Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers autorisés de l'Ontario

Honourable Hugh Segal
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Ontario Basic Income Pilot

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RE: RNAO feedback on preliminary outline of discussion paper on Basic Income

Dear Hugh,

It was a pleasure for our team to meet with you on August 18, 2016 to learn more about your work in developing a discussion paper on an Ontario Basic Income (BI) Pilot. The Registered Nurses' Association of Ontario (RNAO) further appreciates the opportunity to provide feedback on the draft preliminary outline and consultation questions. Given the critical role that income and its distribution plays in determining health and health equity, RNAO deeply appreciates the provincial government's commitment to exploring a BI pilot as a means to addressing poverty.

Feedback on draft outline of Ontario BI Pilot discussion paper

In section B. on why poverty matters and how a pilot can help, RNAO recommends that the cost of poverty in Ontario be described in terms of health, social, and economic implications at the individual, family, and community/societal levels. Research such as the Code Red series, for example, showed a 21-year difference in average age of death between the lowest and highest income neighbourhoods in Hamilton.[1] The Project for Ontario Women's Health[2] and Health Quality Ontario[3] are additional examples of population health resources that have quantified years of premature deaths and increased incidence of chronic disease by income level. Estimates of some of the social and economic costs of poverty in Ontario are in the range of $32.2-$38.3 billion or 5.5-6.6 per cent of Ontario's GDP.[4]

In addition, RNAO very strongly recommends that the proposed pilot be situated within the current demographics of poverty both in aggregate terms (such as number of Ontarians living in poverty, percentage of population living in poverty,) and disaggregated by different markers such as Indigenous status, racialized status, gender, sexual orientation, age, disability status, etc.). This information is critical as it demonstrates that some groups in society are disproportionally bearing the burden of poverty.[5] [6] [7]

We fully agree with you that the status quo is clearly not working as many workers struggling with low-paid, precarious employment and those receiving social assistance have great difficulty with meeting basic human needs for food security[8] and affordable housing.[9] Single people and couples, with and without children, are all living in a greater depth of poverty now than they were in 1993.[10] A single person without children receiving Ontario Works (OW) faces the largest poverty gap of 59 per cent or $12,301, which is the shortfall between the Low Income Measure after taxes ($20,811 annually) and total benefit income by family type ($8,510 annually).[11] A single person without children who is a beneficiary of the Ontario Disability Support Program (ODSP) receives $14,028 annually, which is still a poverty gap of 33 per cent or $6,783 annually.[12] Toronto Public Health has calculated that in contrast to the 30 per cent goal of income being spent for rent, a one-person household working full-time on minimum wage would require 48 per cent of income for rent.[13] Those receiving social assistance are in even worse shape as a one-person ODSP household would need to spend 90 per cent of income for rent and the one-person OW household would need to spend the impossible--121 per cent of income for rent.[14] Pointing out some of the stark realities of the current system of precarious, low-paid employment and dangerously low social assistance rates helps to contextualize the discussion of a BI pilot proposal.

With respect to section E. on what specifically should the pilot test, RNAO recommends the addition of principles and mechanisms to safeguard against harm. In addition to ensuring that none of the individual participants are worse off, it is also essential that consideration be given to protecting communities and systems that are public goods from any inadvertent harm.

Some proponents support the BI concept as "an excuse or reason to cancel other forms of social spending and social programming" by casting citizens as consumers empowered "to purchase social welfare needs in the market."[15] Trends that reinforce the power of market forces for ideological reasons linked with neoliberalism, such as privatization, deregulation, trade liberalization, lower taxes, and shrinking of the welfare state[16], are of concern to RNAO as they increase social and health inequities. The evidence of systematic reviews in health care have shown that for-profit provision of health services results in higher mortality,[17] [18] worse health outcomes,[19] and greater cost[20] [21] compared with non-profit provision of health services. What can be learned from the experience in health service delivery is that market solutions actually lead to worse outcomes for people with less effective use of public resources. For these reasons, care must be taken that the BI pilot be monitored to ensure that neither labour rights nor universal health and social programs be weakened or undermined.

While a randomized controlled trial is "the gold standard" in certain biomedical and pharmaceutical contexts, its applicability to complex societal challenges with already vulnerable people is uncertain. RNAO strongly recommends that a robust ethical accountability mechanism equivalent to university and hospital ethics review boards be put into place as soon as possible. In addition to experts in ethics, social policy, population health, and community health nursing, it is critical that people with lived experience be actively engaged in the design, implementation, and evaluation of the BI

pilot. For example, a recognized nursing scholar Dr. Cheryl Forchuk and her colleagues tested an intervention to prevent homelessness among individuals discharged from psychiatric wards. They had to stop their randomized control design early when the intervention group (housing advocate plus fast-tracked income support) had statistically significant results which suggested that "the participants in the control group were being seriously disadvantaged by usual care."[22]

Feedback on draft discussion questions

While the draft questions for discussion touch on many important aspects, RNAO would like to supplement them with the following additions:

- How can safe spaces and meaningful ways to be engaged for people with lived experience be operationalized throughout the BI pilot process?
- How can we ensure adequate time and resources for implementation and evaluation of the BI project regardless of which government is in place over the next five years?
- Are there additional ethical considerations or safeguards that need to be in place to protect participating individuals who are already vulnerable?
- In addition to a focus on individual outcomes, how can we monitor impacts at community/societal level?

RNAO tremendously values the opportunity to provide feedback on this critical initiative and we look forward to any and all opportunities to support a fairer and healthier Ontario. As we articulated to you on August 18th, while we will assess developments related to BI for alignment with our organizational priorities in advancing the social determinants of health, we cannot risk undermining these priorities (e.g. fair minimum wage,[23] [24] [25] [26] [27] improving social assistance,[28] [29] [30] affordable housing,[31] [32] [33] [34] addressing poverty[35] [36] [37] [38] [39]).

Hugh, we want to thank you for your work and ask that we be kept fully engaged throughout the consultation process. Please communicate updates and opportunities for involvement to Mr. Tim Lenartowych, Director of Nursing and Health Policy: TLenartowych@RNAO.ca

Warm regards,

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