	£250	£13,000	£520	£27,040	£790	£41,080

Table 2: Tax-benefit formula for scheme 1 of an unconditional, guaranteed Basic Income of £50 per child; £75 per adult aged 18-64; £205 per adult aged 65+.

Changes to the benefit system	A conditional system that assesses people's needs (disability, unemployment, housing etc) and means (savings, wealth etc) to supplement Basic Income payments through Universal Credit and disability related benefits (Personal Independence Payment (PIP), Disability Living Allowance (DLA) etc) as well as locally assessed costs (rent, Council Tax, childcare, school dinners etc).
	For each benefit unit,* part of the Basic Income is disregarded for the purposes of calculating means-tested support (Universal Credit, Pension Credit and any other legacy benefits). The value of the disregard is £20 multiplied by the number of people in the benefit unit. So, for a single adult with no children the disregard is £20, whereas for a couple with three children it is £100. This ensures that adults and children in low income families gain something from the introduction of the Basic Income. The payment above this disregard is counted as income for the calculation of other benefits. The effect of the disregard is to raise lower net incomes by more than they would be without it. If the whole of the payment was counted as income for means-tested benefits, the net cost would fall and the income gains at the bottom would be lower.
	Child benefit and existing state pension are abolished.
	The existing state pension of £203.85 per week is converted into an unconditional flat rate 'citizens' pension' of £205 per week.
	With the new pension scheme abolished, eligibility for the state pension would become automatic for citizens above the state pension age, rather than conditional on an adequate contributions record, as at present. This would raise the income of those with incomplete contribution records, mostly women, and the group most vulnerable to pensioner poverty.
Changes to the existing tax system	Income tax personal allowance is reduced to £800 per year. Retaining a small allowance ensures that those undertaking small one-off jobs don't have to fill out a tax form.
	Current income tax higher rate threshold stays at £50,270 gross income.
	Existing income tax rates are raised by 3p taking them, in England, to 23p (basic rate), 43p (higher) and 48p (additional).
	The employee National Insurance contributions (NICs) primary threshold is reduced to £15 a week (so NICs are payable on all earnings) and the rate of employee NICs is set at 13.25% for all earnings above the primary threshold. NICs for the self-employed are equalised with employees at 13.25% (currently 9%).

* A benefit unit refers to a subset of a household, consisting of a single adult or a married or cohabiting couple and any dependent children.

The changes to the system in scheme 2 compared with scheme 1 are shown in Table 3.

Table 3: Tax-benefit formula for scheme 2 of an unconditional, guaranteed Basic Income of £75 per child; £185 per adult aged 18-64; £205 per adult aged 65+.

Changes to the existing tax system beyond scheme 1	For each member of a benefit unit, £10 of the Basic Income is disregarded for the purposes of calculating means-tested support.
	Employee and self-employed NICs are abolished with employer NICs retained at their current levels.
	These tax and NI changes are intended to reduce complexity, regressive impacts and disincentives to employment.

The changes to the system in scheme 3 compared with scheme 2 are shown in Table 4.

Table 4: Tax-benefit formula for scheme 3 of an unconditional, guaranteed Basic Income of £100 per child; £295 per adult aged 18-64; £295 per adult aged 65+.

Changes to the existing benefits system beyond scheme 2	Most means-tested benefits and transfer payments (Universal Credit living costs payments, legacy benefits, Pension Credits) are eliminated except for housing costs (Universal Credit housing and childcare elements and Housing Benefit for pensioners are maintained).
	Universal Credit disability additions are maintained where the total amount paid to disabled claimants is higher than the Basic Income level.
	There is no Basic Income disregard as a result of the changes above.
	Disability Living Allowance, Personal Independence Payment, Attendance Allowance are maintained (as in the other two schemes).
	Carer's Allowance, contributory Jobseeker's Allowance and contributory Employment and Support Allowance are also abolished. Any legacy benefits and tax credits equivalent to Universal Credit are also abolished (except for disability additions where the total amount paid to disabled claimants is higher than the Basic Income level).
	Other income tax allowances are abolished (eg dividends, savings, transferable allowance for married couples).

Our findings about scheme 1, alone, are transformative in that they indicate that universalism has the potential to help those 'who need it most' more than targeted schemes have previously managed. It overturns welfare orthodoxy across the political spectrum and indicates that

simplicity need not come at the expense of cost. Schemes 2 and 3 provide a route to eliminating poverty as currently measured and creating the most equal nation in the world as measured by Gini coefficient.[67]

Table 5: The impact of introducing schemes 1, 2 and 3: benefit unit winners and losers, changes in poverty, inequality and means-testing levels, as at 2022-23

	Changes to benefit units	Scheme 1	Scheme 2	Scheme 3
Decile 1 (poorest)	Gaining	100%	100%	100%
	Gaining more than 5%	99.0%	100%	100%
Decile 2 (second poorest)	Gaining	73.2%	84.3%	100%
	Losing	26.8%	15.7%	0.0%
	Gaining more than 5%	61.4%	64.7%	99.5%
	Losing more than 5%	7.5%	5.5%	0.0%
Impact on poverty compared with 2022-23 levels	Child poverty (currently 29.2%)	11.8%	6.2%	5.5%
	Working-age adult poverty (currently 20.6%)	14.6%	8.6%	5.1%
	Pensioner poverty (currently 18.8%)*	7.2%	8.1%	1.6%
Inequality (Gini Coefficient)	Currently 0.350	0.305	0.249	0.158
Proportion of households claiming means-tested benefits	Currently 20.4%	19.9%	14.0%	6.5%

The higher initial costs of the second and third schemes are also likely to lead to higher returns on investment in terms of increase in economic activity, improvement in health and reduction in crime, particularly in left-behind communities. Initial costs could be met by reforming the DWP, increasing the rate of corporation tax, introducing wealth and land taxes and equalising tax rates across all forms of earnings to reduce regressive impacts via wealth. Alongside this, taxes that incentivise corporate behaviour that support environmental goals, such as taxes on large businesses based on carbon emissions, may be particularly useful. At a time of multiple crises, British citizens, particularly in our devolved nations and regions outside the south-east, need more security and predictability in their financial affairs; Basic Income provides that.

* Poverty among pensioners rises between schemes 1 and 2 because this is relative poverty and while the Basic Income payments are increased for working age adults and children in scheme 2 compared to scheme 1, payments are unchanged for pensioners in the two schemes. Hence some pensioners are pushed below 60% of median because the median increases.

6. Modelling the impact of income on health

In our previous RSA report we used analysis of large national surveys to highlight the profound impact of financial insecurity, low income and inequality on the mental health of young people. Now, we extend that analysis to physical and mental health across the whole adult (18+) population using 12 waves (2009-2021) of data from Understanding Society: The UK Household Longitudinal Study.[68] In all of the following results, we are referring to household income,* even when we refer to an individual's income.

We used a "within-between" model to examine associations based on both increases or decreases in individuals' income compared with their average over time (the within component) and individuals' average income compared with the average of the population (the between component) on the one hand and health on the other. We believe that this model captures a number of key income-based drivers of health, including:

- Temporary income shocks (within component), which see individuals' income increase or decrease in one wave compared to their average.
- Permanent income shocks (between component), which see an individual's average income either be closer to or further away from the population average.
- Objective inequality (between component), which see differences between individuals' average income, which is calculated over a longer, enduring, period.
- Subjective social status inequality (between component), which is the psychological phenomenon driven, in part, by income inequality.

It does not, however, capture what we anticipate through our model of impact to be very substantial benefits from Basic Income of increased security of income and protection from destitution for a very large proportion of the population in even relatively highly paid jobs.

Using this model, we found that increases in income and higher average income is associated with:

- Better **mental** health, through reduced symptoms of depressive disorder as measured by a higher score on the SF-12 Mental Component Summary. Correspondingly, a relationship between lower income and worse mental and physical health is also apparent.
- Better **physical** health, using the SF-12 Physical Component Summary, a measure of functional physical health.

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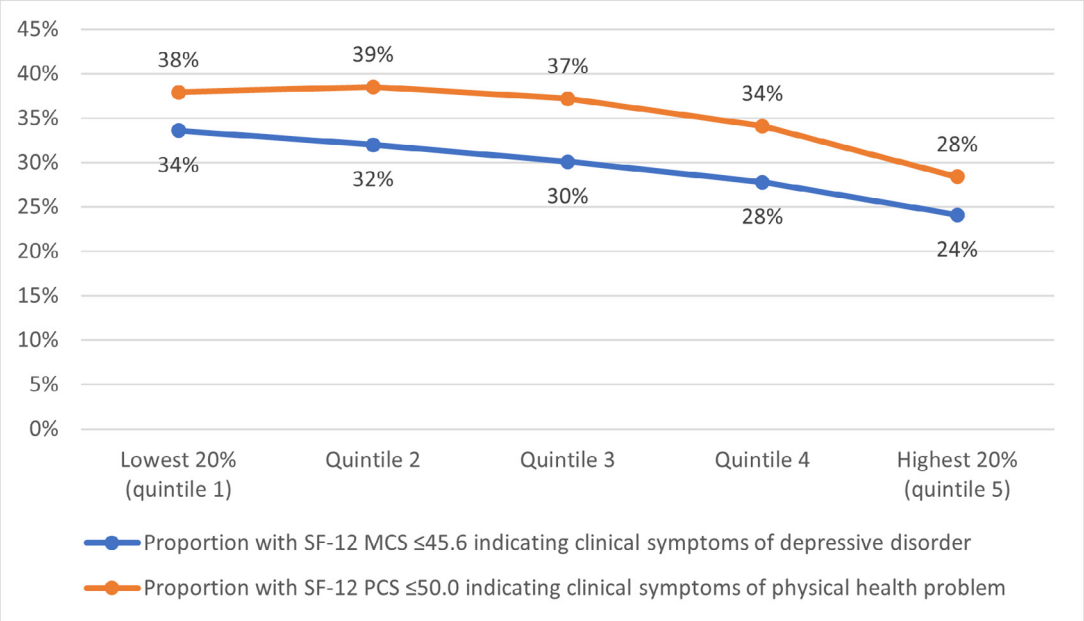
* A household is defined as one person living alone, or a group of people (not necessarily related) living at the same address who share cooking facilities and share a living room, sitting room or dining area. A household can consist of a single family, more than one family or no families in the case of a group of unrelated people.

Using a separate logistic regression with quintiles of average household income (Figure 2), we found that individuals with the lowest 20% of income have a higher probability than the second lowest of reporting clinically significant symptoms of both depressive disorders (based on an SF-12 MCS score of ≤45.6)[69] and a physical health condition (an SF-12 PCS score of ≤50.0)[70]. The second lowest has a higher probability than the middle quintile and so on up the income scale.

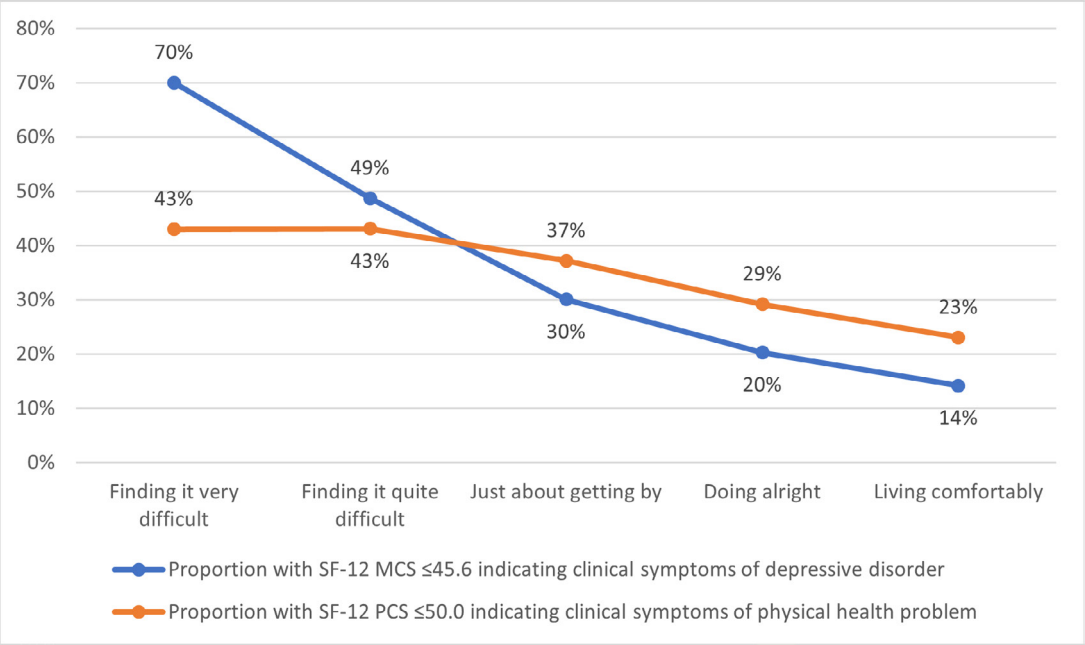
Figure 2: Probability of reporting clinically significant symptoms of depressive disorders and physical health problems by net equivalised household income quintiles



Financial strain,* a subjective measure of how well people feel they are currently managing financially, has even steeper gradients of association with both mental and physical health in Figure 3. This suggests that there may be potentially greater impacts to be gained from a Basic Income intervention, and accompanying policy to deal with financial overcommitment, that provides security and predictability to the whole population.

* Financial strain, here, refers to responses to the question 'How well would you say you are managing financially these days? Would you say you are...? 1 Living comfortably 2 Doing alright 3 Just about getting by 4 Finding it quite difficult 5 Finding it very difficult'.

Figure 3: Probability of reporting clinically significant symptoms of depressive disorders and physical health problems by answer to question "How well would you say you yourself are managing financially these days?"



Once available, our article analysing the relationship between income and health will be listed on our project website, with a preprint available in our project archive, available here.

These findings add to the substantial and growing evidence from decades and even centuries of work that indicate the importance of income to both mental and physical health. In developing parts of the world, it is uncontroversial to propose programmes that increase people's resources. These results suggest that we need to ensure both that people's objective incomes are increased and also that they experience security and predictability in their lives to avoid financial strain that can often be the result of a difference between expected income and expenditure and sudden shocks to either.[71] Basic Income fits the bill.

7. Modelling the health & economic impact

Based on the evidence collected in chapters 3 and 4, we developed microsimulation modelling in order to understand the potential scale of impact on physical and mental health from the three Basic Income schemes. We employed data from 12 waves (2009-2021) of Understanding Society: The UK Household Longitudinal Study to look at cases of depressive disorder, physical health problems and deaths prevented or postponed and estimated cost savings, alongside quality-adjusted life years (QALYs) and associated social and economic value gained between 2010-30. Each QALY has been assigned a value of £30,000 based on NICE guidance which suggests that between £20,000 to £30,000 per QALY gained as a result of an intervention may be deemed cost effective.[72] The Treasury's Green Book proposes a much higher value of £70,000.[73] However, we have attempted to produce a reasonably conservative estimate that is more likely to be deemed cost-effective in the context of Government health expenditure.

Given the picture of extreme economic insecurity described in the introduction to this report and given that we anticipate effects from Basic Income through pathways based on factors other than outright increases in income, the impacts described below may well be very conservative.

The microsimulation indicated that if Basic Income schemes 1, 2 or 3 were introduced in the year 2023:

- Between 125,000 and 1 million cases of depressive disorders could be prevented or postponed.
- Between 120,000 and 1.04 million cases of clinically significant physical health symptoms could be prevented or postponed.
- Between 130,000 and 655,000 quality-adjusted life years (QALYs) could be gained, valued at between £3.9 billion and £19.7 billion.
- Based on depressive disorders alone, NHS and personal social services cost savings in 2023 of between £125 million and £1.03 billion assuming 50% of cases diagnosed and treated.
- Physical health NHS and personal social services savings are more difficult to calculate. However, it is reasonable to anticipate that they may be even higher, given that the 2022/23 clinical commissioning groups (CCG) budget for mental health, learning disability and dementia services in England is just £13.3 billion, or 13.8% of the total.[74]

Once available, our health impact microsimulation modelling article will be listed on our project website, available here, with a preprint available in our project archive, available here.

> "Pressures on health services, already intense, will only increase with our ageing population. There is growing evidence that financial insecurity drives unhealthy behaviour and creates sustained physiological responses that raise the risk of serious illness. Therefore, upstream interventions to tackle precarity could massively improve our health and well-being, and may well be essential for the long-term viability of the NHS."
>
> - Jason Madan, Professor of Health Economics, Warwick Medical School

Our approach used Waves 1-12 of Understanding Society: The UK Household Longitudinal Study and modelled SF-12 Mental Component Summary (MCS) and Physical Component Summary (PCS) scores using a "within-between" regression specification to show the relationship between net equivalised household income on the one hand and mental and physical health on the other, controlling for a range of other individual characteristics including age, gender, ethnicity, disability, country of birth, educational qualifications and economic status. We also controlled for household characteristics including region and housing tenure. We modelled the relationship between mental and physical health for different quintiles of the income distribution.

We also used software from QualityMetric to convert the SF-12 scores into a utility-based SF-6D score which can be used to calculate the change in QALYs for the UK population arising from changes in the distribution of income as a result of introducing Basic Income schemes with accompanying funding mechanisms. The three Basic Income schemes modelled in this report reduce inequality and increase the average incomes of the lowest quintile (poorest 20%) of household net incomes in particular. It is this boost to income for low-income households which drives the projected increases in population health arising from the introduction of Basic Income.

Table 6 shows that between 130,000 and 655,000 QALYs could be gained in 2023, valued at between £3.9 billion and £19.7 billion.

Table 6: Modelling results indicating the estimated number and value of QALYs gained as a result of each Basic Income scheme in 2023

	Number of QALYs gained	Value of QALYs gained (£30,000 each)
Scheme 1	130,000	£3.9 billion
Scheme 2	375,000	£11.3 billion
Scheme 3	655,000	£19.7 billion

Table 7 shows the number of cases of anxiety and depression and of clinically significant physical health symptoms prevented or postposed under each scheme.

Table 7: Modelling results indicating cases of depressive disorders and physical health problems among 18+ adults prevented or postponed in 2023

	Cases of depressive disorders prevented or postponed	Cases of physical health problems prevented or postponed
Scheme 1	124,000	118,000
Scheme 2	537,000	548,000
Scheme 3	1,005,000	1,042,000

Table 8 shows NHS and personal social services costs savings as well as total costs savings associated with the cases of depressive disorders prevented or postponed in 2023.[75]

Table 8: Modelling results indicating per year depressive disorders cost savings from different perspectives

	NHS and personal social services cost savings assuming 50% of cases diagnosed and treated	Total (including patients' related) cost savings assuming 50% of cases diagnosed and treated
Scheme 1	£125 million	£560 million
Scheme 2	£550 million	£2.45 billion
Scheme 3	£1.03 billion	£4.58 billion

Again, with caveats regarding the likely underestimate of impact, the savings from NHS and patients' related costs could pay the full economic cost for between 7,481 (under scheme 1) and 61,184 (under scheme 3) additional hospital-based nurses* per year.[76] Physical health NHS and personal social services savings are more difficult to calculate. However, it is reasonable

* This is based on a band 5 nurse at £74,856, which includes salary and all other associated costs and overheads.

to anticipate that they may be even higher, given that the 2022/23 clinical commissioning groups (CCG) budget for mental health, learning disability and dementia services in England is just £13.3 billion, or 13.8% of the total.[74]

Our findings are indicative of the kind of scale of the health impact that Basic Income could have on the adult population through a pathway of increased incomes. There are other types of impact – such as improved productivity, reduced crime and improved educational outcomes – alongside further rounds of health savings as initial impacts create a longer-term feedback loop, that are likely to provide greater resources to fund Basic Income as an intervention.

This modelling exercise assumes that low income is causally related to both functional physical health and depressive disorder, and that increasing income can fully reverse the risk. The association between income and health has been shown in experimental and observational studies (see Introduction). However, the heterogeneity of the implementation of the income transfer policies and the reported health outcomes make evidence synthesis difficult. Large, representative trials of Basic Income, or evaluation of full policies, that capture comprehensive and comparable data in the real world are crucial.[77]

"As a GP, I increasingly find that my patients are in financially precarious positions, regardless of whether they are in work or on benefits, and this has a clear impact on their physical and mental health. Put simply, financial precarity is making people sick, something I see increasingly in my clinical work. The detailed modelling in this report suggests that Basic Income could significantly reduce this precarity, with consequent positive effects on health and wellbeing. The opportunity to make a concrete difference to health outcomes is exciting both at the level of individual patients and communities, but also from the perspective of the NHS as we wrestle with increasing demand. The report shows that the public understand this and, crucially, are supportive of bold measures to try and improve things. Basic Income represents an opportunity to follow in the footsteps of previous bold interventions to address the causes, not the symptoms, of illness."

- Dr Jonathan Coates, GP in Newcastle upon Tyne and NIHR In-Practice Fellow, Durham University

The modelling across the adult population and covering both physical and mental health represents a significant development and fills a gap identified in our previous work on mental health among 14- to 24-year-olds. There remains an opportunity to model the health impacts of changes through all pathways identified in Figure 1.1 on all major disease types. This would enable much greater specificity in the types of health problems addressed and associated savings, including when extrapolating from trials. However, it is clear that there is already evidence of very substantial impacts that would help to address up-front costs of implementing Basic Income on a national scale. In other words, while further evidence should be pursued both to build the case for the introduction of such a policy and to support its evaluation, this should not distract from efforts to bring about such policy change given urgent public health need for upstream interventions and a rapidly declining economic environment.

It is important to note that the cost-of-living crisis and the high inflation period that we are currently experiencing has compressed, and will compress further, household incomes, accelerating the urgent situation in public health further by negatively affecting the pathways we set out in our model of impact. Given that belt-tightening in public spending currently appears to be the most prominent Government response to the situation, it is likely that there will be substantially more limited access even to appropriate reactive treatment. This suggests that our modelled estimates are conservative and that research on Basic Income policies is continuing to build both in relevance and electoral salience.

8. Public Preferences for welfare system designs

Conjoint survey experiments

A key challenge presented to the introduction of a Basic Income policy is its political feasibility. We have shown previously that an assumption among some policymakers that Basic Income is unpopular among the British public is wrong,[78] with more than two-thirds expressing strong support. However, we wanted to examine what people value in a welfare system to allow policymakers to understand what kinds of attributes there is support for and how the perceived pros of a welfare system (such as generosity) and the perceived cons (such as cost) trade off in people's minds. This work helps to ensure that a finalised policy chimes with the priorities of the public who will be affected by its introduction.

We therefore conducted a series of 'conjoint' survey experiments with a representative sample of UK residents. Respondents repeatedly chose between pairs of welfare policies with randomly generated sets of attributes, such as payment size and health impact. While similar work has been undertaken in relation to Basic Income previously,[79-81] this is the first time this level of detail, including prospective impacts on physical and mental health, has been included. Each of the sets of options appeared as in Figure 4, below. Each feature was described in greater detail prior to these selections.

Figure 4: Conjoint survey policy options example

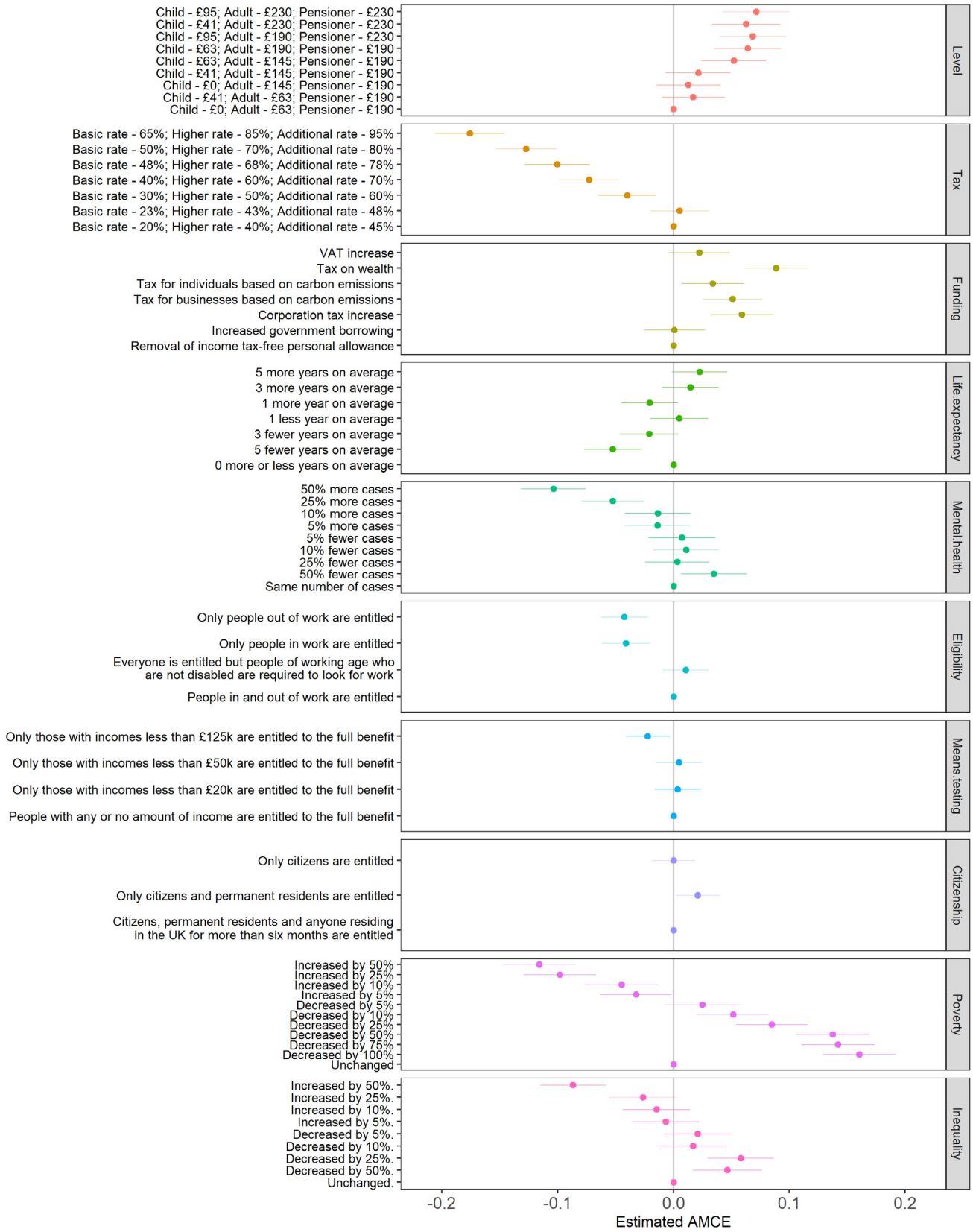
Welfare scheme preference

(1/15) Choose your preferred option below:

	Policy 1	Policy 2
Payment size:	Child - £0; Adult - £63; Pensioner - £190	Child - £63; Adult - £145 Pensioner - £190
Income tax:	Basic rate - 40%; Higher rate - 60%; Additional rate - 70%	Basic rate - 30%; Higher rate - 50%; Additional rate - 60%
Funding options:	Tax for businesses based on carbon emissions	Removal of income tax-free personal allowance
Years in perfect health:	3 more years on average	1 less year on average
Anxiety and depression:	Same number of cases	25% fewer cases
Work conditions:	Everyone is entitled but people of working age who are not disabled are required to look for work	People in and out of work are entitled
Income conditions:	Only those with incomes less than £125k are entitled to the full benefit	People with any or no amount of income are entitled to the full benefit
Citizenship conditions:	Only citizens and permanent residents are entitled	Only citizens are entitled
Poverty:	Decreased by 50%	Increased by 5%
Income inequality:	Increased by 50%	Increased by 10%
	○	○

Results are summarised in Figure 5, below. In the figure, a value greater than zero means that, other things being equal, having that feature made people more likely to choose a policy. The further above zero the value, the stronger the preference. A negative value means that having that feature made people less likely to choose it.

Figure 5: Marginal value attached to different attribute levels from a conjoint survey experiment



Notes: N = 697. Points indicate parameter estimates and horizontal lines the 95% confidence interval. The marginal value is expressed relative to the reference level at the bottom of each feature, which has a marginal value of 0 by definition.

In terms of policy outcomes, we found the following:

- The attribute that made most difference to preference was the effect on poverty.
    - Respondents prefer systems that reduce poverty and ideally want a system that removes it altogether.
    - They dislike systems that increase poverty.
- Respondents prefer more generous benefits to less.
- Respondents value systems that improve health and reduce (compared to increasing) cases of anxiety and depression.
- They also value reductions in inequality itself.
- The desire for these other features was not as strong as the desire to see poverty reduce.

On the funding side, other things being equal, we found the following in relation to respondent preferences:

- They prefer lower income tax rates to higher, though with small increases of three percentage points in each rate deemed as preferable as the status quo.
    - This preference is not, however, stronger than their preference for poverty reduction. That is, if poverty could be reduced, the positive value they would place on this would outweigh their lower preference for higher income tax rates.
- Other forms of funding the policy, notably a wealth tax, were popular.

In terms of eligibility, our findings are that respondents were swayed little by whether:

- the system was an unconditional or a conditional one.
- whether there was any means testing.
- whether access was restricted to citizens.

In summary, there was no evidence of any intrinsic dislike for giving 'money for nothing' or targeting the deserving. This work suggests that British people are open to whichever system improves health and reduces poverty in the most efficient way possible.

We have conducted sub-group analyses, and although there are some minor differences, the fundamental valuation of a welfare system is surprisingly similar between young and old or Labour and Conservative voters.

> "The British public want to see poverty reduced, and health and wellbeing increased. They are prepared to pay for these objectives to be delivered. They are quite happy with a universal and unconditional system if it will secure these objectives".
>
> - Daniel Nettle, Professor of Community Wellbeing, Northumbria University, and Directeur de recherche, Institut Jean Nicod

These findings both confirm and challenge received opinion. The public prefers not to have large increases in income tax for example, which should be relatively obvious in the current economic climate. However, they would trade this off for a reduction in poverty and improvement in the health of society. In this case it needs to be explained how Basic Income, despite being universal and flat, has greater net benefit for people at the lower end of the income distribution and is thus an anti-poverty policy. However, on the other hand, factors that many politicians build their brand on – conditionality and ensuring that 'undeserving' people do not gain from the system – appear to be unimportant in the round. So many people in Britain are now economically insecure that these in/out group distinctions are unlikely to remain, if they still exist now.[78,82] It is the large-scale effects across the population driven by universality and more ambitious designs that are likely to be Basic Income's greatest assets. Those seeking to obtain public support must recognise that it is believable impact on people's material conditions that is likely to secure electoral success, as it did for the Conservatives in 2019 when they employed clear statements of levelling up in left-behind areas and decisive action on Brexit.

Public Policy Preferences Calculator (PPPC)

Work in this area, however, should not be regarded as purely theoretical and without real-world application. To support policymakers in designing Basic Income, and other welfare, policies, we have created an online Public Policy Preferences Calculator (PPPC).

The calculator is open-source and web-enabled. It combines a conventional tax-benefit microsimulation model with Conjoint Analysis. Conjoint Analysis is survey-based technique that produces estimates of how popular a scheme with multiple attributes (in this case, health improvements, tax rates, poverty levels, etc.) would be with the public. Using the calculator, a user can see not only the fiscal impacts of a policy change (gainers and losers, incentive effects, inequality, etc.) but also an indication of the acceptability of the scheme with the general public, and of which parts of the scheme are particularly popular or unpopular. We believe this is its first use of Conjoint Analysis in a fiscal context.

You can find the Calculator through our project website.

> "Both policymakers and the general public have an interest in understanding the distributive and health impacts of policies and the relationship of outcomes to public acceptability. This calculator gives stakeholders the capacity to understand policy and its effects."
>
> - Graham Stark, Senior Research Fellow in Public Policy,

This is groundbreaking work that recognises that policymaking depends both on evidence-based outcomes and a willingness to acknowledge pragmatic consideration relating to electoral feasibility. The calculator enables users to balance the economic effects they wish to see with public preferences in one place. Rather than having to reassess each policy option, a range can be developed with the most promising put through to further public engagement if required.

9. Citizen engagement

Policies, and the pilots and trials preceding their introduction, are often designed without meaningful community consultation or participation, which raises significant ethical and practical concerns. Even where there are consultations, there is often a failure by policymakers to respond meaningfully by revising their plans, which became particularly prominent and problematic during the rollout of Universal Credit and Personal Independence Payment. If Basic Income pilots are to be developed in a manner that is sensitive to communities and ethically implemented, local co-production must be a key part of the process. Through a series of qualitative workshops in Jarrow, South Tyneside, we explored and categorized local concerns, hopes, and suggestions for piloting Basic Income in the area.

This citizen engagement has now been given additional impetus due to the publication of a proposal for Basic Income micro-pilots in Jarrow, alongside East Finchley in London.[43] This initiative partners two areas supported by Big Local, a civil society project funded by the National Lottery Community Fund that aims to support local power over local development, Local Trust, Basic Income Conversation and Autonomy and Northumbria University. For this project, we worked with Big Local Central Jarrow in co-producing citizen engagement research on residents' perception of the public health impact of Basic Income in their community.

Jarrow is an important site for this work, since it is an area likely to be among the most affected by introduction of Basic Income. The South Tyneside local authority was the 22nd most deprived in England in 2019 based on the overall Index of Multiple Deprivation (IMD), 13th for income, 11th for health, and third for employment.[83] Modelling suggests that greater benefits from Basic Income would result to those lower down the socioeconomic ladder.[40, 84]

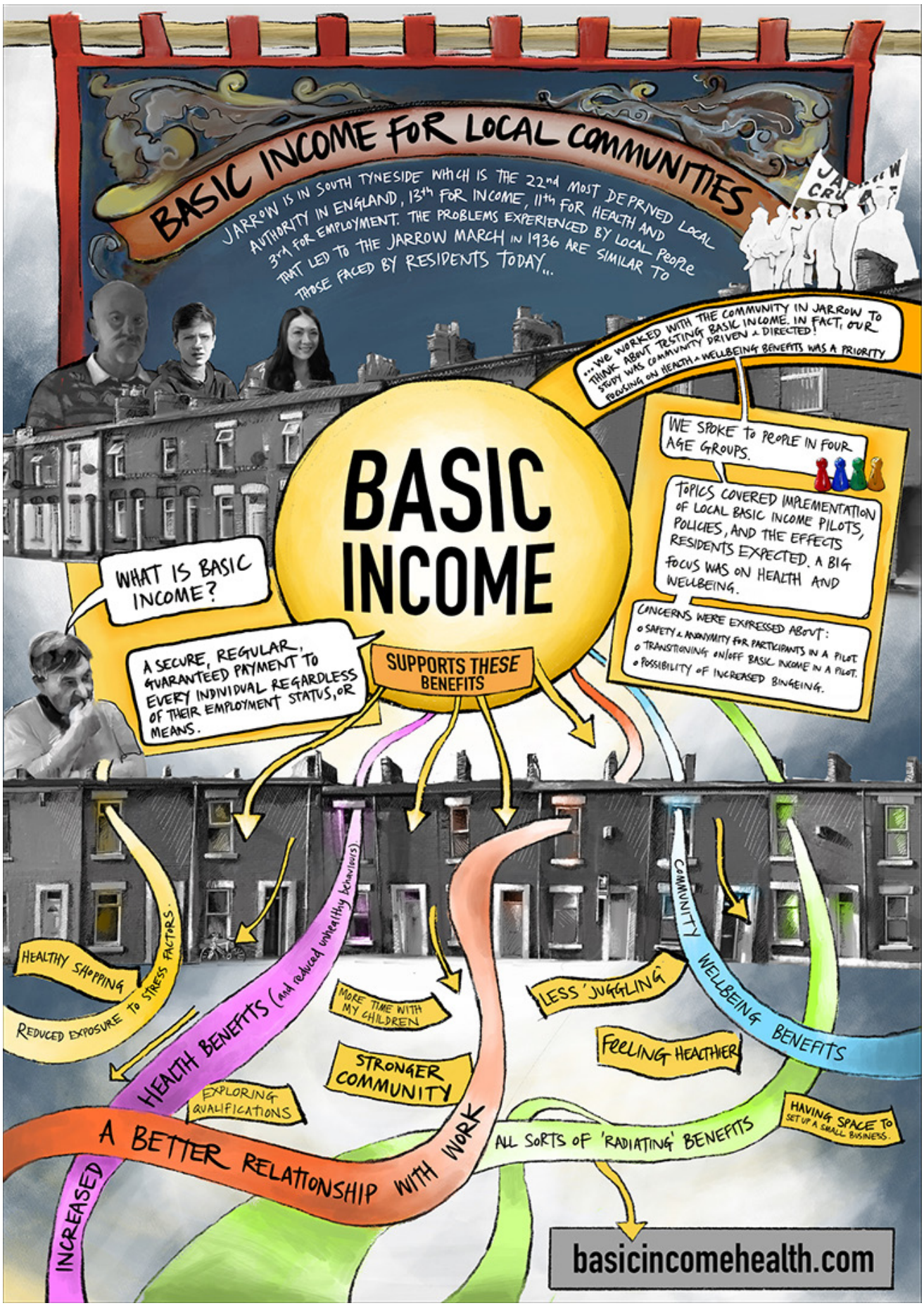
The research team held two two-hour workshops at Big Local Central Jarrow with around 20 participants in each. Participants were recruited by members of Big Local Central Jarrow using social media and word-of-mouth and aimed to ensure coverage of each of the four main adult generational groups – Baby Boomers (born 1946-1964), Generation X (born 1965-1980), Generation Y/Millennials (born 1981-1996), and Generation Z (born 1997-2012) – to enable workshop findings to reflect concerns across the life course. Care was also taken to ensure gender balance and diversity in terms of occupation and socioeconomic status. All participants were remunerated for their time at Northumbria University research assistance rates to mitigate ethical concerns about exploitation of research participants. All groups were accompanied by a facilitator to

guide conversation and prompt discussion around hopes, desires, and research participants. All groups were accompanied by a facilitator to guide conversation and prompt discussion around hopes, desires, and concerns related to Basic Income and its piloting.

In the first workshop, 'Understanding the Feasibility and Desirability of a Universal Basic Income Pilot', conversation was framed with the following big-picture questions: 'If a pilot were to happen here, what should it look like? What would your hopes be for this pilot? What of your worries? How could it be designed to deal with those worries?' The second workshop – 'What Impact Would a National Basic Income Have Here?' – built on the findings of the first but sought to explore in greater depth people's perspectives on Basic Income as a potential social policy. This session sought to examine the prospective positive and negative impacts a Basic Income could have on a community like Jarrow, with a focus on work, precarity, poverty, wellbeing, and, of course, health.

A written summary is below, but an intuitive and accessible version of the findings is available in visual form in Figure 6. This image was created by Ian Robson, Associate Professor in Children and Young People, Northumbria University, who uses visual methods to support interdisciplinary dialogue.

Figure 6: Illustration of findings from citizen engagement



Participants across our age cohorts were intrigued by the idea of Basic Income as a social policy, felt it could have a great deal of positive impact and felt attracted to the prospect of something as significant as a pilot taking place in the community of Jarrow. Importantly, there was a recognition of a context in Jarrow in which "poverty is everything". There was also a widespread recognition of the general inefficiency, ineffectiveness and indignity of the current social security system. As one Generation Z participant said to general agreement in his group, 'It's not like they're helping you. They're not giving you the help that you need. They're just on your back, pushing you'. Both of these contextual factors should be remembered as underpinning a number of the findings below.

Participants expected the following potential positive effects of a Basic Income policy in their local community:

1. Improved relationships with work

Freedom from financial pressures that 'push' people into inappropriate work was at the heart of participants' views on how Basic Income might improve relationships with, and wellbeing through, economic activity. For example, one participant had worked in factories her entire life. She said that it was common for women to return to work quickly, even after major surgery, because sick pay was simply insufficient to meet their basic needs. Others felt Basic Income could help people to refuse difficult, dangerous, or undignified work, and instead to choose something better, including through retraining for more meaningful, and financially rewarding, employment.

2. Reduced exposure to stress

Participants were clear that being poor is stressful; it involves constant worry over how to meet basic needs and it involves the frequent, exhausting juggling of work. One participant had to manage five different, zero-hours contracts just to get by, with no regular certainty either about the work on offer in any given week or the income that this would provide. Basic Income, on the other hand, would provide a stress-reducing material floor on which to stand. Another said "I think it's the stress of not knowing, like not being able to put food on the table, like you'll have money to like to fall back on. That stress would be gone pretty much instantly with a [Basic Income]."

Across the groups, and particularly among those of working age, there was general dislike and distrust of the social security system, which was viewed as insensitive, punitive, and abusive, frequently either forcing people into pointless, 'make-work' activities that benefitted almost no-one, or treating those unable to work with distrust. This created a negative cycle of ill-being as it massively increased people's stress. One disabled man from the Generation X group shared the following

anecdote on this point: “To me, a Basic Income would feel far more dignified. I mean, we’ve been through some awful things. Still going through them... I get people every four years coming to my house asking whether I'm still as blind as I was four years previously... and a lot of our income... hinges on that. So that happens every four years, which is stressful... because straightaway... you know they’re coming from a point of view of ‘we don't trust you”. Another said “They're not giving you the help that you need. They're just on your back, pushing you towards menial jobs, low paid crap shitty work that this government obviously would like to see everybody in – low paid, underpaid work, where you can't actually buy food, so you go into food banks as well. Hopefully [Basic Income] would get rid of that.”

3. Enhanced freedom over use of time

Participants suggested that Basic Income could have beneficial impacts on their community through its ability to give individuals greater freedom over how they use their time. One participant said “With a [Basic Income], you could take care of yourself as well. Take care of your mental well-being, just go for a walk or chat to your kids or your family.” Another added that “Maybe the reason why we find it difficult to eat healthy or to exercise or to find the things that we enjoy doing is partly because our brains are changed because of the stress that we're under...so I wonder whether actually just having a different system where we have that money, would mean we were under less stress and have more chance.”

4. Increased healthy behaviours and decreasing unhealthy ones.

Respondents linked the benefits above to anticipated increases in healthy behaviours and decreases in unhealthy ones. Multiple participants, for example, suggested that people would be able to afford healthier food. Others suggested that people would exercise more or even “go on holiday”, an important aspect of wellbeing. Participants further suggested that people would leave stressful jobs, be able to invest in house repairs and, if necessary, end toxic relationships. This was linked to a potential reduction in alcohol and drug use, with a community worker participant saying “We run a project for people who use substances, and we support substance misuse workers to understand the background that trauma has for people who end up using substances, and I think it is really really profound how much of a role poverty plays – like I can’t, I don’t think I can even explain how important it really is. A [Basic Income] would definitely help with that.”

5. Radiating of indiviudal benefits out to the community.

The benefits above were framed by participants in community as well as individual terms. For example, parents pointed to the increased time they would spend caring for their children and the wellbeing benefits that all

would enjoy as a result. Others went further, arguing that Basic Income would liberate people's "contribution energy" and free them and the community as a whole to engage in life-affirming, communal activities. A second community worker participant suggested the following scenario: "I do think that [by] having this extra money there's going to be pros and cons... but I think some of the pros we're talking about relate to poverty. Like, if you've got extra money, you maybe wouldn't have to be working all hours, like carers, having to work all hours under the sun. You could have extra time where you could do community-based things, like... community allotments, where you grow your own food amongst the community, share amongst the community, educate each other about things like 'you don't have to be taking drugs, you can take your mind off things in other ways.'" Other members of this group concurred, and the conversation ranged for 10 minutes over how community life might flourish again once the 'better angels of our human nature', as one man put it, had time and space to take flight.

While many positive potential impacts were identified, participants also felt that the following negative effects might occur. Some of these are described in greater detail below in relation to pilots:

- More bingeing (on alcohol, drugs etc.) due to increased availability of resources.
- Theorised negative economic effects like inflation caused by greater spending.
- Theorised negative social effects due to not needing to work.

In terms of the practicalities of pilot design, participants identified the following:

- Randomisation with quotas for specific groups (e.g. employment status, contract type, income levels, gender, age, disability etc.) in selection of participants within communities (e.g. similar to a 'lottery' or random selection from the electoral roll) to reduce the chances of participants being the target of antisocial and/or criminal behaviour.
    - One participant stated that 'who get these benefits [Basic Income] are going to be targeted by other members of the community who aren't getting it', while another added, 'if it was done really randomly like picking out of a hat, then it would be hard for people to target'.
    - This was related to perceptions of fairness in a context of deprivation in the community.
- Some participants were clear on the need to assess impact on people with different employment contract types, recognising the importance of precarity, and income levels, but some felt it would be best to have an income cut off to maximise the benefit to the local community of a pilot.
- Participants struggled to agree on the length of a pilot or trial, with some arguing for the likelihood that longer pilots would help evidence the long-term benefits, while others favoured a shorter period as

- Participants also disagreed on the size of payment.
  - General consensus in the youngest age group was that the money should be 'at least over what benefits would be', with a specific suggestion of 'National minimum wage on full time hours, that's about £1,600 because that way it's bringing people up to that threshold and that is the point behind this pilot – not leaving people behind.'
  - Older age groups felt it was difficult to settle on one amount due to the different needs that each household might have and that £1,600 might be too much for some.
- Beyond the concerns of targeting of participants, others worried about **recipient dependence**, the potential for **harmful bingeing**, and the **interaction between Basic Income and existing welfare structures**.
  - For example, once participantzsaid that 'if I know the people that I know in Jarrow, if any of them got £1000 I know where it would be going, doodoodoodoole, they would be drunk!... I've watched it my whole life...People have got money in their pockets knowing they want the pints.' However, there were also discussions about how a larger, more secure income might help reduce stress and the substance use that can accompany it.
  - While some felt crime could increase due to the targeting, others felt the opposite wass possible, with one participant saying that people may not have to shoplift if they had more money, potentially freeing up police time for other priorities.
  - Concerns over the interaction between Basic Income in a trial and existing benefits and day-to-day money management were raised, with one participant saying 'we've got a debt management plan because we have so much debt. They've got it down to an affordable amount on what our current incomes are and what we pay out, but once we have an extra grand coming in [from a pilot], that's going to change the full plan I've got with them'. Another said 'it is hard getting back on benefits and so recipients could face challenges once the trial was finished', with others mentioning the stress that transitioning off Basic Income might cause, contrary to the intended consequences of a pilot.
- In terms of mitigating these risks, themes were raised of **protection**, **support**, and **coordination with the authorities**.
  - Randomisation and anonymity were, again, thought to be important. One participant said 'if you're sensible and don't want to get yourself hurt, then it's on you to not tell people'.
  - Regarding support, all groups agreed that relational support to recipients during the pilot would be of paramount importance, for example through group meetings and counselling. One participant suggested that "At these meetings, there could maybe be specialists to help with the mental health aspect in case people are struggling, maybe a financial advisor there as well, you know official types who can help if it's not going as well as they'd hoped."

- Another suggested that counselling support 'could be extended to have contact throughout the full process, almost like a helpline'. Others suggested Big Local Central Jarrow-style community organising/social work as a model to follow, and others support for financial management: 'if you're not used to paying your own rent and things, then help managing those monthly outgoings'. Support leading up to and after the pilot was also a key focus of discussion, with importance particularly given to how the Basic Income would interact with current systems, including student loans, housing, debt management plans, taxes, child support, Universal Credit, and other benefits.

It is clear from this work that policymakers need to consider further a number of key areas.

First, there is evidence from other, carefully designed, controlled and supported studies that place-based Basic Income trials may produce richer understanding of the prospective impacts of schemes without triggering social conflict. It is crucial that the concerns of communities affected are taken seriously and that interventions ensure that the risks of conflict are minimised.

Second, support architecture in pilots, such as financial literacy training, counselling and community organising are important areas of study and are crucial to participant safeguarding. While such support is unlikely to be feasible in the case of a national Basic Income policy, the challenges relating to interaction with existing forms of conditional support are also less likely to exist, reducing some potential pressures. There remains a tension between piloting schemes that reflect likely future policies and addressing issues arising from the current system. Researchers must take extremely seriously the risks posed to participants in pilots, especially given that any data produced is likely to have little statistical value.

Third, development of effective communication to explain the reasons for pilots and the ways that they might affect participants and communities is also crucial.

Importantly, however, residents' responses provide lived-experience detail and illustration to the main pathways to impact modelled in our Basic Income model of health impact (Figure 1). As one participant, a community worker said:

> "I think the [Basic Income], it's going to free up people's time a little bit, to do other things to help each other. Like I said before, if you're not working 16 hours a day and sleeping for four hours, you've got that extra money where you can contribute to helping be a community again and caring about each other again, and it doesn't just necessarily have to just be just Jarrow, care about society as a whole."

In other words, while Basic Income as a welfare policy might be paid to individuals, the impacts are likely to radiate out to all levels.

In response to the consultation, we have revised the model to highlight the increases in 'prosocial', 'relational' behaviour, such as voluntary work, that are likely to have community benefits (Figure 1), and the effects that this is likely to have not just on individual health, but that of the whole community.

> "Given decades of measurable failure based on externally dictated interventions, it should be clear that people in local communities affected by poverty, insecurity and lack of opportunity are the authoritative voice on what they need to enhance their health and wellbeing. We need to listen to their expressed needs and lived experience and create policies that support them to flourish."
>
> - Kate E. Pickett, Professor of Epidemiology,

10. Conclusion

The findings of this report, like others before it, are clear: there is no obvious alternative to Basic Income that has the same multipurpose function and impact across society. Our society and its institutions are fundamentally broken in ways we are only now beginning to understand. Whereas previous generations saw pathways to careers, property and family through work, today's young people have been cut adrift following the financial crisis, a lost decade and the economic consequences of a pandemic and now cost of living crisis. But even older people are exposed to a risk of destitution that would have seemed far-fetched even 15 years ago: put simply, if people in their 50s lose their jobs these days, there is a significant risk not only that they will not work again, but that they will lose homes for which they have spent decades making mortgage payments, compounding the coming crisis in social care. People know that they are at risk, they know that they need secure income and, a secure income is the actual and obvious means of meeting people's fundamental needs.

All too often people place income and services at odds with one another; they are complementary in complex forms. What is clear, however, is that free bus travel does not feed families and free hospital treatment can only treat the symptoms of long-term ingrained poverty. When explained effectively, people endorse generous Basic Income schemes because they recognise that generous schemes are those they need to protect themselves against an insecure economic climate, particularly in terms of securing mortgage payments.

Far from its weakness, Basic Income's universality is what shifts people's perception of welfare as something for others, to something that is of central importance to the interests of the vast bulk of society: hardworking, aspirational and responsible members of society. It is no coincidence that, where politicians endorse Basic Income they achieve success. The Welsh devolved administration and the pioneering work in Greater Manchester and North of Tyne are clear examples for Westminster politicians to follow.

This is not a time for the politics of modesty and inertia.

- Matthew Johnson, Professor of Public Policy, Northumbria University

As a GP, I increasingly find that my patients are in financially precarious positions, regardless of whether they are in work or on benefits, and this has a clear impact on their physical and mental health. Put simply, financial precarity is making people sick, something I see increasingly in my clinical work. The detailed modelling in this report suggests that Basic Income could significantly reduce this precarity, with consequent positive effects on health and wellbeing. The opportunity to make a concrete difference to health outcomes is exciting both at the level of individual patients and communities, but also from the perspective of the NHS as we wrestle with increasing demand. The report shows that the public understand this and, crucially, are supportive of bold measures to try and improve things. Basic Income represents an opportunity to follow in the footsteps of previous bold interventions to address the causes, not the symptoms, of illness.

- Dr Jonathan Coates, GP in Newcastle upon Tyne and NIHR In-Practice Fellow, Durham University

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