

Sent by email at: basicincome@ontario.ca

January 17, 2017

Honourable Helena Jaczek
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Honourable Chris Ballard
Minister of Housing
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Dear Minister Jaczek and Minister Ballard,

On behalf of the Association of Local Public Health Agencies (alPHa) and the Ontario Public Health Association (OPHA), we are writing to reiterate our strong support for the Ontario basic income pilot and to convey our high-level feedback as part of the current consultations. Both of our organizations passed resolutions in support of basic income in 2015^{1,2}. As such, we were pleased to see that the recommendations made in the Honourable Hugh Segal's discussion paper, *Finding a Better Way: A Basic Income Pilot Project for Ontario*, are consistent with piloting a strong, health-promoting basic income. Our support for basic income is informed by overwhelming evidence of the powerful link between income and health. People living with a lower income are at far greater risk of preventable medical conditions across the lifespan, including cancer, diabetes, heart disease, mental illness, and their associated health care costs, compared with those living with higher incomes. Children are particularly vulnerable to the impacts of growing up in low income, due to its attenuating effect on early childhood development. The experience of childhood poverty leads to vulnerability, both to negative health outcomes and social outcomes, including reduced educational attainment and greater risk of involvement with the justice system. Our members feel strongly that ensuring everyone has an income sufficient to meet basic needs and live with dignity would be one of the most important initiatives the provincial government could pursue to promote health, well-being and equity amongst Ontarians.

The Hon. Hugh Segal's discussion paper provides important considerations for designing the pilot. **We have prepared detailed feedback in collaboration with Public Health Ontario (PHO) on these considerations in a separate technical submission, in accordance with your *Consultation Guide for the Basic Income Pilot Project*.**

To complement that detailed feedback, this letter serves to outline the views of alPHa and OPHA on key, high level aspects of the basic income pilot.

We believe that a set of principles should guide the design of a basic income program, including the type of basic income to be piloted in Ontario. A principle-based approach is consistent with the recommendations of Basic Income Canada Network³, the Basic Income Initiative (a multi-faith, indigenous and multi-sector collaboration)⁴, and the resolutions passed by our respective organizations^{1,2}:

- the pursuit of equity, both health and social;
- income security for all, across the lifespan and regardless of employment status;
- universality, leaving no one behind;
- non-conditionality, other than based on income level and family composition;
- dignity, creating a process for receiving basic income that is comparable to other well-accepted income security programs in Canada, such as child and seniors' benefits; and
- autonomy, ensuring that recipients of basic income have the ability to spend money as they see fit to support the wellbeing of themselves and their family.

Additionally, we feel that key elements should guide the design of the pilot itself, consistent with scientifically rigorous public health research methods:

- designed to produce valid and reliable results, including the ability to detect outcomes of basic income; this will require an adequate benefit level, and sufficient length and sample size of the pilot, amongst other considerations;
- designed to produce generalizable results; this will require pilot sites and participants that reflect Ontario's demographic and geographic diversity, including indigenous communities;
- emphasis on health and social outcomes;
- overseen by those with research expertise, and by an advisory body of diverse stakeholders and those with lived experience of poverty and precarious employment; and
- long-term commitment to implementing, evaluating and sharing the results of the pilot.

These elements are described in more detail in our collaborative technical submission with PHO.

The Hon. Hugh Segal made several key recommendations in his discussion paper, which we support as in keeping with the above principles and elements:

- Much better alignment of income amounts with the cost of living and improved health outcomes, than current Ontario Works (OW) and Ontario Disability Support Program (ODSP) rates
- Replacement of OW and ODSP with basic income
- Use of the negative income tax model
- The testing of two benefit amounts, 100% and 75% of the Low Income Measure, over a period of, minimally, three years
- The testing of a higher and lower tax back rate to earned income
- The stipulation that no one be worse off than before the basic income program

We would emphasize, however, that basic income is an important form of income security not only for those on OW and ODSP - who are the primary targets of the discussion paper proposal - but also for those who are employed yet still living in poverty, including the precariously employed. Accordingly, the pilot methods and results should reflect this range of relevant recipients. This would require that pilot eligibility be based on income level, and not on current receipt of OW or ODSP.

While we clearly see a great deal of promise in a basic income pilot and program, we also believe that basic income can only have a strong impact on the health-damaging conditions of poverty and precarious employment if it is part of, and not a replacement for, a comprehensive approach that includes progress on other key policies and programs. This includes affordable high quality child care, affordable housing, expanded health benefits, and labour law reform, amongst others. In the immediate future, we also strongly urge the Province not to delay increasing social assistance rates to sufficient levels to meet the basic needs of all Ontarians in the short-term, while the basic income pilot is in progress.

Thank you for this opportunity to comment, and for your ongoing and internationally-recognized leadership on this pivotal health and social matter. We would welcome the opportunity to further support the design, implementation and evaluation of the basic income pilot.

Yours Sincerely,



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alPHa President



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OPHA President

- c. Dr. David Williams, Chief Medical Officer of Health
Hon. Eric Hoskins, Minister of Health and Long-Term Care
Hon. Michael Coteau, Minister of Children and Youth Services
Hon. Indira Naidoo-Harris, Associate Minister of Education (Early Years and Child Care)
Roselle Martino, ADM Population and Public Health Division
Paul Miller, NDP Critic, Poverty Reduction
Julie Munro, PC Critic, Poverty Reduction Strategy
Board of Health Chairs
Medical Officers of Health

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Collaborative Public Health Technical Submission to Ontario's Basic Income Pilot Project Consultation

Prepared by The Association of Local Public Health Agencies (alPHA), The Ontario Public Health Association (OPHA), and Public Health Ontario (PHO); January 17, 2017

Response to Consultation Guide Discussion Questions

Section 1: Determine eligibility for the Pilot

1.1 Are there specific groups of people or populations who should be targeted in the Pilot, such as the under-employed, social assistance recipients, or newcomers? Why?

The Pilot should include a cross-section of people living with insecure income, so that the experience and outcomes of Basic Income for different such groups of people can be assessed. All individuals whose income falls below the pre-determined threshold, regardless of their source of income, should be potentially eligible. In particular, however, the Pilot should target:

- **Social assistance recipients.** This will allow the Pilot to determine the impact of a change from a traditional welfare approach to a Basic Income approach, as well as a change (increase) in the income amount. The Honourable Hugh Segal's discussion paper clearly outlines the rationale to emphasize this population (1).

The working poor, including those precariously employed and under-employed. The poor health consequences of precarious employment have been well demonstrated (2, 3). As Lewchuk and colleagues note, precarious workers have the potential to "face more difficult working conditions, experience higher levels of job insecurity, have lower levels of control over their working conditions and arrangements, experience poorer quality social interactions, or be exposed to particular demands associated with their employment arrangements." (4) The working poor do not currently qualify for substantive benefits, and the precariously employed often fall through the cracks of current income security programs. Rates of precarious employment are already considerable and are anticipated to increase in the coming years (4, 5). In Ontario, the trend continues to shift towards a low-wage economy with substantial increases in part-time and temporary employment and fewer gains made in full-time employment opportunities (6). It is therefore imperative that the Pilot explore the implications of Basic Income for this population and phenomenon. Further, attention should be paid to the employment experience of populations over-represented as precarious workers, including women, racialized persons, indigenous persons, immigrants, people with disabilities, and youth (7, 8).

- **Young adults transitioning from school to the labour market.** According to Forget and colleagues, young adults transitioning from education into the labour market are very likely to experience precarity in the job market and, therefore, their labour market participation is more likely to be affected by a basic income than most other age groups (9). While a Basic Income allows them to gain valuable experience and train further as appropriate, it also makes it possible for them to delay committing to a full-time paying job. Forget and colleagues note the potential concern from this delay, as reduced attachment to the workplace at a young age has long-term negative impacts on wage and career outcomes (9). Therefore, they recommend that young adults be closely examined by the Basic Income (BI) Pilot, to understand how to achieve the most positive outcomes for this population (9). Given the known health impacts of future income level and employment conditions (10, 11), we support this recommendation.

In addition to these target populations, we recommend that the Pilot also include:

- **Youth between the ages of 16 and 17 years old living independently of a parent or guardian.** The Honourable Hugh Segal's discussion paper suggests restricting the age for Pilot participation to 18-64 year olds (1). However, at the age of 16 years old, young people are legally able to move out of the residence of their parent/guardian but are no longer eligible to receive the Canada Child Benefit, and are not yet eligible to receive benefits through OW or ODSP until they reach the age of 18 unless they are able to identify a trustee¹. Youth is a critical transitional stage in the lifecourse between childhood and adulthood. Opportunities and experiences that occur in youth can set lifelong trajectories and can have long-term impacts on health and development in areas including employment and health (12). Youth who are forced to flee from unsafe family or domestic living arrangements (e.g., domestic violence, child abuse) are at heightened risk of adverse financial, educational, socio-emotional and health outcomes stemming from lack of familial, social and economic supports. These vulnerable youth should have access to a secure income source to provide them with the financial supports to live independently from adverse home environments, without facing homelessness. Therefore, it would be appropriate to include them in the Basic Income Pilot, in order to understand the implications of basic income for them as part of the eligible 16-64 year old population.

1.2 What should the Pilot use to determine eligibility? Should eligibility be based on an individual's income, or should eligibility be determined by total family income? Why?

We agree with Hugh Segal's recommendation that eligibility be based on family income level, while also respecting the need for individual income autonomy (1). He has suggested that the amount of benefits received by participants would be a function of both their net family income and their family composition, but that Basic Income payments would be equally divided and paid to all adults in the family in order to provide each adult with financial autonomy (1). He also suggests that mechanisms

¹ Note: If the Child, Youth and Family Services Act that was introduced by Minister Coteau in December 2016 is passed before Basic Income is piloted, this age recommendation may be reconsidered. If the Bill is passed, the age of eligibility for protection services would be raised from 16 to 18, which may address this gap in supports for this vulnerable population (Ministry of Children and Youth Services, 2016).

should be in place to allow for changes in family income and composition to be reflected in the payments within a given year, including circumstances such as divorce (1). Together, these recommendations would provide the ability for individuals to leave unhealthy relationships if necessary, without the fear of being without a source of income.

Section 2: Select the sites

2.1 What are the most important things to think of when selecting a Pilot location? Why?

The most important consideration is selecting a Pilot location that enables the primary research question(s) of the BI Pilot to be answered. The choice of BI Pilot location will have a significant impact on important factors related to the experiment, such as: the study population, project budget, hypothesized outcomes, etc. The context of the Basic Income experiment will impact the hypothesized outcomes across potential sites. Therefore, it is important to select a site that most appropriately allows the primary research questions to be investigated while maximizing BI Pilot efficiencies (e.g., costs, sample size).

2.2 How do you think Pilot sites should be selected?

As stated above, the BI Pilot site should be selected to most effectively and efficiently answer the primary research questions, prioritizing scientific principles. The population demographics of a proposed site will be critical to selecting an appropriate study population. The study population should be representative of the group of individuals to which the BI Pilot results should be generalizable to (i.e., the target population). For example, this may be those who would be eligible to receive a basic income should the Pilot be adopted for the whole province. Ideally, the BI Pilot should be designed to assess whether the impact of receiving a Basic Income is consistent across specific sub-populations of interest (e.g. social assistance recipients or the working poor) and geographic contexts (such as rural, small urban, large urban, and First Nations communities). This decision should be made prior to the initiation of the BI Pilot as these sub-populations will need to be oversampled within an RCT, or prevalent within a saturation site community, to ensure there is enough sample size to properly investigate the impact of the Basic Income within these groups. For example, to study the impact of receiving a Basic Income on perinatal outcomes, which have been shown to be positive(13, 14), a sufficient number of expectant mothers would have to be included in the BI Pilot to investigate this potential outcome. Similarly, sufficient low-income families with school-age children would need to be sampled to examine whether increased income through a Basic Income would translate into the hypothesized improvements in child test scores (15, 16) or Readiness to Learn (or Early Development Vulnerabilities) based on the Early Developmental Instrument (EDI)(17). Therefore, special consideration should be given to ensure that the study population from any proposed Pilot site is representative of the target population, to ensure the generalizability of the BI Pilot findings to the intended groups.

Community characteristics should also be considered in selecting a site. The degree to which a community is geographically isolated may also be important if a saturation site approach is selected, to reduce contamination of intervention effects across geographical borders. Additionally, available infrastructure, the working relationships between different sectors (e.g., housing, children's services,

social assistance) and available data resources may also be considered to improve efficiency in administration and management of the BI Pilot.

Finally, a community's willingness to participate in the BI Pilot should also be considered.

2.3 Do you think it's important to have saturation and RCT sites? Why?

The choice of main research questions and outcomes should drive the design of the BI Pilot. It should be emphasized that there is no "best" study design for the BI Pilot without a specific research question. Different study designs will be more or less effective for answering specific research and policy questions. For example, an RCT design may be more effective in answering questions related to the optimal parameters of the negative income tax model, whereas a saturation site would be necessary to measure the community level impact, or social multiplier effect, resulting from the interactions between individuals receiving a Basic Income. Not measuring the social multiplier would result in an underestimation of the impacts of receiving a Basic Income. Forget hypothesized a social multiplier was at work during the MINCOME experiments, helping to explain why high school students in Dauphin were more likely to complete high school than their rural or urban counterparts (16). Therefore, the BI Pilot study design should be closely linked to research questions to enable the impacts of receiving a Basic Income to be detected, and to causally link Basic Income to the main study outcomes.

Independent of the choice of study design, the comparability of the selected control group is an important factor for consideration. Selecting control participants or community(s) (i.e., those that do not receive the Basic Income intervention) that are as similar as possible to the intervention community (e.g., in demographic characteristics and health status) is essential for minimizing potential confounding effects (both measured and unmeasured) and therefore ensuring that any observed effects are caused by the Basic Income intervention. For example, concerns have previously arisen around the comparability of the intervention and control groups when examining the effects of unconditional income transfers on birth outcomes (18). Methodologically, there are a number of approaches that should be considered for deriving control groups, such as: collecting primary data from controls, propensity score matching and synthetic control groups.

2.4 Should the government consider phases for sites e.g. starting with RCT and doing saturation sites later?

No. There is sufficient evidence to proceed with investigating the benefits of the BI Pilot for both the RCT and saturation sites simultaneously. Delaying the experiment in phases will only delay the evidence to move forward with policy-options informed by the BI Pilot.

However, it would be advised that the distribution method of the intervention (i.e., getting the income to the participants), regardless of the Pilot design, be tested before initiation of the main BI Pilot. This will reduce any complications associated with the delivery of the intervention that would have an impact on potential outcomes. This may require committing additional resources to help participants navigate delivery of the intervention.

Section 3: Design the benefits

3.1 Should the Basic Income amount be enough to significantly raise incomes and reduce poverty, or should it provide a base level of financial modest income floor to provide a certain level of stability? Should the benefit amount alone get people out of poverty or should it be a combination of benefits and earnings that accomplish this goal? Why?

The Basic Income amount should provide enough money to meet basic needs, and to live with dignity and the opportunity for societal participation (i.e. reduce many aspects of the poverty experience). The benefit amount alone should be sufficient to raise people out of poverty, as that is the intention of Basic Income: to ensure that, regardless of circumstance, all individuals have enough money to meet their basic needs. There will always be people who cannot participate in paid work or are unable to find a job for a range of reasons. The Basic Income amount should be sufficient to ensure that these individuals are not living in poverty, and that the health consequences of poverty are prevented.

It is difficult to suggest a Basic Income amount that would be 'sufficient' from a health perspective, as there is a gradient in health improvement with each level up the income ladder (11). Simulation modelling could be undertaken prior to the Pilot commencement to better estimate health improvements at different levels of the LIM. However, 100% of the low income measure (LIM) is a reasonable estimate to achieve the intended purpose of Basic Income and to anticipate health improvements. Using the Nutritious Food Basket Survey approach required of all Ontario Boards of Health within an example health unit area (19), data suggests that 100% of LIM would have the benefit of allowing a family of four to purchase healthy food and to sit below the threshold for spending 30% or more of their total household income on shelter expenses – a marker of housing affordability (data available upon request). For one-person households receiving 100% of LIM, after purchasing healthy food one would still need to spend over 30% of income on shelter, but a considerably lower proportion of income than current OW and ODSP recipients do (data available upon request). Therefore, these calculations indicate that a Basic Income amount of 100% of LIM would lead to greater likelihood of all Ontarians being able to afford adequate food and housing – key determinants of health - regardless of personal financial circumstances. Furthermore, it is known that Canadians in the lowest income quintile experience a disproportionately high burden of morbidity and mortality; a recent report from the Public Health Agency of Canada estimates that socio-economic health inequalities cost the health care system \$6.2 billion annually, with the lowest income quintile accounting for 60% (or \$3.7 billion) of those costs (20). At 100% of LIM for individuals (\$19,460 after-tax) (21), people would be brought above the current upper threshold for the lowest income quintile (\$16,000 after-tax in 2010)(22), holding promise for improved health.

With that said, it has been calculated that guaranteeing 100% of the LIM or the LICO to all individuals would represent a very large increase in public expenditure(23, 24), even though it is likely in the short, medium, and long-term to lead to progressive savings in health care spending and many other areas of public spending. If there is potential that this expenditure will not achieve the necessary public and political will for long-term implementation, it is prudent to also pilot a lesser amount that is still a substantial improvement from current social assistance rates. As such, we support the piloting of 75% and 100% of LIM as recommended by Hugh Segal, in order to compare the outcomes of these

approaches. Either way, if a Basic Income program were to be fully implemented in future, it would be imperative that it be indexed to inflation so that benefits rise with costs of living.

Beyond the health impacts of individual income levels, evidence strongly suggests that the extent of income inequality in society is an important determinant of population rates of a range of poor health and social outcomes (25). While the Basic Income amount itself may only go a moderate distance in addressing the large income inequalities that currently exist in Canadian society, the choice of taxation approach through which it is funded has strong potential to help address this important issue.

3.2 Beyond money, what other services and supports (e.g. employment, mental health, housing, etc.) are needed to accompany the Basic Income? Which are most important? AND

3.3 What elements of Ontario Works and ODSP should Basic Income replace? What about other benefits outside of Ontario Works and ODSP, such as help with childcare, employment start-up benefits to help cover the costs of trade tools, uniforms, etc., or drug and dental benefits? Why or Why not?

Response to 3.2 and 3.3:

We recommend that Basic Income should replace direct money payments to current OW and ODSP recipients, and should also provide these payments to others in low income who are not currently receiving OW or ODSP (as per our response to Section 1.1). Basic Income should not, however, replace other benefits currently provided to OW and ODSP recipients, such as medical and dental coverage, employment and housing assistance benefits and other mandatory and discretionary benefits as indicated by the Ministry of Community and Social Services (26). These benefits should continue to be provided to OW and ODSP recipients as well as to anyone else receiving Basic Income, as many of these benefits are otherwise unaffordable on a modest income and people may be faced with having to make a choice to purchase them or purchase other essential goods and services. In turn, foregoing benefits that are vital for adequate prevention or early treatment could lead to detrimental health and social outcomes.

We strongly support and see a great deal of promise in a BI Pilot and program in Ontario. We would like to emphasize, however, that a Basic Income can only have a strong impact on the health-damaging conditions of poverty and precarious employment if it is part of a comprehensive approach that includes progress on other key policies and programs. These include an affordable high quality child care system, affordable housing, labour law reform, and expanded health benefits, amongst others, as has been advocated for by public health organizations (27-29).

3.4 What other factors should be considered when determining the Basic Income level. Why?

We support Hugh Segal's recommendation to provide more income to people with disabilities, due to the additional barriers faced to paid employment and the extra costs of living with certain disabilities (1). We also suggest that it may be warranted to provide additional income to lone parents, given the unique barriers they also face to paid employment, their considerable over-representation amongst low income families, and the substantial health and social consequences faced by children raised in poverty

(30). Rates of food insecurity are also higher among lone parent households than non-lone parent households (31).

Section 4: Deliver the Basic Income Pilot project

4.1 The Discussion Paper recommended a NIT model for the Basic Income. Do you agree with this recommendation? Why or why not? If not, what model would you prefer?

Both a universal demogrant or a negative income tax (NIT) model would inherently increase incomes for those in low income groups. While the demogrant model has the potential of eliminating the stigma of income benefits due to its universal nature (32), the NIT model used in the MINCOME experiment has also been demonstrated to reduce stigma (33). An NIT is considerably less costly to fund at the outset, and therefore it has been suggested that it is the more feasible model in the Canadian setting and (34), as such, may be the most appropriate model to pilot.

4.2 Should the Pilot consider delivering payments in an alternative method to the Canada Revenue Agency delivery system proposed in the Discussion Paper, if they are available?

Whichever method is selected should be simple, reliable, and work smoothly in conjunction with other benefit payments. One advantage of using the Canada Revenue Agency is that it would build infrastructure for other basic income experiments to take place in other provinces, and also test a more sustainable model should the policy be scaled up to the full populations of Ontario or all of Canada.

4.3 How should the Basic Income respond to changes in income circumstances?

An important feature of Basic Income is its ability to respond to changes in income circumstances, so that it provides income security (with its associated health implications) to people with anticipated and unanticipated fluctuations in income. This may include job loss, personal illness, need to care for a young child or aging parent, changes in marital status, etc. The ability for income level and Basic Income payments to be assessed and change on a frequent basis if required, as recommended in Hugh Segal's discussion paper, is a necessary element (1).

Section 5: Evaluate the Pilot's outcomes

As outlined in Hugh Segal's Discussion Paper, the receipt of Basic Income is hypothesized to impact a number of potential outcomes (1). How to incorporate the required complexity into an evaluation framework presents an important challenge and should not be underestimated. For both Basic Income advocates and sceptics alike, the selection and measurement of appropriate outcomes on which to base the success of the BI Pilot will be essential to the evaluation of this important social experiment.

With this in mind, we support two recommended actions articulated in Hugh Segal's Discussion Paper to evaluate the outcomes of the BI Pilot (1). **First, the establishment of both a Basic Income Pilot Advisory Council (AC) and a Research Operations Group (ROG) is essential to oversee the planning and execution of the BI Pilot's evaluation.** With a function of advising on and overseeing the operations of the Pilot, the AC should be representative of the perspectives of community members, community agencies as well as public health organizations such as the Association of Local Public Health Agencies

and the Ontario Public Health Association. The ROG should bring together a group of experts from the proposed outcome areas who will assist in selecting primary research questions to test regarding the impacts of the BI Pilot, identify outcomes and advise on evaluation methodology. For example, Public Health Ontario is ideally situated to provide scientific and technical advice on population/public health outcomes. Ideally, the ROG would also inform the study design, participant selection, availability of data and data collection procedures including how best to measure the proposed outcomes. **Second that the proposed phased implementation for the BI Pilot be adopted to ensure that appropriate infrastructure (e.g., data sharing agreements, data infrastructure and standardized measurement tools) are in place prior to rolling out the BI Pilot.** Collecting data from pre-baseline (if possible), baseline, during the experiment as well as longitudinal follow-up (either directly or through administrative data) would be advantageous to evaluate the impact of the BI Pilot. An organized approach will maximize synergies to allow for efficient data collection and analyses to evaluate the impact of the BI Pilot.

5.1 The discussion paper recommends measuring ten outcome areas. Rank these outcome areas in order of importance:

The time horizon of the BI Pilot is an important factor when considering which outcomes are likely to be impacted. With this in mind, it is necessary to specify whether a meaningful change in a potential outcome from receiving a Basic Income would be expected over the short-, medium- or long-term. Outcomes that are highly sensitive to short-term income relief are most likely to show meaningful change during the time horizon of the BI Pilot. For example, in the short-term receiving a Basic Income is hypothesized to alleviate **poverty and food insecurity** (i.e., lack of access to adequate food because of financial constraints) (35-37), **reduce psychosocial risk factors** such as life stress (i.e., worrying less about money) (38), and **increase mental bandwidth** (resulting from decreased participation in social assistance system) (39).

Moreover, significant health impacts over the short term that have been associated with providing increased incomes or rent-geared-to-income housing include those related to mental health, psychological distress, and pain (38, 40, 41). In the BI Pilot it will be important to collect data regarding the impact of receiving a Basic Income on acute measures of mental and physical health. Where possible, this information should be collected using validated measurement tools similar to existing population-level data sources to allow for comparability across other study populations in Ontario and Canada, such as the Canadian Community Health Survey (CCHS). This will facilitate the comparison of BI Pilot participants with the Ontario population and sub-populations of interest. Further, oversampling of the CCHS or other Statistics Canada surveys could possibly be done in areas where the basic income is implemented as an efficient and cost effective way to build on existing data collection infrastructure using validated survey tools.

In addition to health outcomes, the impact of receiving a Basic Income could impact health-care utilization and costs, which are also indirect measures of health outcomes. Both low socioeconomic status (i.e., low income) and food insecurity are highly associated with high-cost health care users in Ontario (42, 43). In addition, *future* high cost health care utilization has been shown to be associated with income, education, food security and housing in Ontario (44). In the MINCOME experiments, Forget

highlighted the impact of receiving a Basic Income on decreasing the gap between intervention and control communities for hospitalizations related to “accidents and injuries”, hypothesizing that influencing factors may be that individuals with more income security would not need to work in dangerous jobs, would be less likely to consume alcohol and other substances that put them at risk for injuries, and children may have greater parental supervision (16). Further, hospitalization due to mental health diagnoses followed a pattern very similar to that of accidents and injuries (16).

Where possible the BI Pilot should collect information on outcomes that have been questioned by some as potential unintended consequences of receiving a Basic Income; for example reduction in labour force participation or increased prevalence of negative health behaviours (e.g. smoking, alcohol and drug use). While there is often no or little evidence to support these claims, it is important to understand, anticipate and measure potential unintended consequences of interventions.

It is necessary to consider more than solely which outcomes to evaluate in the BI Pilot. **A detailed theory of change describing the complex mechanisms through which receiving a Basic Income is hypothesized to change the primary outcomes should be developed before the BI Pilot is initiated** (45). By clearly articulating the proposed mechanisms, and resulting data collection, a more complete understanding of how outcomes were changed can be used to possibly explain circumstances when the hypothesized change did not occur.

Within the proposed time horizon in Hugh Segal’s Discussion paper (1), it will be challenging to assess the impact of the Basic Income on mid- to long-term outcomes. It is important that consent to be followed up for research and evaluation purposes be sought from all participants in the BI Pilot. This will enable secondary research and evaluation, not part of the original BI Pilot timetable, and thereby enhance the potential learning opportunities from this important social experiment. For example, consent to follow-up would enable Basic Income recipients to be invited to participate in focus groups or key informant interviews to better understand for whom, how and in what contexts the intervention works. In addition, permission and the necessary information to link BI Pilot participant data to administrative and health databases will greatly enhance research and evaluation efforts to understand the impact of the BI Pilot on both primary and secondary outcomes over longer time horizons. The benefit of administrative health data in evaluating population health interventions were observed in evaluating the health impacts of the MINCOME experiment (16).

More details are provided in the alpha-OPHA discussion paper on “Measuring Community Health Outcomes for a BI Pilot” submitted to the Honourable Hugh Segal as part of his consultations for the Basic Income Discussion paper.

We have commented primarily on health outcomes including food insecurity, though we see value in measuring many of the other listed outcome areas as well, particularly to establish a theory of change. Some of these are essential in order to understand the operational aspects of basic income (i.e. administrative efficiency, and functionality for users), and many others are themselves important determinants of health (i.e. social inclusion, housing, education, etc.). We would suggest that ‘work behaviour’ be replaced by or supplemented with ‘time use’, so that non-market forms of work and

caregiving and time for personal health are also captured (e.g. volunteer work, child care, parental care, personal sick leave in absence of other benefits, etc.).

To facilitate research and evaluation operations a number of considerations should be taken into account to evaluate the BI Pilot:

1. Build a flexible research infrastructure, similar to the Social Data Research Initiative described by Hugh Segal in his Discussion Paper (1), and make it available to independent researchers. This will greatly increase opportunities for research and evaluation outside of the main objectives of the BI Pilot, and therefore enable the Pilot itself to have more focused objectives. For example, adding income information collected for tax purposes to administrative datasets will provide a more objective measure of income and wealth in study participants. The data infrastructure should aim to enhance data collected as part of the BI Pilot through linkage with routinely collected administrative data. This process would leverage existing data routinely collected by the government to build a rich new data resource while reducing administrative costs and complexity of collecting data on all potential outcomes of the BI Pilot (9). Ideally, the effort would result in the creation of harmonized datasets including information on income, health, health care utilization, education, employment, interactions with the judicial system and other relevant public organizations, including municipalities and regions. Making this resource available to independent researchers, whether through Statistics Canada Research Data Centre Networks or other means such as the Institute for Clinical Evaluative Sciences (ICES), would greatly increase the utility of this resource to produce policy-relevant evidence regarding the effectiveness of the BI Pilot.
2. Identify areas of potential synergy between research infrastructure and the administration of the BI Pilot more generally during pilot development phase. For example, cooperation between Provincial and Federal Government could be used as a model for Basic Income experiments across Canada (of which there is great interest). In addition, it is also worth considering how any infrastructure used to evaluate the BI Pilot could be used if a universal Basic Income policy was scaled up.
3. Dedicated funding should be specifically allocated to support research and evaluation of the BI Pilot, including the proper research and evaluation infrastructure. Moreover, providing funding opportunities to support independent researcher projects, for example in collaboration with the Canadian Institutes for Health Research (CIHR), will greatly enhance the evidence generated from the BI Pilot.

5.2 Do you think that data and evaluation results should be made public in an ongoing basis?

Yes. A robust knowledge translation (KT) strategy will be essential to explain to the public the BI Pilot findings and their implications, including recommendations on why a Basic Income policy should or should not be undertaken. Critically, public awareness needs to be built over the course of the Pilot, and not only at the end.

5.3 What changes in behavior would you expect to see with a BI? What kind of results should we see from the Pilot to call it a success? Why?

Much of this question has been discussed above. However, one additional point is that success should not be determined based on cost-effectiveness of the BI Pilot alone. Regardless of the study design, it will be impossible to truly measure the impact (on any outcome including costs) of receiving a Basic Income. The degree to which the BI Pilot helps support the values related to the alleviation of poverty (e.g., respect for human dignity) and the improvement of social assistance programs (e.g., ease of receiving benefits and reduction of stigma) are important outcomes.

5.4 What strategies can we use to encourage people to participate in the Pilot?

For participants who are offered a Basic Income, it will be necessary to provide assurance that payments will be secure, sufficient, and adaptable to their changing circumstances. Also, they should be assured that no one will be worse off as a result of their participation.

For those selected as controls, if they are required to dedicate time for their participation, then a small additional amount of income could be given to respect their time spent answering questions, to potentially improve their willingness to participate, and to reduce attrition.

5.5 To measure outcomes, we would need people to share their personal information, including linking administrative data together. What concerns would you have about using this information to see how people use benefits and services differently after getting a BI? How can we make you feel that your information is secure?

Any data collected as part of the Pilot should be governed by the highest standard of research ethics and privacy, for example those set out in the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (46).

5.6 So that we can compare the outcomes of BI to the status quo, we would need people to share their personal information, even if they didn't receive the BI. Would you be comfortable with this so that we can understand these differences?

Yes, as long as any data collected as part of the Pilot should be governed by the highest standard of research ethics and privacy, for example those set out in the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (46).

5.7 If you are a Pilot participant, should you receive results prior to any public report release?

Yes. BI Pilot participants should receive aggregate level results prior to the release of any public report. This is consistent with standard research ethics.

Additional comments

Two additional points raised in a Mowat Centre report by Forget and colleagues warrant emphasis (9). First, the experience of MINCOME made clear that it is essential that a proactive approach be taken to

ensure the complete implementation of the BI Pilot, along with its full analysis and reporting, regardless of economic or political circumstances. Consideration should be given to legislating this (9).

Second, a robust community engagement strategy will be critical as the Pilot is planned, implemented, and evaluated, to ensure that the public is well informed and engaged throughout, as the notion of a Basic Income is a considerable shift in social policy that most of the Ontario public is likely not yet familiar with. This engagement strategy should be deliberate and inclusive, in order to begin to address frustration and mistrust that exists among some individuals and organizations across the province on the issue of social assistance and poverty, and to help overcome this potential barrier to successful implementation of the BI Pilot.

Thank you for this opportunity to provide feedback into the design of Ontario's Basic Income Pilot.

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Submission to Special Advisor on Basic Income Hugh Segal, August 17, 2016

Overview

The Association of Local Public Health Agencies (alPHa) – Ontario Public Health Association (OPHA) Health Equity Workgroup is pleased to have this opportunity to provide additional input into the basic income pilot discussion paper being prepared by Special Advisor Hugh Segal. Following our consultation meeting with Hugh Segal and Maripier Isabelle on July 14, 2016, further advice was requested on the measurement of community health outcomes. The Table on page 4 provides the specific community health indicators and data sources we recommend, and the remainder of the submission provides rationale for these recommendations, as well as related recommendations on study design, individual-level data collection, and the potential role of the public health sector.

The Complex Relationship between Income and Health

Understanding the complex relationships between income and health can inform the design of Basic Income Pilot study. Income is related to health in three ways: through the gross national product of countries, the income inequalities that exist within a country/province, and the actual income of individuals (Marmot, 2002). The latter two are the most important when considering health inequalities in a high income country such as Canada. While providing a Basic Income (BI) may have some influence on income inequalities - especially if provided widely at a provincial level - it is most likely the influence on recipients' income levels and income security that will be associated with the most significant health outcomes in a community.

Beyond individual income levels and income security, neighbourhood level effects also contribute to health status and can mitigate or exacerbate the impacts of individual income. Considering this, the BI pilot must impact a sufficient number of individuals within a community and provide a sufficient enough increase in income to actually impact the health of a community. Taking into account both individual and community level impacts of a basic income, two approaches to measurement of health outcomes are required. First, an overall estimate of the community level change in a health outcome, and second, disaggregating (i.e. breaking down) each health outcome by income level to determine if there is more of a change in those in the lowest income group. We would anticipate that the improvement in health for those in low income (and who, therefore, may receive BI) would be greater than the improvement for those in high income, contributing to lessening health inequalities, which is an important outcome to demonstrate. This "income gradient" is usually examined by comparing the health of the highest income quintile (top fifth) in a community versus the health of the lowest income quintile (lowest fifth) in a community, either by dividing their rates (a relative measure of inequality) and/or by subtracting them (an absolute measure of inequality) (CIHI, 2015).

It is also important that the changes in the income gradients for health outcomes are examined within the context of the overall change to income inequalities in the community as a result of the BI provided to residents of the pilot community. For example, one might expect to see a reduction in health inequities between income groupings that mirrors the reduction of income inequalities themselves.

While the relationship is complex between income and health, it is worth considering the key mechanisms through which income is thought to impact the measured outcomes, i.e., through a direct effect on material needs (e.g. healthy food, safe housing, affordable prescription drugs and dental care), or through an effect on social connectedness and the opportunity to control life circumstances (e.g. ability to make choices, reduced stress). Both aspects should be considered in the selection of community level health outcomes.

The Basic Income Pilot and Community Level Health Outcomes

Receiving a basic income is hypothesized to impact health outcomes through a number of complex mechanisms. The most well-known and documented health outcomes associated with income are: smoking, chronic diseases, all-cause mortality, and life expectancy. These health outcomes and their associated inequities are slow to change over time, and may not be the best ones to select when the time horizon to examine outcomes is relatively short, as in the case of a BI Pilot. A number of studies that have examined the health impacts of providing income and/or housing supports have found limited improvements in health outcomes, often because follow up periods are too short (Larrimore, 2011; Pickett & Wilkinson, 2015). Therefore to understand changes in community level health outcomes, indicators need to be selected which are highly associated with income but also where a meaningful change would be expected in a short period of time.

Some of the shorter term significant health impacts that have been associated with providing increased incomes or rent geared to income housing include those related to mental health, psychological distress, and pain (Costello, 2003; Dunn, 2015; Gibson et al, 2014). In addition, there have been improvements in outcomes that are more closely related to income itself, such as food insecurity (i.e. affording nutritious food) and life stress (i.e. worrying less about money) (Emery et al, 2013; Dunn, 2015). As well, Tarasuk et al (2015) has shown that household food insecurity is, in turn, a robust predictor of health care utilization independent of other social determinants of health.

The most direct health evidence we have of possible health outcomes related to BI comes from Forget (2011) and Brownell (2016). Forget (2011) highlighted the impact of increased incomes on decreasing the gap between intervention and control communities for hospitalizations related to “accidents and injuries”, hypothesizing that influencing factors may be that individuals with more income security would not need to work in dangerous jobs, would be less likely to consume alcohol and other substances that put them at risk for injuries, and children may have greater parental supervision. In addition, hospitalization due to mental health diagnoses followed a pattern very similar to that of accidents and injuries. Another source of direct evidence is from Brownell et al (2016). This research examined the impact of receipt of an unconditional prenatal income supplement over six years in Manitoba. Health impacts included a 21% reduction in low birth weight and an 18% reduction in preterm births, along with improvements in small for gestational age births, breastfeeding and large for gestational age births. Shankardass (2014) showed similar relationships in perinatal outcomes with income in Nova Scotia.

The perinatal period and early childhood experiences can change one’s health trajectory over an entire life course. These two critical stages along with other times of vulnerability and dependence such as the transition to adulthood (“emerging adult” years) and older age, is where the impact of the social determinants of health can have more influence (Davies, 2011). Therefore health outcomes associated with these specific vulnerable life stages may be more likely to show a shift as a result of BI. Examples of perinatal outcomes have been mentioned previously (Brownell, 2016) and support this hypothesis. In addition, studies have reported on improvements in child test scores associated with increased incomes (Milligan & Stabile, 2011; Forget, 2011). Importantly, there have been consistent associations between Readiness to Learn (or Early Development Vulnerabilities) based on the Early Developmental Instrument (EDI) and income levels (CIHI, 2014).

Beyond health outcomes specifically, there are a number of social outcomes that are closely related to health (i.e. social determinants of health) which are very important to measure. We have not included substantial content on these outcomes in this submission as we were asked to focus on community health outcomes, however we would be happy to comment on these further in future. Examples include prevalence of housing affordability (those spending 30 percent or more of their income on housing costs) and unemployment, which could be monitored with the long form census, and [Ontario's Poverty Reduction Indicators](#), specifically high school graduation rates, education progress (grade 3 and 6 EQAO results) and the prevalence of youth not in education/ employment/ training, which are valuable indicators that are related to an individual's health trajectory and may be available at a community level.

When examining prevalence of a health outcome, statistical power is maximized when the prevalence occurs in about one-half of the population. For a very low prevalence (e.g. <10%, such as for certain perinatal outcomes), it is worth noting that a larger sample size will be required to detect significant differences when the effect of an intervention actually exists. This was considered when making recommendations on potential indicators, generally suggesting outcomes that are of relevance to most of the population and not so rare that too few cases will be found in the community under study.

Disaggregation of the Outcomes by Sex and Income:

It is also worth noting that a couple of studies that were reviewed indicated that examining the changes in health outcomes by sex is important, as some outcomes may be more likely to occur in males versus females (such as emotional problems and pain) or in females versus males (such as improvements in food security) (Milligan & Stabile, 2011; Dunn, 2015).

As described earlier, it is not only the absolute change in health outcomes at a community level that should be considered over the duration of the pilot, but also the change in the gap in each outcome between the richest and poorest members of the community. Outcomes need to be disaggregated by income groups, so that the change in health for each group and the change in health inequality (or gap) between groups can be detected.

Association of Public Health Epidemiologists in Ontario (APHEO) Core Indicators:

Based on the considerations above, the table on the following page summarizes the community health indicators and data sources that may be most appropriate for consideration for Ontario's BI pilot.

APHEO has collaborated with partners to develop over [120 standardized public health indicators](#). Many of these indicators are already being reported at a local level by public health units and baseline values may be available for larger communities. Wherever possible, the use of standardized indicators is recommended and consultation with local public health unit epidemiologists is advised.

Table: Community Level Health Indicators to Measure for a Basic Income Pilot

Category	Indicator	Data Source(s)**
Shorter Term Outcomes (< 3-5 years) – <i>most appropriate for a Basic Income Pilot</i>		
Mental Health & Addictions	Self-Rated Mental Health Life stress* Sense of Community Belonging* Emergency department visits for a mental illness or an addiction (Health Quality Ontario, 2016)	CCHS or RRFSS CCHS CCHS IntelliHEALTH
Household Food Insecurity	Household Food Insecurity* Vegetable and Fruit Consumption* (may be improved as a consequence of improved food security)	CCHS CCHS or RRFSS
Healthcare Utilization	All-cause Emergency Department Visits All-cause Hospitalizations Primary Care Visits	IntelliHEALTH IntelliHEALTH ICES (special data request)
Injury	Injury-related Emergency Department Visits* Injury-related Hospitalizations*	IntelliHEALTH IntelliHEALTH
Intentional Self-harm	Intentional Self-Harm Related Hospitalizations*	IntelliHEALTH
Perinatal Outcomes	Low birth weight* Pre-term birth rate* Small for gestational age*	IntelliHEALTH or Better Outcomes Registry & Network (BORN)
Medium Term Outcomes		
School Readiness	Children Vulnerable in Areas of Early Development (see CIHI, 2014)	The Early Development Instrument (EDI)
Self-Rated Health	Self-Rated Health*	CCHS or RRFSS
Smoking	Adult Current Smokers*	CCHS or RRFSS
Longer Term Outcomes (10+ years)		
Chronic Diseases	Chronic Disease Hospitalization* Prevalence of Chronic Diseases	IntelliHEALTH CCHS or RRFSS or a special request from ICES
Diabetes	Prevalence of Diabetes (special data request from ICES)	Ontario Diabetes Database
Mortality	Potentially Avoidable Mortality* All-cause Mortality* Life Expectancy*	IntelliHEALTH (Vital Statistics) IntelliHEALTH (Vital Statistics) IntelliHEALTH (Vital Statistics)

* indicates an APHEO core indicator

** a description of each data source can be found here: <http://core.apheo.ca/index.php?pid=261#Data%20Sources>

Finding the Signal in the Noise: Evaluating the Impact of the Basic Income Pilot on Community Health Outcomes

While selecting appropriate health outcomes is critical, this cannot be done without considering the methodological challenges that exist when attempting to attribute the impact of receiving a basic income on changes in health outcomes at the community level. Essential to disentangling these complex mechanisms is an appropriate study design and data collection plan.

Study Design

The design of the Basic Income Pilot will have a significant impact on the ability to measure resulting impacts on community health outcomes. Important features include:

- 1) Consideration should be given to the **benefit level (basic income) provided to participants in the intervention group** to ensure that it is at a level that is hypothesized to improve health outcomes. In addition, there may be consideration given to the value of randomly varying levels of the minimum basic income assigned to participants to be able to study the potential dose-response relationship related to changes in the basic income level on health.
- 2) **The size and number of communities that receive the basic income intervention.** Of particular concern is **to ensure sufficient statistical power to detect differences in health outcomes** that may result from BI, there needs to be a large enough sample size of people whose incomes have been enhanced/supplemented as part of the Basic Income Pilot. This can be achieved by (i) picking a large community to pilot, (ii) ensuring a saturation model is used as the intervention, and (iii) sampling sufficient respondents from the community to measure health outcomes. A statistician can be consulted to assist with both sample size as well as study design characteristics.
- 3) **The comparability of the selected control community(s) is an important factor for consideration.** Selecting control participants or community(s) (i.e. those that do not receive the basic income intervention) that are as similar as possible to the intervention community (e.g. in demographic characteristics and health status) is essential for minimizing potential confounding (both measured and unmeasured) and therefore ensuring that any observed effects are caused by the basic income intervention. For example, concerns have previously arisen around the comparability of the intervention and control groups when examining the effects of unconditional income transfers on birth outcomes (Racine, 2016).
- 4) **The time horizon of both the Basic Income Pilot and the follow-up for changes in health outcomes.** Extending the Basic Income Pilot over several years is essential for examining the potential cumulative effects of receiving the intervention. This approach would enable the study of whether the impacts of receiving a basic income go beyond protection against short-term income shocks and help shape life course trajectories for educational achievement, employment and health. In addition, the **study follow-up** for such a pilot needs to be long enough for health effects to be able to be seen. For some conditions and diseases, such as cancer, the impacts are not felt until many years later. Changes in eating behaviours and physical activity are compounded over time and lifelong changes may be necessary to see health impacts. As mentioned previously, shorter term health outcomes related to income are often most highly related to those with a direct tie to income, such as food insecurity, psychological distress, and self-rated mental health.

Therefore, to assess the impact of basic income on community health outcomes, careful consideration must be given to the benefit level assigned in the intervention, the population receiving the intervention, the comparability of the control population to the intervention population and time horizon of the Basic Income Pilot and study follow-up. To help ensure the strongest statistical power to detect changes in

community health outcomes from BI, one would want to consider a larger community, with a saturation site, over a prolonged period of time (as long as possible given this is a pilot project). If no improved health outcomes are found, it may not be an indication that BI is not achieving such outcomes, but that the initiative is too small and has not been in place long enough to see the delayed health impacts in the population. Short follow up periods have been noted as a challenge in previous studies that examined income interventions and their association to health outcomes.

Data Collection

To evaluate the impact of the basic income intervention on health outcomes, high quality data from before, during and after the intervention will be necessary. In parallel with the Basic Income Pilot and the measurement of community health outcomes as described above, it would be extremely valuable if individual level health outcomes were also measured by setting up a cohort study. The study population should include all participants receiving the basic income intervention and a control arm of comparable participants from Ontario receiving the current social assistance and benefits available to all Ontarians. The cohort study should encompass data collection on demographic factors, social determinants of health (e.g. food insecurity, housing), sources of income, aspects of the intervention (e.g. barriers to participation, what the money was used for, stigma), social assistance participation, health behaviours and mental health, social networks and other primary and secondary outcomes of interest. In addition, the survey should encompass other areas impacted by the Basic Income Pilot, including information on educational achievement, employment and economic outcomes. Where possible, this information should be collected using standardized measurement tools similar to existing data sources to allow for comparability across other study populations in Ontario and Canada. Moreover, collected data should be enhanced through routinely collected administrative data through data linkage. For example, adding income information collected for tax purposes for a more objective measure of income and wealth in study participants.

It is important that consent to be followed up for research and evaluation purposes be sought from all participants in the Basic Income Pilot study cohort. This will enable secondary research and evaluation, not part of the original Basic Income Pilot timetable, thereby enhancing the potential learning opportunities from this important social experiment. For example, consent to follow-up would enable BI recipients to be invited to participate in focus groups or key informant interviews to better understand for whom and how the intervention works. In addition, to enhance the health data collected as part of the cohort, permission and the necessary information to link project data to administrative and health databases will greatly enhance research and evaluation efforts, particularly the impact of basic income on health over longer time horizons. The benefit of administrative health data in evaluating population health interventions were observed in evaluating the health impacts of the MINCOME experiment (Forget, 2011).

Is a Basic Income Pilot Cohort Study necessary?

While there are existing data sources that can provide some of the information described above, primary data collection will be necessary to fully disentangle the impact of the Basic Income Pilot. A number of challenges can occur when trying to measure the health status at a community level, especially in smaller towns or rural locations. Consideration should be given to the following:

- **Individual Level Data:** There is no existing data source that will have individual level information on the intervention, outcomes of interest and potential confounders (e.g. demographic information) necessary to evaluate the community level health impacts of the Basic Income Pilot.
- **Administrative Data:** In the absence of including tax information into administrative data, it will likely not be possible to identify participants who received the intervention in the Basic Income Pilot. Data is also limited to information routinely collected by the health system. Information is often lacking at

individual level on socio-demographic factors and health behaviours. Using area-level indicators derived from the census will not be specific enough to evaluate an individual level BI intervention.

- **Survey Methodology:** Surveys such as the Canadian Community Health Survey may not be designed for analysis at the community level of geography and the predefined weights may not be appropriate to use. This is an important consideration for community level health outcomes comparisons, if for example CCHS participants were to be targeted as a potential control group. In order to effectively use CCHS data to measure outcomes of the pilot, the geographical area selected for the pilot needs to be defined in a way that is compatible with Statistics Canada's sampling methods. For instance, selecting Census Metropolitan Areas would ensure the CCHS sampling frame aligns with the pilot. In addition, changes to survey methodology are also important to consider for trends over time or combining multiple years of data. The CCHS underwent a major redesign for the 2015 cycle. As a result, Statistics Canada is recommending that data from 2015 onwards not be compared to data prior to 2015 (Statistics Canada, 2015).
- **Risk Factor Surveillance System (RRFSS):** Data collection could be enhanced through established collections of community level survey data such as the Rapid Risk Factor Surveillance System (<http://www.rrfss.ca>). In order to have sufficient sample size for the health outcomes associated with a Basic Income pilot, a customized survey available through RRFSS may be a solution. The purpose of RRFSS is to provide timely data relevant to local community needs where a specific sample size for a specific geography can be purchased with results available within 2 months. There are over [250 different modules](#) to choose from, and additional modules can be added at request. Fourteen of the 36 public health units in Ontario are currently using RRFSS and may be producing population health estimates at the municipal level.
- **Small Sample Sizes and Large Confidence Intervals:** There may appear to be changes in health outcomes over time, but because of small sample sizes there may be large confidence intervals (i.e. uncertainty about the exact size of the health effect). This, along with the many statistical comparisons to be made for various health indicators, may result in health differences that are not statistically significant. Sample sizes also need to be large enough to be able to disaggregate the community level health outcome into income groups (often quintiles), essentially increasing the required sample size five-fold.

Role of the public health sector in the BI pilot

Measuring the impact of the Basic Income Pilot on community health outcomes in Ontario will require an extensive multidisciplinary study. The public health community in Ontario has invaluable experience in this regard. The Association of Local Public Health Agencies (aLPHA) - Ontario Public Health Association (OPHA) Health Equity Workgroup, in collaboration with the Association of Public Health Epidemiologists in Ontario (APHEO), can provide important perspectives as to current community level health inequities in Ontario and which community health indicators should be assessed, in addition to supporting community-level conversations on basic income. We welcome the opportunity to provide advice on the planning and implementation of a Basic Income Pilot in these regards. In addition, a provincial-wide organization with extensive experience evaluating the impact of population-level interventions on population health and health inequities in Ontario would be ideal for conducting the proposed study. Public Health Ontario is one potential organization with the appropriate expertise, among others. Funding an independent study of the Basic Income Pilot can help avoid the MINCOME experience, where the pilot was ended without much analysis or a final report (Forget, 2011). Planning for and executing a proper study will be key to translating any findings from this experiment into knowledge and practice.

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