

# Examining the ethical underpinnings of Universal Basic Income as a public health policy: prophylaxis, social engineering and ‘good’ lives

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**Abstract:** At a time of COVID-19 Pandemic, Universal Basic Income (UBI) has been presented as a potential public health ‘upstream intervention’. Research indicates a possible impact on health by reducing poverty, fostering health-promoting behaviour and ameliorating biopsychosocial pathways to health. This novel case for UBI as a public health measure is starting to receive attention from a range of political positions and organizations. However, discussion of the ethical underpinnings of UBI as a public health policy is sparse. This is depriving policymakers of clear perspectives about the reasons for, restrictions to and potential for the policy’s design and implementation. In this article, we note prospective pathways to impact on health in order to assess fit with Rawlsian, capabilities and perfectionist approaches to public health policy. We suggest that Raz’ pluralist perfectionist approach may fit most comfortably with the prospective pathways to impact, but will still have concern for allocation of resources.

**Keywords:** Universal Basic Income; Upstream intervention; Rawls; Capabilities; perfectionism

COVID-19 has brought the UK’s health policy to the forefront of public consciousness. Although recent Conservative Governments have sought to pursue a ‘prevention agenda’[1] in order to shift public understanding of the National Health Service as consisting solely of a ‘National Hospital Service’,[2] the state’s response to the pandemic has seemed reactive and *ad hoc*. Given that no vaccine is available at the time of writing and that treatment is, at this stage, experimental, there is good reason to consider alternative means of promoting health. In that context, Laura Webber and colleagues[3] have called for a ‘health in all policies’ approach grounded in ‘upstream interventions’ that address the social determinants of health, such as inequality, rather than the behavioural consequences further ‘downstream’, such as diet.[4] The importance of such interventions has become apparent during the pandemic, which has disproportionately affected those in lower socioeconomic groups and been exacerbated globally by inequality.

Universal Basic Income (UBI) has been presented as one such intervention,[5, 6] with research indicating a possible impact on health by reducing poverty, fostering health-promoting behaviour and ameliorating biopsychosocial pathways to health.[7] UBI ensures a minimum income, but, unlike the UK’s Universal Credit,[8] it is not allocated on the basis of need or means. This is because, as the recent World Bank Report suggests,[9] UBI is defined by its being ‘paid to all, unconditionally, and in cash’, albeit with numerous caveats with regard to ‘amount and frequency, and whether children or noncitizens would benefit’ (p. 57). The novel health case for UBI as a public health measure has a complicated relationship to other justifications grounded in promoting citizens’ rights[10] increasing efficiency in welfare systems[11] and promoting growth.[12] With the Spanish Government announcing that it will introduce UBI as a direct response to the social and economic insecurity caused by COVID-

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19,[13] it is essential that the ethical underpinnings of a health focus are examined, since the philosophical justification for the policy has clear implications for design and implementation. This is true irrespective of the health system of a particular country, since the mechanism of impact is via social determinants of health.

In this article, we outline our theoretical pathways to health impact in order to examine three possible political philosophical approaches to advancing the policy. Bidanure's review of political philosophical positions on UBI indicates a spread of approaches ranging from clear Rawlsian deontic positions on one side and perfectionist, consequentialist positions at the other.[14] There are ways in which the health case for UBI maps on to and accentuates this schema. We have identified three emblematic positions that fit onto a deontological and perfectionist continuum to demonstrate the different implications that ethical underpinnings present to a novel health case for UBI. We suggest that the commitment of Rawlsian deontic accounts to neutrality may lead them to reject UBI as a public health measure on account of its potential to transform conceptions of the good. We then suggest that this may be less problematic for the capabilities approach, but that UBI may be rejected in favour of targeted interventions. Finally, we suggest that Raz' pluralist perfectionist approach may fit most comfortably with the prospective pathways to impact, but will still have concern for allocation of resources. We set aside questions regarding UBI's impact on other aspects of people's interests, but acknowledge that a transformative intervention such as this may have myriad incidental or indirect consequences. We begin by outlining the pathways to health.

### **Pathways to health**

While there have been few schemes that uphold UBI's universality, a number of studies of programmes that resemble UBI have indicated an impact on health.[15] These programmes include: minimum income guarantees, such as those in Gary, Indiana, US, Manitoba (MINCOME) and Finland (which replaced conditional welfare payments with unconditional payments to existing recipients, but rejected universality); periodic dispersions of public goods, such as the Alaska Permanent Dividend Fund and the Tribal Casino Cash Transfer; and small-scale experiments involving small cash transfers, such as the Madhya Pradesh Unconditional Cash Transfer Pilot (MPUCT).

The programmes in Gary, Indiana, US and the Alaska Permanent Dividend Fund have shown evidence of a positive impact on birth weight.[16, 17] The MPUCT pilot was associated with a 46% reduction in illness and injury not requiring inpatient hospital treatment,[18] the Finnish trial with reduced stress,[19] MINCOME with improved adult mental health,[20] and Tribal payments with reduced rates of psychiatric and substance abuse disorders among children.[21] Gibson, Hearty & Craig have produced a table of existing evidence as part of a systematic review of studies and, as part of this, have defined different conditional and unconditional cash transfer schemes.[22]

Johnson, Johnson and Weber[5] have argued that, although the evidence is clearly incomplete and studies designed and evaluated inconsistently, it is possible to identify three theoretical pathways to health through the introduction of UBI as an upstream intervention. This is summarised in figure 1. The pathways relate to transformation of people's socio-economic circumstances. First, UBI can reduce poverty, which increases the ability of individuals to satisfy their basic needs.[23] Second, UBI can provide social security to mitigate 'health inequalities and the structural conditions that put people "at risk of risks"', such as 'discrimination, poverty, residential segregation, inadequate schools, unemployment' (p. S47).[24] This reduces exposure to long-term social sources of stress, such as workplace and domestic bullying and abuse,[7, 19] which foster a wide range of stress-related conditions, as indicated by the Whitehall II Study of Civil Servants.[25] Third, by reducing unpredictability, UBI can reduce health-diminishing behaviour seen in those unable to perceive longevity.[26]

Where UBI fosters predictability, it can promote longer-term thinking that contributes to health and wellbeing, which may explain improved health among recipients of Tribal Cash Transfers.[27]

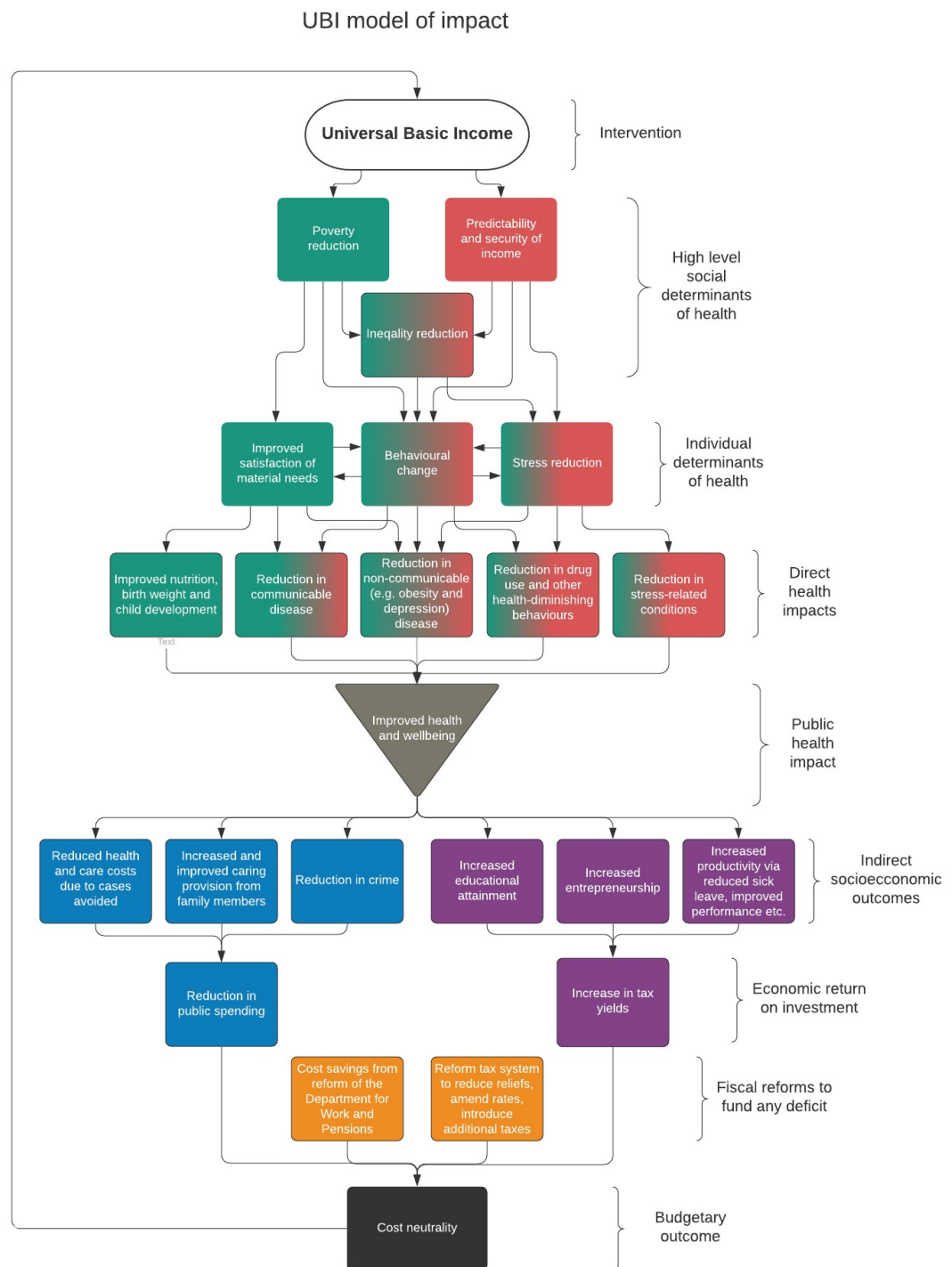


Figure 1. UBI model of impact

Each of these pathways requires that income be significant in size. Moreover, the focus on stress suggests that some health impacts can only be achieved if the income is unconditional. If the pathways depend upon individuals satisfying basic needs, then the cost may even amount

to something approaching the Minimum Income Standard (MIS).[28] In the UK, the MIS for 2019 for a single person with no children was £313.68 per week (net of direct taxes, such as income tax and national insurance, but gross of council tax).[28] What proportion of that income is derived from UBI is a source of disagreement for proponents. As we shall now show, different ethical underpinnings lead to different configurations.

### **Ethical muddles**

The notion that public policy should advance population health is a core working assumption for a number of key organizations to have assessed UBI, including Compass – a non-party political organization focused on social reform[29] – What Works Scotland[22] and, understandably, the World Health Organisation.[15] There is a working instrumentalist assumption that policies that promote health are good and, where UBI promotes health, it is good. In this regard, health is treated both as an unalloyed good and as a facilitative good for whatever other ends individuals may wish to pursue. Yet, there is seldom concern for the possibility that such goods can be realised through very different and much more clearly coercive means. There is not necessarily awareness that the line of reasoning may be shared with puritans within the Temperance Movement (and the Taliban) who sought to promote health via prohibition of intoxicating substances and criminalisation of those engaged in ‘private’ vices.[30] The enormous expansion of the prison population and the side-effects of prohibition on users’ health speak to the difficulty of promoting health coercively.[31] Such issues also speak to the ways in which conceptualisation of health may be subject to culturally contingent formulation,[32] even if health in terms of homeostasis may not.[33] It is for these reasons that liberals, such as Hayek,[34] have viewed state planning as the first stage on a slippery slope toward tyranny. There is not, yet, adequate consideration of that possibility in this instance.

This lack of concern for ethics is only exaggerated by proponents of UBI associating its prospective health impact with the ‘good life’.[35] This, clearly, has perfectionist, Aristotelian connotations in its association of health with human potential and its use of UBI as a means to that end. That UBI’s health proponents do not necessarily interrogate the normative ethics of their broader positions on promoting health may seem anodyne. However, understanding precisely their intention is fundamentally important to understanding what place instruments of health promotion play within broader, and often competing, public policy agendas. Improving understanding is one key step to developing more effective justifications for, and means of addressing opposition to, the policy.

### **Health as facilitative**

Whether social democratic left[36, 37] or libertarian right (e.g. Friedman and Friedman’s negative income tax),[38] the majority of UBI’s proponents have presented UBI deontologically as a means of upholding justice.[14] As Kantian approaches, they follow Rawls’[39] formulation of the right being prior to the good, viewing policy as a means of upholding respect for persons by acknowledging the dignity of human reason. In terms of Berlin’s[40] categorization of liberty, such proponents of UBI uphold negative liberty, being concerned with preserving a private sphere in which individuals are free from interference. In this regard, UBI resembles a Rawlsian social primary good[41] – one of several building blocks that secures freedom for individuals. Indeed, Rawls[42] follows Friedman, Hayek and others in upholding a minimum income guarantee. This account of UBI is concerned with the opportunity aspect of liberty.[43] Providing security from the coercion of others grants individuals opportunity to pursue their own conceptions of the good, whatever they may be. It enables the state to remain neutral with regard to particular conceptions of the good.[44]

Whether individuals achieve their conceptions of the good or not is only relevant in instances of individuals being prevented through coercion by others. Concern is for means, not ends.[45]

Perhaps the clearest indication of where UBI might sit as an instrument is provided by work by and on Rawls. Rawls views health as a natural primary good that is a pre-requisite of the pursuit of conceptions of the good[46, 47] which is subject to arbitrary distribution and not directly under the control of the basic structure of society.[42] Although mention of means of promoting health are sparse, Rawls does note that inoculation against disease may be beneficial to communities in sum[42] and that there is scope for government to promote public health, which may have distributive effects.[42] However, he also suggests that questions of healthcare relate only to special cases beyond the normal range of the citizen body[42] and that the primary good of income and wealth provides means of securing adequate treatment. Green[46] suggested that health's importance means that it ought to be introduced alongside the basic principles of justice, with citizens entitled to equal access to care irrespective of income. In contrast to this invasive revision of Rawls' principles of justice, Daniels (p. 165)[48] regards healthcare institutions as a fundamental means of providing 'for fair equality of opportunity'. Daniels is clear that socio-economic inequality fosters inequality in health and that without health, there cannot be equality of opportunity.[49, 50] As such, he favours a range of interventions to address socio-economic inequality, including investment in childhood development, nutrition programmes, and transformation of work to improve worker autonomy and skills development as well as to reduce stress.[51] This is attuned to the underpinning concerns in the prospective pathways to health outlined above. Rawls revised may provide support for a basic UBI. After all, UBI is 'basic' because it is grounded in concern for people's 'basic' needs, on which the attainment of health rests.[52]

This account is compatible with Mia Birdsong's[35] invocation of the 'good life':

Money (or the absence of it) can limit what you think is possible for your life, how you're able to spend time with your loved ones, where you're able to go, how you feel about yourself, and who you can be. Money, practically and psychologically, impacts how much agency we have. We all want 'the good life' however we define that, and these conversations made me think about what we believe about who deserves it (and who doesn't).

In Rawlsian terms, as an 'upstream intervention', UBI may serve as a basic public good on which all 'reasonable' comprehensive doctrines can agree, even if individuals themselves elect to pursue ways of life that are fundamentally detrimental to their health. In this regard, UBI may resemble what Rawls envisaged in terms of inoculation as a social good. Prioritizing the right over the good means that there can be no guarantee that individuals achieve the ends that they themselves regard as valuable, let alone a value that others may regard as valuable, such as health among the organizations noted above. Even if individuals invoke a 'good life', the state is not so obliged.

However, as Moskop (p. 335)[53] argues, the provision of support via UBI is uneven and may constitute a 'bottomless pit able to swallow all available resources and more'. Providing equal opportunity via health may reduce opportunities for the pursuit of other ends. Individuals may regard health as a subjective good[54] that ought not to be the basis for redistribution. Moreover, if UBI has a causal impact on health or promotes a particular conception of health there may be grounds for considering the possibility that it is coercive and partial. The behaviour change theoretical pathway to health may indicate just that. This coercion is both distinct from, and attendant to, any coercion involved in procuring tax to fund the programme. For that reason and others, Rawls may provide justification for a basic UBI

well below the MIS, such as that proposed by Reed and Lansley[26] to complement forms of income from the other opportunities facilitated by primary goods.

Rawlsian accounts view conceptions of the good as relatively fully formed and unmoving. Yet, there is evidence to suggest that economic status can influence personality type [55, 56] and that economic interventions, such as UBI, can affect personality traits[57, 58] as well as behaviour.[59] People's personality traits' being altered by an intervention challenges the assumption that conceptions of the good are fixed. The suggestion that economic instruments can be used as a means of promoting ways of life undermines the neutrality of the state. While both inoculations and UBI may have a prophylactic effect, the latter may also have an effect on people's very being in general and their conceptions of the good, in particular. Although not physically invasive, it may more closely resemble circumcision or other identity constitutive interventions that are justified on the grounds of public health.[33] Any justification for such transformative impact on the grounds of people's personalities being forged pathologically by harmful socio-economic circumstances slides very quickly away from respect for people's empirical selves, to concern for the 'true' or 'rational' selves associated with positive accounts of liberty.[40]

In this context, Hayek's[34] concern that a state's bureaucratic partiality leads to a general diminution in liberty may seem hysterical given that the end pursued is health. However, given that funding such an intervention necessarily requires an increase in taxation and given that the likes of Hayek[34] view taxation as being fundamentally coercive, there are reasons for such thinkers either to minimise or reject.[10] In this regard, the likes of Daniels may need to reconsider the extent to which investments in creating opportunity end up shaping citizens' thinking. This may be one philosophical reason for the UK Conservative Government's opposition to UBI.

### **Health as capabilities**

If Rawlsian approaches may find fault with UBI on the basis of health's relationship to conceptions of the good, there are some paradigms, such as Nussbaum's [60] capabilities approach, that speak forcefully of health as a central facet of human flourishing.[61] In this regard, it is not simply that health is the basis for opportunity, but that its absence precludes the realisation of human potential.[62] A life without health is not a fully human existence. Despite this Aristotelian heritage, Nussbaum upholds the priority of the right over the good [62] and the opportunity aspect of liberty. She holds both that practical reason, as the key distinguishing human capability, can only be realised in the absence of interference [62, 63] and that human dignity can only be upheld through respect for personhood.[61] However, she is less likely to be constrained by concern for social engineering than Rawls. This is because she invokes adaptive preference to explain people's preferences for conceptions of the good that undermine their broader interests. She cites the case of women in patriarchal societies who support FGM by way of illustration.[60] As such, although she shares Rawlsian commitment to the priority of the right over the good, she believes that injustice has the capacity to shape people's perspectives, including with regard to health. If achieving justice removes adaptive preferences, so be it.

Put simply, Nussbaum is clear that it is rational to realize health,[61] that policy ought to promote the resources that individuals require in order to realise health and that the quantity and type of resources required necessarily differ from the person to person due to the uniqueness and separateness of persons.[64] The specificity of needs is particularly important insofar as it indicates that justice depends upon differential treatment of citizens. Disabled people necessarily require additional goods in order to live good lives.[64, 65, 66] Concern for the particular needs of individuals is one of the key reasons that Nussbaum rejects as inadequate the primary goods approach of Rawls.[66] This calls into question the value of 'upstream'

interventions grounded in equal provision of goods. As such, Nussbaum is more likely than Rawlsians to view UBI only as part of a more comprehensive set of interventions to support realisation of health. Indeed, there are good reasons to suggest that any support for UBI from the capabilities approach would lead to a low-level cash transfer. Nussbaum is not necessarily attuned to concern for the effect of material inequality on people's health[67] that lies at the heart of the inequality and behavioural pathways to ill-health. Rather, she is sufficientarian, arguing that 'Having decent, ample housing may be enough: it is not clear that human dignity requires that everyone have exactly the same type of housing. To hold that belief might be to fetishize possessions too much' (p. 41).[63] Having enough may be comparatively little and there may be reason to suggest that the capabilities approach may be much more clearly wedded to targeted health interventions in keeping with other needs- and means-based systems.

Although capabilities is a universalist approach with concern for human need that asserts the objective importance of health, it sits uneasily with deployment of UBI as an upstream health intervention. This may be one reason for centrist politicians informed by capabilities[68] to reject the policy. How, though, might UBI sit with perfectionist approaches?

### **Health as perfection**

Although the majority of UBI's proponents are deontic, there are some perfectionist accounts that might more naturally be attuned to promotion of health. Maskivker,[69] for example, argues that freedom from paid employment is central to pursuit of a particular ideal of a 'good life'. Similarly, in Skidelski and Skidelski's[70] *How much is enough?*, the authors examine the possibility that a fetishization of wealth has deprived individuals of the capacity to realize eudaimonic ends. This is implied by Srnicek and Williams (p. 121),[71] who draw upon Marx's alienation thesis to claim that UBI would enable workers to 'slow down and reflect, safely protected from the constant pressures of neoliberalism'. In referencing the 'good life', Psychologists for Social Change (p.3)[72] have stated that

UBI is likely to lead to a general increase in social trust and a lessening of the shame, humiliation and devaluation that comes with relying on means-tested welfare benefits or being occupied in unpaid caring.

The sense here is that individuals cannot live good lives burdened by those negative emotions. The notion of health's being integral to a good life is apparent in Psychologists for Social Change's (p. 2)[72] claim that there is 'potential for UBI to increase all five psychological indicators of a healthy society: agency, security, connection, meaning and trust'. These are goods that proponents regard as objectively valuable independently of individuals' conceptions of the good. Informed by such a perspective, the state could legitimately seek to impose that conception via UBI.

In contrast to Nussbaum, because perfectionist approaches are concerned with exercise, rather than opportunity,[43] there is good reason to be concerned with health as functioning, not just as capability. Unconstrained by deontic concern for neutrality, the likes of Joseph Raz assume no 'principled limits to the pursuit of moral goals on the part of the state', but do believe that there are 'limits to the means that can legitimately be adopted in promoting the well-being of people and in the pursuit of moral ideals' (p. 420).[73] These limits mean that perfectionist policies must 'be confined to the creation of the conditions of autonomy' (p. 422).[73] Like Nussbaum, Raz upholds an account of human wellbeing grounded in capacity for cultivation of reason, but, unlike Nussbaum, he believes both that people's ability to achieve wellbeing depends on the state's ability 'to create morally valuable opportunities, and to eliminate repugnant ones' (p. 417).[73] This does not mean coercive imposition, however, since that deprives individuals of the capacity for autonomy. Rather, Raz believes in a duty of the state

to ‘help in creating the inner capacities required for the conduct of an autonomous life’, including ‘health’ (p. 407).[73] This perfectionism is consistent with paternalist concern ‘for laws improving safety controls and quality controls of manufactured goods, and apply similar reasoning to demand strict qualifications as a condition for advertising one’s services in medicine, law, or the other professions’ (p. 422).[73]

In this context, UBI may serve effectively as a paternalist measure to promote health via the pathways to health noted above. Indeed, it may function more effectively than direct health promotion via targeted measures. This is not only because it affects all citizens, rather than just target cohorts, but also because targeting may actually serve to entrench health inequalities by imposing extrinsic mortality cues that compound impulsive, health-diminishing behaviour.[26] This is apparent in smoking cessation campaigns that actually increase perceived mortality and foreshorten people’s interests.[74] It may also remove disincentives to health imposed by needs-based welfare systems.[75, 23] Simply transforming people’s perceptions of their lives has the capacity to transform their conceptions of the good, opening up longer-term thinking and planning as a means of achieving greater health. As such, there are good perfectionist reasons to support UBI as a non-coercive instrument precisely because of the pathways to health impact noted above. In this regard, although Hayek[34] and others are right to state partiality has the potential to make unequal the state’s treatment of conceptions of the good, the deployment of UBI as an upstream, institutionally constrained public health measure may not propel society headlong down the slippery slope to puritanical imposition.

However, the objection raised by Moskop regarding the cost of investment remains salient here. If there are many different good lives and different elements to those good lives, what cost can be allocated to promotion of one specific element? If there are finite resources, how best can perfectionists make use of resources to promote the good? While use of resources is a general issue to be addressed by any approach to policy making, the concern is particularly pressing for perfectionists by virtue of their need to understand the effect of instruments on very specific ends. If the model of impact (fig. 1) is correct, perfectionists have *prima facie* reason to support those schemes that meet the MIS in full.

### **Conclusion: the practical importance of understanding ethics**

Much of the discussion above may seem anodyne and, for organisations like Compass, the categorization of their ethical commitments may seem solely of academic importance. After all, given that UBI is intended to be ‘basic’ rather than comprehensive, it is unclear that it can promote any one particular ‘good’ life. The fact that it may be the basis for ‘good’ lives to be pursued means that, *prima facie*, it fits more closely with an opportunity concept, than an exercise concept. However, when examined in terms of pathways to impact, it may more comfortably be pursued as an arm of perfectionist policy. Exploring the ethical foundations to people’s invocation of UBI as a public health measure is a precondition of understanding the limits and limitations of the policy as a whole and to ascertain whether health is a fundamental or incidental element of the approach. It is also an essential means of considering the relative importance of UBI to health in relation to other goods, values, interests and concerns, which we map in table 1 below. Getting to grips with people’s ethical underpinnings enables assessment of other issues, such as the different circumstances, if any, under which the payment can be removed, such as an individual’s being imprisoned[37] or failing to fulfil civic duties.[76] It enables consideration of the size, budget and regularity of payment, maintaining other welfare payments, as well as non-monetary means of satisfying need, as in the case of disabled people.[77, 78] It enables consideration of possible negative health impacts associated with lump-sum payments that might support other important social activity.[79]

Table 1. Summary of ethical approaches and positions on UBI for health impact



	Rawlsian	Capabilities	Perfectionism
Ethics	Deontic	Deontic	Consequentialism
Value of health	Instrumental	Instrumental/Intrinsic	Intrinsic
Relationship of health to liberty	Opportunity	Opportunity/Capability	Function
Prospective position on UBI for health impact	Basic	Rejected	Comprehensive

Without clear ethical underpinnings, this could be a botched and unhelpful public health intervention. Raising the level of awareness among organizations and policymakers not only makes the policy more coherent, it gives a much clearer sense of legitimacy to public health measures in the context of a deeply controversial and expensive intervention.[80] Given the pressure placed by the COVID-19 Pandemic on health systems, however they are configured, public budgets and people’s wellbeing, it is vital that these issues be examined in greater depth through collaboration between political philosophers, health researchers and policymakers. With evidence showing no negative impact on labour market activity,[81] the case for such work is compelling.

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