# Compiled Evidence for Economy Depression Contention

**Uniqueness**

**Trump’s tax cuts have boosted the economy, we can’t go backwards**

The Investor’s Business Daily, April 10, 2018, https://www.investors.com/politics/editorials/trump-tax-cuts-revenues-deficits-paying-for-themselves/

Among the many details in the report, the one reporters focused on was the CBO's forecast that the federal deficit would top $1 trillion in 2020, two years earlier than the CBO had previously said. And, naturally, most news accounts blamed the tax cuts. "U.S. budget deficit to balloon on Republican tax cuts" is how Reuters put it in a headline. But there's more to the story that the media overlooked. First, **the CBO revised its economic forecast sharply upward this year and next.** Last June, **the CBO said GDP growth for 2018 would be just 2%. Now it figures growth will be 3.3% — a significant upward revision. It also boosted its forecast for 2019 from a meager 1.5% to a respectable 2.4%. "Underlying economic conditions have improved in some unexpected way**s since June," the CBO says. Unexpected to the CBO, perhaps, **but not to those of us who understood that Trump's tax cut**s and deregulatory efforts **would boosts growth.** IBD Newsletters Get exclusive IBD analysis and action news daily. SIGN UP NOW! **In any case, the CBO now expects GDP to be $6.1 trillion bigger by 2027 than it did before the tax cuts.** The CBO report also makes clear that this faster-growing economy will offset most of the costs of the Trump tax cuts. In a table buried in the appendix of the CBO report, it shows that, before accounting for economic growth, the tax cuts Trump signed into law late last year would cut federal revenues by $1.69 trillion from 2018-2027. But it goes on to say that higher rate of GDP growth will produce $1.1 trillion in new revenues. In other words, 65% of the tax cuts are paid for by extra economic growth.

**UBI punishes the creation of real wealth and value in order to subsidize less productive activities**

Tyler Durden 2017 (“The Dangers Of A "Universal Basic Income", http://www.zerohedge.com/news/2017-01-17/dangers-universal-basic-income)

Where UBI Proponents Go Wrong A universal basic income is not the god-sent welfare policy that it initially seems to be. **It does not create incentive to work**. **It won’t** help **solve unemployment, and it will not alleviate poverty**. **The truth is that a UBI will exaggerate all of these factors in comparison to what would exist in a more unhampered market**. There is even reason to think that it would be worse in the long run than traditional, means-tested welfare systems. **First, UBI does not eliminate the disincentives to work** that are **inherent in welfare programs; it simply moves them around**. **This program must be financed** after all, **and** any welfare system, including the **UBI, is necessarily a wealth redistribution scheme**. Wealth must be forced from those who have it to those who do not. This means that at some point on the income ladder, **people must go from being net receivers** of benefits **to** being **net payers of benefits**. The progressive taxation that is necessary to finance a UBI means that the more a person earns, the higher percentage of their wealth will be taken from them. **The work disincentives are therefore still very much present in the tax system**. They’ve simply been transferred onto different, higher income groups of people. The universal basic income shares another problem with traditional welfare systems. **Far from promoting the unemployed from searching for work the market rewards, it actually subsidizes non-productive activities**. The struggling entrepreneurs and artists mentioned earlier are struggling for a reason. For whatever reason, the market has deemed the goods they are providing to be insufficiently valuable. **Their work simply isn’t productive according to those who would potentially consume the goods or services in question**. **In a functioning marketplace, producers of goods the consumers don't want would quickly have to abandon such endeavors and focus their efforts into productive areas of the economy**. The universal basic income, however, allows them to continue their less-valued endeavors with the money of those who have actually produced value, which gets to the ultimate problem of all government welfare programs. **In the marketplace, wealth is earned by generating value**. When someone buys a good, they’ve earned the money they are spending by having produced something else. **This is not so with welfare programs like a universal basic income**. **Money is forcibly taken from those who have produced enough to earn it, and given to those who haven’t**. **This allows for people who aren’t producing wealth to continue to consume scarce goods**. Eventually, **all government welfare leads to the consumption of wealth**, or, at the very least, a reduction in the amount of wealth that would have been accumulated otherwise. When entrepreneurs have less need to respond to the needs and desires of their customers**, consumers will find themselves with fewer choices and with lower-quality choices. This means that overall welfare makes everyone poorer than they would have been in a free market.**

**These perverse incentives and negative externalities mean that UBI simply magnifies the problems with welfare**

Vanessa Brown Calder 2017 (Policy analyst at the Cato Institute, “Universal Basic Income — Disease or Cure?”, https://www.cato.org/publications/commentary/universal-basic-income-disease-or-cure)

Although UBI is a departure from traditional welfare, the idea isn’t truly devoid of welfare’s pitfalls. **On some fronts, UBI seems not only unable to avoid traditional welfare’s problems, but also likely to exacerbate them**. Many of the utopian qualities that recommend UBI to its supporters are strained in the real world. To begin with, the numbers for UBI don’t seem very feasible — at least not without large tax increases. According to Michael Tanner’s calculations, if the government provided just $12,316 for every individual in the United States, or enough to bring them to the non-elderly federal poverty line, the cost of UBI in the U.S. would be nearly $4.4 trillion, more than the entire U.S. federal budget. In his paper on the topic, he notes that “even if the guaranteed national income replaced every existing anti-poverty program, we would still be some $3.4 trillion short.” In order to make ends meet in this scenario, the tax liabilities of high-income individuals would likely be substantially impacted. The practical realities of budget constraints inevitably lead advocates — at least in the real world — to consider whether to limit the eligible population to strictly low-income individuals. However, this leaves UBI looking a lot less “universal” and a lot more like your average cash transfer welfare program, which fell out of favor in the U.S. in the 1990s. **Outside of the cost of the program, providing every U.S. citizen with a cash grant is likely to have a large and negative behavioral effect. Economists agree that welfare programs create labor supply disincentives, meaning that individuals reduce work because of government benefits.** As the Congressional Research Service has noted, an “increase in [the value of welfare benefits] is expected to cause people to reduce work hours.” While this is true of all welfare programs, only around 1/5th of the current U.S. population is currently impacted. If UBI were instituted, labor supply disincentives would touch 100 percent of the population, rather than a subgroup of eligible applicants. **Finally, whether UBI’s promised transparency/efficiency would actually materialize is an open question. The ability to deconstruct programs which benefit legions of special interest groups seems dubious at best**. In place of that, the ability to amend the U.S. constitution to direct all redistributive spending through a UBI system, as Charles Murray suggests, seems ever more unattainable

**Impacts**

**Recessions have global negative mortality effects that are particularly severe when the downturn is sudden, the magnitude of the turn swamps the case, and health care spending can’t make up for it, and ev that disputes these findings is wrong**

Sanjay **Basu 11**, MD, PhD, Assistant Professor of Medicine at Stanford University and Fellow of the London School of Hygiene and Tropical Medicine, 3/7/11, “The health impact of recession – a look at the data,” https://epianalysis.wordpress.com/2011/03/07/recession/

The financial crisis beginning in 2007 is thought by many economists to be the worst recession since the Great Depression. Early on, the World Health Organization warned us that “it should not come as a surprise that we continue to see more stresses, suicides and mental disorders”; “the poor and vulnerable will be the first to suffer”; and “defending health budgets” will become more difficult. But the report was remarkably vague (in fact, totally absent of any data), so it was difficult to truly understand what the **detailed impact of recession would be on public health** – and therefore, what we should do about it. Well, the data are in…and they don’t look pretty. In this post, we describe: [1] the causes of the crisis and their immediate effects on healthcare, [2] the economic and social determinants of population health during recession, [3] the causes and consequences of the ongoing food crisis (with a simple explanation of speculation), and [4] what we’re supposed to do about it. First, we have to acknowledge how the crisis evolved, to understand its varied public health impacts. The recession really started when banks sold “subprime mortgages”, home loans to poor people who could not reasonably afford to pay them back, in order to continue their practice of bundling these investments together and selling them at high profits through mortgage-backed securities (MBS) and collateralized debt obligations (CDO), which are high-risk investments that derive their value from mortgage payments and housing prices. As more and more of these investments were sold under the false premise of generating fantastic returns, the banks created a massively-inflated housing market – a “bubble” – that popped in 2006 when mortgage-holders began to default on their loans. Suddenly investors realized that their investments were unsound, and so they engaged in a massive sell-off, withdrawing their funds from banks, sparking a “liquidity crisis”, meaning that banks had no liquid assets to lend anymore. Credit was hard to find, stalling the business cycle as regular businesses couldn’t obtain loans to build infrastructure, purchase equipment, or expand their workforce. The housing market crash led to a ripple effect in the overall stock market, **first in the U.S. and then in Europe and the rest of the world**. The end result was a $2.3 trillion lost in retirement savings, $1.2 trillion lost in investments, and $14 trillion lost in overall household wealth. These losses accompanied a rise in unemployment to 10% as businesses without credit could not afford to pay their workers, and consumers could not afford to purchase goods and services without their savings. Early on, as mortgage interest rates overwhelmed the poor and 10% of U.S. mortgages went into delinquent or foreclosed status, the Alameda County Department of Public Health published a report revealing that more than 3 in 10 foreclosed residents in Oakland, California sacrificed medical care due to inadequate finances. To date, much of the discussion about the health impact of recession has focused on this issue of healthcare and healthcare costs, particularly in the United States. The main concern is that loss of employment results in the loss of employer-sponsored healthcare insurance. The uninsured rate in the U.S. has now peaked at 17%. State budgets are facing a $160 billion deficit, of which only $60 billion this year will be offset by federal government stimulus dollars. This has placed great pressure on state comptrollers to cut funds for Medicaid, the healthcare program for poor and uninsured adults in the United States. As a condition of receiving stimulus funds, states cannot restrict Medicaid eligibility criteria (which requires that a person is not only poor, but also disabled, pregnant, or has children). But they are restricting what Medicaid pays for, by cutting benefits. Furthermore, because so many sick adults are childless, many remain uninsured: almost half of these uninsured people have a chronic medical condition, and are three times as likely as the insured to have been unable to pay for basic necessities such as housing or food due to medical bills. Their mortality rate goes up 40% simply by virtue of being uninsured. In 2010, nearly one-third of these uninsured adults used up all or most of their savings to pay medical bills. The Kaiser Family Foundation has covered this issue extensively. But there is a **major problem** with restricting our discussion of the health impact of recession n to healthcare budgets or to the United States: **the impact of recession has been global**, and its effects are **often not through the healthcare sector**. In fact, many are surprised to learn that **health care is not a principal determinant of population-level health outcomes**: a minority (~**10 to 15%) of deaths** in the United States are thought to be due to inadequate healthcare access or poor services. So we need to talk about the **broader determinants of health—the social and economic determinants**—to understand the **overall causes of mortality**. How can we study the larger population relationship between recession and health? It turns out that if we measure the economy in terms of gross domestic product (GDP, a measure of total value of goods and services produced in a country), we come out with all sorts of counter-intuitive results when studying population health: previous researchers have reported that **recession** actually **resulted in reductions in mortality** (and gained a lot of press because of it…the press has been quite funny, alluding to theories as varied as “people behave better when they’re poor, smoking and drinking less” to “the weather has been a contributing factor”). It turns out that many of these researchers made **critical statistical mistakes**. One recent study, based on only 21 data points, concluded that health improved during the Great Depression. But if you reanalyze the data in disaggregated form (by city and state level, rather than averaging across the whole country), and correct for preexisting changes in mortality—such as the steady changes in infectious disease or cancer incidence that were resulting from other social changes at the time—**you get the opposite result**. GDP is a terrible measure of what actually happens to people during recessions; **unemployment is a better measure** because the GDP just reflects an arithmetic mean income (and more billionaires were created in the last year, during the recession, than in the previous decade, artificially elevating average GDP). Furthermore, just correlating unemployment and mortality is not good enough—we should account for the delayed impact of change in unemployment on changes in mortality rates, and account for a number of other confounding factors like demography changes. When we do this type of analysis on **multiple sets of data**—studying not only the Great Depression but also the East Asian Financial Crisis of the late 1990s and the Eastern European mortality crisis after the fall of the Soviet Union—we find that **recessions seem to cause suicides, homicides, heart attacks and alcohol-related deaths**. But we also find a couple of key caveats : first, that whether or not these deaths increase during a recession is critically dependent on how the government responds; second, that good social support systems tend to mitigate negative mortality effects of recession; and third, that **how fast economic change happens critically affects mortality rates** (presumably because people need time to prepare for drastic changes in their lives). These are the critical social and economic determinants of the effect of recession on health. Recent data show that when European countries respond to recession by funding “active labor market programs”–programs that rapidly reintegrate the unemployed into jobs or preserve jobs for the lowest income sector–they were able to neutralize the impact of recession on mortality in their countries. This statistically explains why Spain has done so much worse than Finland and Sweden in terms of public health during recession. Curiously, active labor market programs **determine more about changes in mortality than does healthcare spending**; in other words, **we can spend a lot of money on medicine, but it doesn’t seem to neutralize the negative effect of producing stress among households by causing job and income loss**. Social support programs seem to be the key to health outcomes. During the Great Depression, the period of government spending on job and social welfare programs correlates to a period of 10% decline in mortality. In contrast, when Eastern European countries cut social welfare budgets, and mortality rates rose by about 40%–the worst peacetime mortality crisis in the past half-century. Further study of the post-Soviet crisis reveals that easy access to alcohol and very rapid economic changes increased the devastation caused by recession, while membership in social clubs (like church groups) buffered some people from economic turmoil by providing social and material support to their members.

**Low tax rates are critical to business investment**

**Kudlow 16** “Trump Must Spend His Political Capital on Tax Cuts Now” Larry Kudlow is a senior contributor at CNBC, and also co-author with Brian Domitrovic of the new book JFK and the Reagan Revolution: A Secret History of American Prosperity, December 24, 2016, <http://www.realclearmarkets.com/articles/2016/12/24/trump_must_spend_his_political_capital_on_tax_cuts_now_102482.html>

That's why pro-growth tax reform is so important. It is reported that Mr. Trump will immediately move to overturn costly Obama regulations, especially on small business. This is good. It will add to growth. But the big decision will be whether to repeal and rewrite Obamacare or enact tax reform as the first order of legislative business. Replacing Obamacare is hugely important, both to improve our health-care system and remove the economic drag of its taxing, spending, and regulating. But business tax reform -- with low marginal corporate rates for large and small companies, easy repatriation, and immediate expensing for new investment -- will have an enormously positive impact on the weakest part of our economy, namely business investment. That's where we'll see 3 or 4 percent growth, higher productivity, more and better paying jobs, and fatter family pocketbooks. If there were a way to combine a two-year budget resolution with reconciliation instructions (51 Senate votes) to reform health care and taxes in one full sweep, that would be ideal. However, if tax reform (be it business or individual) comes second, and the start dates are postponed until 2018, then businesses and consumers will postpone economic activity. That could make 2017 a much weaker economic story than confidence surveys and the recent stock market suggest. There's a great transition going on, but the economy needs immediate attention. Tax reform is the key.

**Taxes crush the economy**

**Romer and Romer 10** (June 2010, Christina Romer is the Garff B. Wilson Professor of Economics at UC Berkeley, David H. Romer is the Herman Royer Professor of Political Economy at UC Berkeley, “The Macroeconomic Effects of Tax Changes: Estimates Based on a New Measure of Fiscal Shocks,” American Economic Review, Volume 100, Pages 763-801, Accessed through EconLit via GALILEO @ UGA)

VII. Conclusions This paper investigates the causes and consequences of changes in the level of taxation in the postwar United States. We find that despite the complexity of the legislative process, most significant tax changes have a dominant motivation that fits fairly clearly into one of four categories: counteracting other influences on the economy, paying for increases in government spending (or lowering taxes in response to reductions in spending), addressing an inherited budget deficit, and promoting long-run growth. The last two motivations are essentially unrelated to other factors influencing output, and so policy actions taken because of them can be used to estimate the effects of tax changes on output. Our results indicate that tax changes **have very large effects on output**. Our baseline specification implies that an exogenous tax increase of **one percent of GDP lowers real GDP by almost three percent.** Our many robustness checks for the most part point to a slightly smaller decline, but one that is still typically over 2.5 percent. In addition, we find that the output effects of tax changes are much more closely **tied to the actual changes in taxes than to news about future changes**, and that investment falls sharply in response to exogenous tax increases We also examine the behavior of output following changes in other measures of taxes. The estimated output effects obtained using broader measures of tax changes, such as the change in cyclically adjusted revenues or all legislated tax changes, are substantially smaller **than those obtained using our measure of exogenous tax changes**. Thus, failing to account for the reasons for tax changes can lead to substantially biased estimates of the macroeconomic effects of fiscal actions. Finally, we find suggestive evidence that tax increases to reduce an inherited budget deficit do not have the large output costs associated with other exogenous tax increases. Our results are largely silent concerning whether the output effects operate through incentives and supply behavior or through disposable income and demand stimulus. The persistence of the effects is suggestive of supply effects. But other studies have found that monetary policy, which necessarily works through demand, also has highly persistent output effects (for example, Ben S. Bernanke and Ilian Mihov 1998; and Romer and Romer 2004). The speed of the effects is suggestive of demand effects. But rapid supply responses are not out of the question.34

**Link**

**1，Tax Increase Bad Contention**

**UBI would cost $3 trillion, much more than current welfare spending**

**Tanner 14** (Michael D. Tanner – Cato Institute senior fellow, Michael Tanner heads research into a variety of domestic policies with a particular emphasis on poverty and social welfare policy, health care reform, and Social Security. – “The Basic Income Guarantee: Simplicity, but at What Cost?” – CATO Unbound – August 26, 2014 – http://www.cato-unbound.org/2014/08/26/basic-income-guarantee-simplicity-what-cost)

Zwolinski does not propose any specific income, but cites Charles Murray’s suggestion of $**10,000 per person spread over a U.S. citizen population of roughly 296 million**, the cost of such a program **would be $2.96 trillion, or almost 3 times our current welfare expenditure**. And **there is considerable question as to whether $10,000 would be a sufficient grant**.

Right Vision Media, May 31, 2018, This is How We Make Basic Income a Reality, http://blogs.lse.ac.uk/politicsandpolicy/how-to-make-a-universal-basic-income-a-reality/

Left-wing supporters of the system say that it could lower poverty rates. For the right-leaners, it's a route to a less bureaucratic wellfare system.

The program would likely be funded by an increase in income taxes across all income levels.

**To pay every adult and child in the United States a yearly income of $10,000 (£8,045) per year, the government would likely have to cut most non-health social spending programs and raise the share of GDP collected in tax by ten per cent, according to the Economist.**

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Among the many details in the report, the one reporters focused on was the CBO's forecast that the federal deficit would top $1 trillion in 2020, two years earlier than the CBO had previously said. And, naturally, most news accounts blamed the tax cuts. "U.S. budget deficit to balloon on Republican tax cuts" is how Reuters put it in a headline. But there's more to the story that the media overlooked. First, **the CBO revised its economic forecast sharply upward this year and next.** Last June, **the CBO said GDP growth for 2018 would be just 2%. Now it figures growth will be 3.3% — a significant upward revision. It also boosted its forecast for 2019 from a meager 1.5% to a respectable 2.4%. "Underlying economic conditions have improved in some unexpected way**s since June," the CBO says. Unexpected to the CBO, perhaps, **but not to those of us who understood that Trump's tax cut**s and deregulatory efforts **would boosts growth.** IBD Newsletters Get exclusive IBD analysis and action news daily. SIGN UP NOW! **In any case, the CBO now expects GDP to be $6.1 trillion bigger by 2027 than it did before the tax cuts.** The CBO report also makes clear that this faster-growing economy will offset most of the costs of the Trump tax cuts. In a table buried in the appendix of the CBO report, it shows that, before accounting for economic growth, the tax cuts Trump signed into law late last year would cut federal revenues by $1.69 trillion from 2018-2027. But it goes on to say that higher rate of GDP growth will produce $1.1 trillion in new revenues. In other words, 65% of the tax cuts are paid for by extra economic growth.

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**2.1 Inflation Bad Contention**

**Redistribution of wealth causes adverse market reactions and guarantees massive inflation**

Heiner Flassbeck 2017 (Leibniz Information Centre for Economics, “Universal Basic Income Financing and Income Distribution – The Questions Left Unanswered by Proponents”, https://www.ceps.eu/system/files/IEForum22017\_3.pdf)

The **introduction of a basic income without generating a rise in inflation is hardly imaginable**. It would only be possible – and this is an absolutely essential condition – if the implementation of a UBI was the explicit result of state redistribution and if the redistribution measures are widely accepted by all powerful actors in the economy. This is basically unthinkable. **For example**, **if** the **UBI were financed through higher VAT rates**, **this would clearly be inflationary, because companies would pass along the bulk of the higher taxes to customers.** **The consequences for those people relying fully on the UBI would be fatal. Their basic incomes would be insufficient for a decent living.** Would the government then be obliged to step in and add conditional aid and social protection to the poorest? **Imagining that one can achieve a massive redistribution of income without triggering adverse reactions through the markets is a dangerous illusion**. Picture a monthly UBI of about €1,000 a month for a country like Germany. With a population of about 80 million people, the German government would need roughly €800 billion to finance the UBI. This additional revenue is more than the current tax total revenue in Germany, which stands at about €700 billion. Implementing a UBI would thus require a doubling of the tax current level. Some argue that the government would no longer pay social benefits and that the savings could be used to finance a UBI. But this is wrong. The government would indeed no longer be required to pay some €400 billion in social contributions, but it would also no longer receive social security contributions at a similar level. The social security systems in most countries, including Germany, have approximately balanced budgets. Some savings opportunities do exist, as the government normally subsidises pension systems, but the amounts are rather small given the overall burden of a UBI. On the other hand, totally un-solved is the question of health care. Health care contributions could not be covered by a UBI of €1,000 without pushing those fully dependent on UBI back into poverty. Hence, health care would either remain in the realm of the government, involving expenses of 10-15% of today’s GDP (roughly €300 billion), or a monthly UBI of €1,000 would clearly not be sufficient to allow for a decent and independent livelihood. But even a UBI of €1,000 would destroy the pillars of the system we are used to living in. **Doubling government revenue by doubling tax rates would trigger a distributive struggle the likes of which we have never seen before. The ratio of taxes to GDP in most highly developed economies today is close to 25%. To raise the level of taxes and other contributions to 50% would be a revolutionary act**. This act, however, would come with the acknowledgement that this is explicitly being done to allow quite a few people to avoid contributing anything tangible to the fabric of our societies anymore. The outcry of those who are expected to contribute as much as or even more than before would be ferocious. **To be unmistakably clear: Given the distribution of power in our societies, it is preposterous to assert that the government would double its tax revenue without powerful groups – entrepreneurs, big companies and rich people – passing on the additional tax burden to customers and the powerless.** It is cynical to talk about a UBI without talking about the distribution of power and the many different options available to powerful groups to avoid being taxed for this purpose. **And if the powerful are indeed able to avoid significant extra payments and receive a UBI nevertheless, the overall effects on the distribution of income may be catastrophic**. A**s said above,** **the most likely outcome is a spike in inflation, as an increase in the VAT rate will be the only tax measure accepted by the powerful groups**. **The negative effects of a bout of inflation on the distribution of income would fall on the poor and would immediately bring about a call for special and additional measure by the government to protect the poorest. Once that happens, Pandora’s box will be open, and many will ask for conditional measures to correct the dismal outcome of an unconditional basic income on the distribution of income.**

**Greater fear of inflation means the Fed over reacts and raises rates too fast, undermining the economy, causing** **a recession**

**Macrotheme Capital Management 17**, 11-7-2017, "Fed Watch: 3 More Hikes And Done?," Seeking Alpha, https://seekingalpha.com/article/4121729-fed-watch-3-hikes-done?page=2

Policy normalization The Fed is currently implementing monetary policy normalization as outlined in the Policy Normalization Principles and Plans in 2014. Specifically, the Fed is **committed to gradually increase** its target range for the federal funds rate, initially from the zero-bounce level to "more normal levels". Essentially, it is in the process of removing the extraordinary stimulus enacted after the 2008 financial crisis. However, the Fed does not define these "more normal levels." Note, it does acknowledge that the policy normalization regime is data-dependent. Thus, the Fed is likely to continue to gradually increase interest rates, as long as economic data continues to support the monetary tightening. Ideally, the Fed would like to move the bar as high as possible, just to make sure that it retains sufficient ability to appropriately ease interest rates when the next recession arrives - **without actually causing a recession.** At the same time, the Fed's failure to increase interest rates to "more normal levels" before the next recession arrives, will severely limit its ability to fight that recession - without resorting to the alternative monetary policy measures. **Thus, the Fed is facing a delicate task of reaching that "not too high - not too low" level for the federal funds rate.** Key risk factor There are two key risk factors related to the Fed's policy normalization: 1) **inflation rises faster than expected so the Fed hikes more aggressively, and thus causes a recession**; or 2) weak economic data or asset market bubbles/busts prevent the Fed in completing the policy normalization process before the next recession arrives. Which one of these two risks is currently more important? Market expectations on future interest rate hikes Based on the Federal Funds futures, we can determine the market consensus expectations regarding the future interest rate hikes. Here is the chart showing the implied Fed Funds rates over the next two-three years: Based on Nov 2017 contract, the current Fed rate is 1.155%. The first 25 basis hike to 1.405% is expected by March 2018 contract expiration, although the January contract shows close to 100% probability for the first hike, which includes the Dec 2017 Federal Reserve meeting. The second 25 basis hike to 1.655% is expected by October 2018 contract expiration. The third 25 basis hike to 1.905% is expected by February 2020 contract expiration. The last available Federal Reserve Funds futures contract is October 2020, and it implies only 1.965%, which means vary small chance of the fourth hike. Market implications The current market consensus is that the Fed will fail to hike past the 2% level - which is clearly not "sufficiently high" or "normal". Thus, investors should focus on the "too low" risk, or the inability of the Fed to finalize the policy normalization process. The current market expectations are that: 1) the Fed will likely hike at the Dec 2017 meeting; 2) the Fed will hike again by October of 2018, so only once in 2018; 3) the Fed will not hike at all in 2019; 4) the Fed will hike one more time by October 2020. Overall, the Federal Funds futures imply that the Fed will not be able to hike beyond the 2% level by October 2020. More importantly, the clarity disappears after October 2018, given expectations of no further policy action in 2019. Based on these observations, it appears that market potentially sees a turbulent second half of 2018, and thereafter. Specifically, the October 2018 level of 1.65% is clearly insufficient for the Fed to counter the next recession. Further, the expected policy inactivity in 2019 potentially signals a recession sometimes in the second half of 2018. This is clearly in nightmare scenario for the Fed. Note, the last recession started with the federal funds rate above 5% and less than $1 trillion on the Fed's balance sheet. If the next recession comes with the federal funds rate below 2%, and more than $4 trillion on the Fed's balance sheet, the Fed will have to resort to negative interest rates and additional QE in response. Practically, this would be bearish for the stock market (SPY), bearish for the US Dollar (UUP) and highly bullish for gold (GLD) and silver (SLV). Key variable to follow The limiting factor on expected federal funds rate is the 10Y T-Bond yield (TLT). Specifically, the long term interest rates reflect expected longer term economic growth and inflation. Currently, the yield on 10Y T-Bond is 2.32%, which reflects anemic inflation and low long term economic growth**. Rising short term interest rates, accompanied with falling or flat longer term interest rates, narrow and eventually invert the yield curve, and thus cause a recession**. Thus, the Fed is currently limited at right around the 2% level. We will continue to follow the implied federal funds rate, as well as the yield on 10Y T-Bond, along with portfolio implications. Note, the Federal Funds futures can be volatile and the interpretation of the implied Federal Funds curve is subjective.

**Recessions have global negative mortality effects that are particularly severe when the downturn is sudden, the magnitude of the turn swamps the case, and health care spending can’t make up for it, and ev that disputes these findings is wrong**

Sanjay **Basu 11**, MD, PhD, Assistant Professor of Medicine at Stanford University and Fellow of the London School of Hygiene and Tropical Medicine, 3/7/11, “The health impact of recession – a look at the data,” https://epianalysis.wordpress.com/2011/03/07/recession/

The financial crisis beginning in 2007 is thought by many economists to be the worst recession since the Great Depression. Early on, the World Health Organization warned us that “it should not come as a surprise that we continue to see more stresses, suicides and mental disorders”; “the poor and vulnerable will be the first to suffer”; and “defending health budgets” will become more difficult. But the report was remarkably vague (in fact, totally absent of any data), so it was difficult to truly understand what the **detailed impact of recession would be on public health** – and therefore, what we should do about it. Well, the data are in…and they don’t look pretty. In this post, we describe: [1] the causes of the crisis and their immediate effects on healthcare, [2] the economic and social determinants of population health during recession, [3] the causes and consequences of the ongoing food crisis (with a simple explanation of speculation), and [4] what we’re supposed to do about it. First, we have to acknowledge how the crisis evolved, to understand its varied public health impacts. The recession really started when banks sold “subprime mortgages”, home loans to poor people who could not reasonably afford to pay them back, in order to continue their practice of bundling these investments together and selling them at high profits through mortgage-backed securities (MBS) and collateralized debt obligations (CDO), which are high-risk investments that derive their value from mortgage payments and housing prices. As more and more of these investments were sold under the false premise of generating fantastic returns, the banks created a massively-inflated housing market – a “bubble” – that popped in 2006 when mortgage-holders began to default on their loans. Suddenly investors realized that their investments were unsound, and so they engaged in a massive sell-off, withdrawing their funds from banks, sparking a “liquidity crisis”, meaning that banks had no liquid assets to lend anymore. Credit was hard to find, stalling the business cycle as regular businesses couldn’t obtain loans to build infrastructure, purchase equipment, or expand their workforce. The housing market crash led to a ripple effect in the overall stock market, **first in the U.S. and then in Europe and the rest of the world**. The end result was a $2.3 trillion lost in retirement savings, $1.2 trillion lost in investments, and $14 trillion lost in overall household wealth. These losses accompanied a rise in unemployment to 10% as businesses without credit could not afford to pay their workers, and consumers could not afford to purchase goods and services without their savings. Early on, as mortgage interest rates overwhelmed the poor and 10% of U.S. mortgages went into delinquent or foreclosed status, the Alameda County Department of Public Health published a report revealing that more than 3 in 10 foreclosed residents in Oakland, California sacrificed medical care due to inadequate finances. To date, much of the discussion about the health impact of recession has focused on this issue of healthcare and healthcare costs, particularly in the United States. The main concern is that loss of employment results in the loss of employer-sponsored healthcare insurance. The uninsured rate in the U.S. has now peaked at 17%. State budgets are facing a $160 billion deficit, of which only $60 billion this year will be offset by federal government stimulus dollars. This has placed great pressure on state comptrollers to cut funds for Medicaid, the healthcare program for poor and uninsured adults in the United States. As a condition of receiving stimulus funds, states cannot restrict Medicaid eligibility criteria (which requires that a person is not only poor, but also disabled, pregnant, or has children). But they are restricting what Medicaid pays for, by cutting benefits. Furthermore, because so many sick adults are childless, many remain uninsured: almost half of these uninsured people have a chronic medical condition, and are three times as likely as the insured to have been unable to pay for basic necessities such as housing or food due to medical bills. Their mortality rate goes up 40% simply by virtue of being uninsured. In 2010, nearly one-third of these uninsured adults used up all or most of their savings to pay medical bills. The Kaiser Family Foundation has covered this issue extensively. But there is a **major problem** with restricting our discussion of the health impact of recession to healthcare budgets or to the United States: **the impact of recession has been global**, and its effects are **often not through the healthcare sector**. In fact, many are surprised to learn that **health care is not a principal determinant of population-level health outcomes**: a minority (~**10 to 15%) of deaths** in the United States are thought to be due to inadequate healthcare access or poor services. So we need to talk about the **broader determinants of health—the social and economic determinants**—to understand the **overall causes of mortality**. How can we study the larger population relationship between recession and health? It turns out that if we measure the economy in terms of gross domestic product (GDP, a measure of total value of goods and services produced in a country), we come out with all sorts of counter-intuitive results when studying population health: previous researchers have reported that **recession** actually **resulted in reductions in mortality** (and gained a lot of press because of it…the press has been quite funny, alluding to theories as varied as “people behave better when they’re poor, smoking and drinking less” to “the weather has been a contributing factor”). It turns out that many of these researchers made **critical statistical mistakes**. One recent study, based on only 21 data points, concluded that health improved during the Great Depression. But if you reanalyze the data in disaggregated form (by city and state level, rather than averaging across the whole country), and correct for preexisting changes in mortality—such as the steady changes in infectious disease or cancer incidence that were resulting from other social changes at the time—**you get the opposite result**. GDP is a terrible measure of what actually happens to people during recessions; **unemployment is a better measure** because the GDP just reflects an arithmetic mean income (and more billionaires were created in the last year, during the recession, than in the previous decade, artificially elevating average GDP). Furthermore, just correlating unemployment and mortality is not good enough—we should account for the delayed impact of change in unemployment on changes in mortality rates, and account for a number of other confounding factors like demography changes. When we do this type of analysis on **multiple sets of data**—studying not only the Great Depression but also the East Asian Financial Crisis of the late 1990s and the Eastern European mortality crisis after the fall of the Soviet Union—we find that **recessions seem to cause suicides, homicides, heart attacks and alcohol-related deaths**. But we also find a couple of key caveats : first, that whether or not these deaths increase during a recession is critically dependent on how the government responds; second, that good social support systems tend to mitigate negative mortality effects of recession; and third, that **how fast economic change happens critically affects mortality rates** (presumably because people need time to prepare for drastic changes in their lives). These are the critical social and economic determinants of the effect of recession on health. Recent data show that when European countries respond to recession by funding “active labor market programs”–programs that rapidly reintegrate the unemployed into jobs or preserve jobs for the lowest income sector–they were able to neutralize the impact of recession on mortality in their countries. This statistically explains why Spain has done so much worse than Finland and Sweden in terms of public health during recession. Curiously, active labor market programs **determine more about changes in mortality than does healthcare spending**; in other words, **we can spend a lot of money on medicine, but it doesn’t seem to neutralize the negative effect of producing stress among households by causing job and income loss**. Social support programs seem to be the key to health outcomes. During the Great Depression, the period of government spending on job and social welfare programs correlates to a period of 10% decline in mortality. In contrast, when Eastern European countries cut social welfare budgets, and mortality rates rose by about 40%–the worst peacetime mortality crisis in the past half-century. Further study of the post-Soviet crisis reveals that easy access to alcohol and very rapid economic changes increased the devastation caused by recession, while membership in social clubs (like church groups) buffered some people from economic turmoil by providing social and material support to their members.

**Impact - - Turns case -- That inflationary pressure negates any benefit of UBI**

Ellis Winningham 2016 (“Universal Basic Income: An Economic “Destabilizer””, MMT and Moden Macroeconomics, http://elliswinningham.net/index.php/2016/05/23/universal-basic-income-an-economic-destabilizer/)

As an addendum to yesterday’s article concerning the Job Guarantee versus the UBI, I’d like to clarify a couple of points concerning the inflationary aspects of a UBI and its inability to discipline inflation. In yesterday’s article I chose to address the potential wage-price spiral effects caused by a UBI, because the point that all income maintenance programs such as a UBI only increase aggregate demand has already been hammered into the ground. However, today I will address this point from a different angle, hopefully providing some clarity to the layman. A UBI increases aggregate demand because more dollars are placed into the hands of consumers above that which they already earn. **The problem arises when that demand eventually causes the price level to rise.** **When it does, the value of the UBI erodes, requiring an increase in the size of the UBI, which then will only increase the price level again**. **Therefore**, we can see that a **UBI has no real mechanism to discipline inflation**.

**2.2 Link Extensions – Greater Inflation**

**increasing employment puts more pressure to increase wages, as there are fewer people to hire. Raising wages means more inflation. If inflation increases the Federal Reserve will likely raise interest rates in an attempt to slow-down the economy by making it more costly for companies to borrow. Rapid and consecutive interest rate increases, however, will undermine the economy**

CNN reported yesterday, Friday February 2nd, http://money.cnn.com/2018/02/02/investing/stock-market-today-dow/index.html

**The Dow closed down 666 points**, or 2.5%, its biggest percentage decline since the Brexit turmoil in June 2016 and steepest point decline since the 2008 financial crisis. A **strong jobs report showed wage growth is finally starting to pick up. That's great news for workers, but it reinforced investors' concern about inflation** and the bond market. "It's all about rates. Asset prices and the economy have become addicted to low rates," said Peter Boockvar, chief investment officer at the Bleakley Financial Group. "Sentiment got euphoric. There is more froth that needs to be taken off." The sell-off knocked the Dow well below 26,000. Both the Dow and S&P 500 suffered their biggest weekly drops since early 2016 -- roughly 4% each. Political turmoil is adding to the uncertainty. Market analysts pointed to the clash between the Trump administration and the FBI as another concern. "There looks like a breakdown of the institutions in our country," said Ian Winer, head of equities at Wedbush Securities. "No matter what side you're on, that's not good." While the point decline on the Dow was large, it paled in comparison with the scary days of the financial crisis. Friday's decline was 2.5%. The Dow plummeted nearly 8% on a single day in October 2008. The stock market is much calmer these days, thanks to a strong economy, record corporate profits and the huge business tax cut enacted by President Trump and Republicans in Congress. Even with this week's slump, the S&P 500 is just 3.9% below its all-time high. **But the tranquility that has defined Wall Street's stunning rally since the election has been punctured**. The VIX (VIX), a measure of market volatility, soared 55% this week. January's jobs report didn't settle the market down. The economy added 200,000 jobs in January, and wages grew at the fastest pace in eight years. But **if wages grow too fast, they could eat into Corporate America's record profit margins**. The other concern: **Wage growth could be a sign that inflation**, which has been ***mysteriously low for years, may heat up. That would force the Federal Reserve to raise interest rates faster than investors may be comfortable with.*** bond yields soarin **Some investors are worried rates could climb high enough to *slow the economy by raising borrowing cost*s**. They also worry that higher returns on bonds will make stocks look less attractive by comparison. "Those rising rates are making it harder to say there is no alternative to stocks," said David Kelly, chief global strategist at JPMorgan Funds. Former Fed Chairman Alan Greenspan said this week that both stocks and bonds are in a "bubble." Of course, this week's slide does little to dent the overall gains the market has achieved since President Trump's victory. The Dow and the Nasdaq have climbed more than 40% apiece since the 2016 election. The S&P 500 has advanced for 10 consecutive months. That hasn't happened since 1959. Even stock market bulls have long said that a pause -- or even a dip -- would help prevent the market from overheating. "We've just gone too far, too fast," said Art Hogan, chief market strategist at B. Riley FBR. "We had this perfection of 2% higher every week -- and that really is just not reality." Some market analysts said the political controversy over the release of the disputed GOP memo is rattling Wall Street. "You've got trouble in the Department of Justice and the FBI at the senior level," said Jeffrey Saut, chief investment strategist at Raymond James. "It all hit when the market was ready to go down anyway. It just accelerated it," Saut said. Wedbush's Winer said the biggest risk is that Robert Mueller, the special counsel investigating Russian interference in the election, is fired. "If Bob Mueller is challenged in a firing, or a prelude to a firing, then you're going to have a problem," he said. Other market analysts think Friday's drop has little to do with Washington. "We're not drawing a connection between the political headlines and the market. Valuations for stocks are high, and we were due for a pullback," said Luke Tilley, chief economist for Wilmington Trust. Related: Here's who's getting a raise these days The latest corporate earnings, which typically drive stock prices, left the markets unimpressed. Shares of Google parent Alphabet (GOOGL) slumped 5% even after the tech behemoth posted its first $100 billion sales year. Disappointing iPhone sales left Apple (AAPL) down 4%. ExxonMobil (XOM) sank 5% after its results widely missed expectations. Selling was widespread. Amazon was one of just 27 stocks in the S&P 500 to finish the day higher. "You've had a stock market that's gone absolutely crazy based on tax reform juicing earnings," said Winer. "And numbers are coming in that are OK, but not blowing the doors off." The question now is whether this market turmoil will persist into next week, or whether investors have been waiting on the sidelines come in to buy after the dip. The Morningstar added on February 2nd, <https://www.morningstar.com/news/dow-jones/TDJNDN_201802027911/market-snapshot-stock-market-falls-as-wage-data-stokes-inflation-fears.html> "The details of this jobs report, especially the numbers behind the wage growth suggest that ***companies are competing for workers and the shortage of skilled workers is pushing up wages***. The trend in inflation is ticking higher and the big question is whether the incoming Fed, which is more hawkish, will allow the economy run hotter in the short term or tighten aggressively," said Quincy Krosby, chief market strategist, at Prudential Financial.

**3. Structural Violence Bad**

**View impact calc from below. Structural violence outweighs.**

Solomon **BENATAR 16**, Emeritus Professor of Medicine at the University of Cape Town and Adjunct Professor in the Dalla Lana School of Public Health, University of Toronto [“Politics, Power, Poverty and Global Health: Systems and Frames,” *International Journal of Health Policy and Management*, Vol. 5, No. 10, October 2016, p. 599-604, Accessed Online through Emory Libraries]

In the context of the health implications of climate change and environmental degradation,27 new ideas and action are required to ensure meaningful progress in the health of whole populations and the sustainability of life on our planet.28 How we view, think about and act on threats to global health critically depends on our belief system that influences how we view ourselves, the world in which we live, to what kind of future world we aspire, and what we consider to be the most appropriate research agenda for the pursuit of such goals.Whichever view is held, or what balance between them is achieved, will influence what action is considered to be necessary. All belief systems mobilize feelings and motivations through symbols that work most powerfully when subliminal. What is believed becomes an important aspect of ‘reality’ whether true or not and this applies both to religious and secular belief systems.29,30 Frames are mental structures with mostly subconscious reference points that determine automatically and repetitiously how knowledge is **constructed and debated**. They allow us to create what we take to be reality and to facilitate our most basic interactions with the world by structuring our ideas and concepts, shaping the way we reason and impacting on how we perceive and how we act. Cognitive bias refers to systematic patterns of deviation from norms of judgment, whereby inferences about other people and situations may be drawn through subjective perception of our own social reality. Metaphors are additional fundamental mechanisms of mind that through indirect comparisons subtly shape our perceptions and structure our most basic understandings of our experience and actions.31 The contemporary dominant belief system and its frames for global thinking are characterized by an emphasis on individualism, freedom, philanthropy and an economy dominated by market considerations, all of which give priority to monetary value and short-term interests in all aspects of life. This is the backdrop that explains the failure to prevent the recent devastating Ebola epidemic, despite ample warnings from previous smaller Ebola and other infectious disease outbreaks, and many think-tank commissions.32 In addition, a narrow version of Human Rights discourse, focused on civil and political rights, has become the favored moral compass in secular societies, with little reference to the full range of rights implicit in the Universal Declaration of Human Rights (UDHR) and no use of other rich moral languages such as those of solidarity, virtue and character.33 It should also be noted that as the achievement of most of the Human Rights referred to in the UDHR is dependent on access to material resources, these Rights are increasingly difficult to achieve in the face of wide economic disparities. Moreover focusing on individual perpetrators and individual victims of ‘human rights abuses’ ignores the vastly greater contribution of flawed systems to the failure to achieve Human Rights more widely for whole populations of people.34 The best-known metaphor in healthcare is war against disease and this is framed within scientific innovation, competitiveness and the ‘right’ to health/healthcare. These combative and technological metaphors and frames are extrapolated to global health and buttressed by linking health to **competitive economic growth** as development, and to an adversarial notion of ethics (Human Rights). Such ways of thinking have been described as ‘the common sense’ of dominant practices that need to be critically re-evaluated and replaced with a new paradigm.35 Challenging the Dominant Belief System and Framing The quality of life enjoyed by, and the ongoing expectations of, the 20% of people in the world who consume 80% of the world’s energy and resources, breed reluctance to admit that our current global ecological and health predicaments are to a considerable extent attributable to endless entitlements and wasteful consumption patterns. This reluctance is supported by the popular notion that more philanthropy and new technology should have the highest priority to overcome current crises.36 Such features of the lives of the privileged and powerful also generate neglect and denial of the need for the **paradigmatic change** needed to restructure power relations in ways that could achieve solutions potentially within our grasp.37,38 In challenging the dominant discourse and agenda for improving global health it is suggested that the major impetus to the ‘progress’ that has led to only about 20% of people in the world having desirable lifestyles arises not only from the invisibility of power structures but more especially from the invisibility of the belief system wherein power is embedded and that determines the way we think and how we frame our ideas, values, and actions [1] .30,39 The recent Lancet-University of Oslo Commission on governance for global health40 is a prominent example of an insightful but incomplete and largely technical diagnosis of global health problems. The Report’s failure to make appropriate recommendations for progress can be explained by its ignoring the underlying economic and political values and forces that shape the ideological, intellectual and research frameworks of global health and its governance, and that underpin the underlying **causal processes of health disparities**.38,41 Those who benefit from this belief system have the privilege and the power to drive or support political agendas that preserve their privilege. Indeed, the global health discourse agenda has been **captured and held hostage** by those with the most power.42,43 However, it has also been proposed that it is not so much our belief system and values that are at fault, but rather our distortions of many highly prized constituent values within our belief system,44,45 and our lack of moral imagination26 that contribute to failure to rectify some of the forces that **promote and sustain major inequalities** in the determinants of global health. The dominant and dominating mind-set of the most privileged people in the world tends to **lock us** into our particular utopian realms of thinking and action that must surely seem mysterious, untrustworthy and irremediable to those whose lives remain severely restricted by socially constructed causes of poverty and lack of opportunities to flourish.46 In their collaborative study on framing global health McInnes and colleagues have used a constructivist theoretical approach to examine both the ideational and the material bases behind contemporary debates and controversies in the discourses about global health.47 It is surprising that a social constructivist approach, based on a combination of ideational considerations and material conditions, yields such a restricted range of frames as they describe. This shortcoming can be attributed to the fact that such frames, like those proposed by others,48,49 have been developed **only from the perspective of the dominant belief system** within a social world where the privileged minority lives with high consumption patterns in what has been called a **‘market civilization’ ideology**.42 Such a belief system, presumed to be universal, underplays the pathophysiology and effects of the exploitation and discrimination associated with the materially impoverished lives of **billions of people**, and ignores the varied alternative belief systems within which other ideational biases could arise. It is legitimate to imagine that in other contexts very different notions of global health could be influenced by socially constructed systems, powerfully shaped by different beliefs. For example dystopic belief systems can arise from feelings of neglect, hopelessness, lack of empowerment, and social violence fueled by hypocrisy, arrogance, corruption, and exploitation.50-52 More optimistic traditional belief systems with their own powerful heuristic influences, as explored elsewhere, cannot be ignored.53,54 It is also possible that the methodology of an inter-philosophies dialogue55 could facilitate a constructive tension capable of modifying the dominant perspective that seems increasingly out of touch with the limits of economic growth and other dangers at a time when human activity **threatens planetary sustainability**.56

**Income inequality intrinsically causes health issues and decreases life expectancy – prefer overwhelming amounts of predictive and historical studies**

**Pickett and Wilkinson 15** (Kate E. Pickett, Professor of Epidemiology in the Department of Health Sciences at the University of York, former Research Career Scientist at the National Institute for Health, and Richard G. Wilkinson, Emeritus Professor of Social Epidemiology at the University of Nottingham, 2015(“Income Inequality and Health: A Causal Review,” Social Science &amp; Medicine, Volume 128, March, <https://www.ahrq.gov/professionals/education/curriculum-tools/population-health/pickett.html//SR>)

The body of evidence on income inequality and health points strongly to a causal connection. The major criteria of temporality, biological plausibility, consistency, and lack of alternative explanations are well supported. Of the small minority of studies that find no association, most can be explained by income inequality being measured at an inappropriate scale, the inclusion of mediating variables as controls, the use of subjective rather than objective measures of health, or followup periods that are too short. Suicides seem to stand as an important exception to the general pattern: they tend to be more common in more equal societies, despite the evidence that depression is more common in more unequal societies.39,132 A possible explanation is that social gradients in suicides are not always consistent internationally.133 Another possibility is that there may be some truth in the view that violence can be directed either outwards or inwards against oneself. If suicide is, like homicide, often a response to adversity, we think it likely that greater equality increases a tendency to blame oneself rather than others for what goes wrong. Epidemiological causal criteria are not exhaustive. A good test of the validity of a scientific theory is its ability to make successful, testable predictions. The theory that more equal societies are healthier arose from one international study17 and has now been tested in many different contexts. The search for a mechanism led to the discovery that social relationships (social cohesion, trust, involvement in community life, and low levels of violence) are better in more equal societies, suggesting that inequality and health are linked through psychosocial processes related to social differentiation and relative deprivation.61 That inequality does have **powerful psychosocial effects** is now amply confirmed. We suggest that the most parsimonious explanation for the effects of income inequality is that larger income differences increase social distances, accentuating social class or status differences. This would explain why income inequality is most closely related to health when measured across whole societies coterminous with social class hierarchies.13,134 Rather than income inequality being a new and independent determinant of health, it is likely to act by strengthening the many causal processes (known and unknown) through which social class imprints itself on people throughout life. This would suggest why, not only health, but a wide range of other outcomes with social gradients are also related to inequality. It also suggests that if class and status are to become a less powerful influence both on individual lives and on whole societies, it will be necessary to reduce the material differences that so often constitute the cultural markers of social differentiation. As whole populations are exposed to societal income inequality, estimates of the population attributable risk will be high even if, for some outcomes, the causal effect on some outcomes is modest. Kondo and colleagues67 estimated that upwards of 1.5 million deaths (9.6 percent of total adult mortality for the 15-60 age group) could be averted in 30 OECD countries if each country reduced its Gini coefficient below 0.30. If individual income is also related to health partly through psychosocial mechanisms involving relative deprivation, then multilevel models that control out its effects may substantially underestimate the effects of inequality.135 It has been estimated that if the United Kingdom reduced its inequality to the average in other OECD countries, the expenditure savings on physical and mental illness, violence, and imprisonment alone would amount to £39 billion per year.136 Future research should move beyond mere replication of these findings in different samples towards more explicit attempts to clarify the causal relationships, including studies of (1) different measures of income inequality (top- and bottom-sensitive measures, for example) in relation to different health and social outcomes, (2) time lags for different outcomes, (3) further modeling and testing of specific causal pathways, and (4) whether inequalities in wealth are as much a part of the picture as inequalities in income. Comparable measures of wealth inequality are available for only a limited number of countries, but initial explorations of the relationships with life expectancy are interesting. Life expectancy in Denmark, which seems to be an outlier in relation to its more equal distribution of income, appears to fall into place in relation to its large inequalities in wealth.137 The evidence that large income differences have damaging health and social consequences is already far stronger than the evidence supporting policy initiatives in many other areas of social and economic policy, and the message is beginning to reach politicians. The world leaders we mentioned at the start of this chapter have all referred to inequality as a cause of social and economic harm. But to recognize the problem is not the same as tackling it effectively. The gap between the richest and poorest 20 percent of households in countries like the United States and United Kingdom is not only very much wider than it used to be in the 1970s, but it is still twice as large as in some other successful market democracies. The reason why politicians do not do more is almost certainly a reflection of the undemocratic power of money in politics and the media.138 Narrowing the gap will require not only redistributive tax policies but also a reduction in income differences before tax. The halving of top tax rates since the 1970s has led not only to a widening of income differences after tax but, more surprisingly, to an acceleration in pre-tax income differences particularly in the private sector where pay for top executives seems unrelated to company performance.139-141 has written about the risks of policymakers requiring unachievable standards of proof in social epidemiology before they are willing to act, and Popper30 emphasized that scientific theories are never finally proven true. Adopting too high a standard of evidence may mean that it is never considered strong enough. Schrecker quotes Michael Marmot143 as saying "While we should not formulate policies in the absence of evidence to support them, we must not be paralyzed into inaction while we wait for the evidence to be absolutely unimpeachable."

**Income inequality hurts health – biological studies and historical coherence**

Pickett and Wilkinson 15 (Kate E. Pickett, Professor of Epidemiology in the Department of Health Sciences at the University of York, former Research Career Scientist at the National Institute for Health, and Richard G. Wilkinson, Emeritus Professor of Social Epidemiology at the University of Nottingham, 2015(“Income Inequality and Health: A Causal Review,” Social Science &amp; Medicine, Volume 128, March, <https://www.ahrq.gov/professionals/education/curriculum-tools/population-health/pickett.html//SR>)

A psychosocial explanation of the effect of income inequality on health and behavioral outcomes is consistent with the biology of chronic stress, new studies of the neuroscience of social sensitivity, and concepts from evolutionary biology. Income inequality is linked to lower levels of social cohesion and generalized trust, suggesting that **inequality acts as a social stressor**.108-110 Chronic stress impairs memory and increases risk of depression, lowers immune responses, elevates blood pressure and risk of cardiovascular disease, and affects hormonal systems.111 Research shows that the ways in which we relate to one another, such as friendship, social support, and social networks, are as protective for health as smoking is deleterious.112 If we have friends, we are less likely to contract a common cold infection in randomized controlled trials.113 Likewise, if we have a difficult relationship with our spouses or partners, we heal more slowly in trials of experimental wound healing.114 A meta-analysis of 208 laboratory studies of acute psychological stressors and cortisol responses shows that stronger cortisol responses were elicited if tasks were uncontrollable or characterized by "social-evaluative threat" (threats to self-esteem or social status).115 Even low levels of psychological distress were found to be related to mortality in a meta-analysis of 10 large prospective cohort studies.116 Telomere length, a measure of cell aging, was found to be shorter by age 9 among African American boys who lived in highly disadvantaged environments compared to those who were raised in more affluent environments.117 Neuroscience studies also highlight the importance of psychosocial factors for human physiology. A neuroimaging study showed that social pain (exclusion) activated the brain in the same ways as physical pain. The anterior cingulate cortex (ACC) was more active during experiences of social exclusion and was positively correlated with self-reported distress.118 In another study, baseline sensitivity to physical pain predicted sensitivity to social rejection, and social exclusion was associated with more sensitivity to physical pain.119 In two experiments, participants received either acetaminophen (a pain suppressant) or a placebo for 3 weeks. Acetaminophen reduced daily reports of social pain, and functional magnetic resonance imaging showed that acetaminophen reduced neural responses to social pain in areas of the brain previously shown to be related to both social and physical pain.120 Evolutionary explanations of human sensitivity to social relationships and hierarchies stress the importance of belonging and people's need for positive relationships and connectedness. **Social exclusion affects cognitive, emotional, and behavioral outcomes**, and adaptations to low social rank in both animals and humans include altered levels of hormones and behaviors, such as withdrawal, apathy, or hypervigilance.121 A theory linking submission and subordination to depression suggests that it results from an inability to stop, or escape from, a submissive defeat strategy, and the evidence reviewed by Johnson and colleagues supports this; in more than 20 research studies, people with depression were more likely to report feeling inferior or experiencing shame.122 Coherence In rich countries, there is no association between average levels of income (e.g. gross national income per capita) and measures of health, such as life expectancy.123-126 Yet within rich countries, there are strong associations between individual income and life expectancy. This pattern suggests that it is relative income within societies that is important for health in rich countries, in turn suggesting that psychosocial mechanisms are relevant. Recent studies of income inequality in relation to psychological states and traits and sociological outcomes lend coherence to a psychosocial explanation of the health and social effects of income inequality on health. International comparisons show that status anxiety is higher in more unequal countries, for all socioeconomic groups.127 Status anxiety and trust were found to mediate the association between income inequality and subjective well-being.128 In more unequal countries, people exhibit higher levels of self-enhancement, i.e., believing themselves to be better than average.129 In both ecological and multi-level analyses, people in more unequal U.S. States scored lower on a measure of agreeableness, reflecting less concern for social harmony and getting along with others.130 In more unequal European countries, people show less solidarity; they are less willing to help others.131

**Deaths from structural violence are greater every year than from wars – changing laws that facilitate inequality is vital**

**Ansell, 17** - David A. Ansell, Senior Vice President, Associate Provost for Community Health Equity, and Michael E. Kelly Professor of Medicine at Rush University Medical Center (The Death Gap: How Inequality Kills, p. 7-10)

There are many different kinds of violence. Some are obvious: punches, attacks, gunshots, explosions. These are the kinds of inter- personal violence that we tend to hear about in the news. Other kinds of violence are intimate and emotional. But the deadliest and most thoroughgoing kind of violence is woven into the fabric of American society. It exists when some groups have more access to goods, resources, and opportunities than other groups, including health and life itself. This violence delivers specific blows against particular bodies in particular neighborhoods. This unequal advantage and violence is built into the very rules that govern our society. In the absence of this violence, large numbers of Americans would be able to live fuller and longer lives. This kind of violence is called structural violence, because it is embedded in the very laws, policies, and rules that govern day-to- day life.8 It is the cumulative impact of laws and social and economic policies and practices that render some Americans less able to access resources and opportunities than others. This inequity of advantage is not a result of the individuals personal abilities but is built into the systems that govern society. Often it is a product of racism, gender, and income inequality. The diseases and premature mortality that Windora and many of my patients experienced were, in the words of Dr. Paul Farmer, "biological reflections of social fault lines."9 As a result of these fault lines, a disproportional burden of illness, suffering, and premature mortality falls on certain neighborhoods, like Windora's. Structural violence can overwhelm an individual's ability to live a free, unfettered, healthy life. As I ran to evaluate Windora, I knew that her stroke was caused in part by lifelong exposure to suffering, racism, and economic deprivation. Worse, the poverty of West Humboldt Park that contributed to her illness is directly and inextricably related to the massive concentration of wealth and power in other neighborhoods just miles away in Chicago's Gold Coast and suburbs. That concentration of wealth could not have occurred without laws, policies, and practices that favored some at the expense of others. Those laws, policies, and practices could not have been passed or enforced if access to political and economic power had not been concentrated in the hands of a few. Yet these political and economic structures have become so firmly entrenched (in habits, social relations, economic arrangements, institutional practices, law, and policy) that they have become part of the matrix of American society. The rules that govern day-to-day life were written to benefit a small elite at the expense of people like Windora and her family. These rules and structures are powerful destructive forces. The same structures that render life predictable, secure, comfortable, and pleasant for many destroy the lives of others like Windora through suffering, poverty, ill health, and violence. These structures are neither natural nor neutral. The results of structural violence can be very specific. In Windora's case, stroke precursors like chronic stress, poverty, and uncontrolled hypertension run rampant in neighborhoods like hers. Windora's ill- ness was caused by neither her cultural traits nor the failure of her will. Her stroke was caused in part by inequity. She is one of the lucky ones, though, because even while structural violence ravages her neighbor- hood, it also abets the concentration of expensive stroke-intervention services in certain wealthy teaching hospitals like mine. If I can get to her in time, we can still help her. Income Inequality and Life Inequality Of course, Windora is not the only person struggling on account of structural violence. Countless neighborhoods nationwide are suffering from it, and people are dying needlessly young as a result. The mag- nitude of this excess mortality is mind-boggling. In 2009 my friend Dr. Steve Whitman asked a simple question, "How many extra black people died in Chicago each year, just because they do not have the same health outcomes as white Chicagoans?" When the Chicago Sun- Times got wind of his results, it ran them on the front page in bold white letters on a black background: "health care gap kills 3200 Black Chicagoans and the Gap is Growing." The paper styled the head- line to look like the declaration of war that it should have been. In fact, we did find ourselves at war not long ago, when almost 3,000 Americans were killed. That was September 11,2001. That tragedy propelled the country to war. Yet when it comes to the premature deaths of urban Americans, no disaster area has been declared. No federal troops have been called up. No acts of Congress have been passed. Yet this disaster is even worse: those 3,200 black people were in Chicago alone, in just one year. Nationwide each year, more than 60,000 black people die prematurely because of inequality.10 While blacks suffer the most from this, it is not just an issue of racism, though racism has been a unique and powerful transmitter of violence in America for over four hundred years.11 Beyond racism, poverty and income inequality perpetuated by exploitative market capitalism are singular agents of transmission of disease and early death. As a result, there is a new and alarming pattern of declining life expectancy among white Americans as well. Deaths from drug overdoses in young white Americans ages 25 to 34 have exploded to levels not seen since the AIDS epidemic. This generation is the first since the Vietnam War era to experience higher death rates than the prior generation.12 White Americans ages 45 to 54 have experienced skyrocketing premature death rates as well, something not seen in any other developed na- tion.13 White men in some Appalachian towns live on average twenty years less than white men a half-day's drive away in the suburbs of Washington, DC. Men in McDowell County, West Virginia, can look forward to a life expectancy only slightly better than that of Haitians.14 But those statistics reflect averages, and every death from structural violence is a person. When these illnesses and deaths are occurring one at a time in neighborhoods that society has decided not to care about—neighborhoods populated by poor, black, or brown people— they seem easy to overlook, especially if you are among the fortunate few who are doing incredibly well. The tide of prosperity in America has lifted some boats while others have swamped. Paul Farmer, the physician-anthropologist who founded Partners in Health, an inter- national human rights agency, reflects on the juxtaposition of "unprecedented bounty and untold penury": "It stands to reason that as beneficiaries of growing inequality, we do not like to be reminded of misery of squalor and failure. Our popular culture provides us with no shortage of anesthesia."15 That people suffer and die prematurely because of inequality is wrong. It is wrong from an ethical perspective. It is wrong from a fair- ness perspective. And it is wrong **because we have the means to fix it**.

**Structural violence is skyrocketing as inequality deepens – policy change focused on concentrated poverty is the key to reversing it**

**Ansell, 17** - David A. Ansell, Senior Vice President, Associate Provost for Community Health Equity, and Michael E. Kelly Professor of Medicine at Rush University Medical Center (The Death Gap: How Inequality Kills, p. 194-198)

The Chicago Transit Authority Blue Line train has a stop just in front of my hospital. The life expectancy around the Blue Line stop in Chicago's Loop, just east of Rush University Hospital, is 85 years. Three stops down the Blue Line from Rush is Mr. M's neighborhood, where life expectancy plummets to less than 69. No measured assessment of the health conditions in America's neighborhoods could fail to connect the marginalized existence of so many and the economic structures and racial discrimination that have enriched many at the expense of the poor. Even if you don't agree that structural violence is the root cause of our neighborhood ills, there can be no doubt that something is dreadfully wrong. Neighborhood and life conditions have deteriorated to the point where they drive patients like Mr. M to madness and, worse, suicide. And yet we are anesthetized by these neighborhood conditions. We have tolerated the wickedness of inequity as if it were a natural condition of a modern capitalist society. We avert our gaze so we do not have to endure the jarring emotional dissonance created by the juxtaposition of great wealth and mammoth poverty. Despite the evidence that structural violence inflicts terrible psychological stress on the poor, the City of Chicago's Health Department closed its mental health clinics a few years ago.5 At the same time, Chicago's jails and emergency rooms overflow with the mentally ill. Under what measure of fairness and justice can this be justified? Concentrated poverty and distress are mushrooming in the United States. For those on the short end of the wealth stick, the system is rigged. The negative impact of structural violence has skyrocketed as jobs, opportunities, and wealth have deserted more and more American neighborhoods in the twenty-first century. The United States now boasts more high- poverty neighborhoods in any time since the 1960s.6 Since 2000, the number of people living in high- poverty ghettos and slums nearly doubled, from 7.2 million to 13.8 million, while poverty became more densely concentrated. More than one in four African Americans and more than one in three Latinos now live in neighborhoods of extreme poverty. Contrast this to white America. One in thirteen white Americans lives in this concentrated poverty—nothing to celebrate, but disproportionate to the US black and Latino experience.7 Because white poverty is more dispersed than black and Latino poverty, the death gaps within the white community can be difficult to discern. While white America experiences better health overall than black America, some neighborhoods in white America are not inoculated against the impact of structural violence. A11 analysis by the Washington Post found that since 2000, American white women have been dying at higher rates expiring in their 30s, 40s, and 50s, an invisible crisis driven by the impact of postglobalization job loss on small-town America. In one of the hardest-hit groups—rural white women in their late 40s—the death rate has risen by 30 percent. As life has evolved in rural America, as jobs have been dispatched overseas, as poverty has swelled, more white men and women are dying prematurely. A greater proportion of Americans lived in poverty in 2015—a **staggering 45 million**—than in the late 1960s. Children are the hardest hit, with almost half of them below five years old living in poverty.8 Chicago is an epicenter for child distress, with the highest child poverty rate in the nation. While black and Latino men have been imprisoned at unprecedented rates, black women and their children have faced an epidemic of evictions because of poverty and racism.9 The wealth gap between whites and minorities is the largest it has been since 1989.10 The wealth gap for single women in America is even starker. Single black and Hispanic women have a median wealth of $100 and $120 respectively; the median for single white women is $41,500. Nearly half of all single black and Hispanic women have zero or negative wealth, meaning that their debts exceed their total assets. These statistics demonstrate graphic inequity, but we should not forget that the preponderance of poverty in the United States is among whites.11 We have performed enough analyses. There are no more observations or judgments to make. If we were studying the impact of structural violence on health and longevity in a randomized clinical trial, the experiment would have been halted long ago on ethical grounds. It is time to act. It is time for healing. Act We can act on behalf of the poor. We can choose to neither objectify nor dismiss their experiences. We can insist on and pursue their right for health and longevity. We can speak up against structural violence. We can **demand political and** **policy solutions** to mitigate or eliminate the structures that impart violence. We can advocate for a fair and equitable health-care system organized around the precept of health as a human right. We can expect our institutions to do more to serve the interests of America's high-poverty communities and their residents. We can expect our leaders and policy makers to hold all our institutions to greater accountability for the lives of the poor. Finally, we can act personally to preferentially serve the poor. To speak against the forces of structural violence- racism; economic exploitation; mass incarceration; the lack of safety, good education, and decent-paying jobs—**requires us to make the invisible visible**. That means we have to acknowledge and address the distress in our high-hardship communities. We can seek to understand all the ways in which racial and anti-poor bias is explicitly and implicitly built into our institutions and then work to overcome these biases. To act against structural violence first requires us to expose the conditions that curtail life and hasten death in our midst.

**4.** **UBI Funds less productive people and enterprises**

**UBI punishes the creation of real wealth and value in order to subsidize less productive activities**

Tyler Durden 2017 (“The Dangers Of A "Universal Basic Income", http://www.zerohedge.com/news/2017-01-17/dangers-universal-basic-income)

Where UBI Proponents Go Wrong A universal basic income is not the god-sent welfare policy that it initially seems to be. **It does not create incentive to work**. **It won’t** help **solve unemployment, and it will not alleviate poverty**. **The truth is that a UBI will exaggerate all of these factors in comparison to what would exist in a more unhampered market**. There is even reason to think that it would be worse in the long run than traditional, means-tested welfare systems. **First, UBI does not eliminate the disincentives to work** that are **inherent in welfare programs; it simply moves them around**. **This program must be financed** after all, **and** any welfare system, including the **UBI, is necessarily a wealth redistribution scheme**. Wealth must be forced from those who have it to those who do not. This means that at some point on the income ladder, **people must go from being net receivers** of benefits **to** being **net payers of benefits**. The progressive taxation that is necessary to finance a UBI means that the more a person earns, the higher percentage of their wealth will be taken from them. **The work disincentives are therefore still very much present in the tax system**. They’ve simply been transferred onto different, higher income groups of people. The universal basic income shares another problem with traditional welfare systems. **Far from promoting the unemployed from searching for work the market rewards, it actually subsidizes non-productive activities**. The struggling entrepreneurs and artists mentioned earlier are struggling for a reason. For whatever reason, the market has deemed the goods they are providing to be insufficiently valuable. **Their work simply isn’t productive according to those who would potentially consume the goods or services in question**. **In a functioning marketplace, producers of goods the consumers don't want would quickly have to abandon such endeavors and focus their efforts into productive areas of the economy**. The universal basic income, however, allows them to continue their less-valued endeavors with the money of those who have actually produced value, which gets to the ultimate problem of all government welfare programs. **In the marketplace, wealth is earned by generating value**. When someone buys a good, they’ve earned the money they are spending by having produced something else. **This is not so with welfare programs like a universal basic income**. **Money is forcibly taken from those who have produced enough to earn it, and given to those who haven’t**. **This allows for people who aren’t producing wealth to continue to consume scarce goods**. Eventually, **all government welfare leads to the consumption of wealth**, or, at the very least, a reduction in the amount of wealth that would have been accumulated otherwise. When entrepreneurs have less need to respond to the needs and desires of their customers**, consumers will find themselves with fewer choices and with lower-quality choices. This means that overall welfare makes everyone poorer than they would have been in a free market.**

**These perverse incentives and negative externalities mean that UBI simply magnifies the problems with welfare**

Vanessa Brown Calder 2017 (Policy analyst at the Cato Institute, “Universal Basic Income — Disease or Cure?”, https://www.cato.org/publications/commentary/universal-basic-income-disease-or-cure)

Although UBI is a departure from traditional welfare, the idea isn’t truly devoid of welfare’s pitfalls. **On some fronts, UBI seems not only unable to avoid traditional welfare’s problems, but also likely to exacerbate them**. Many of the utopian qualities that recommend UBI to its supporters are strained in the real world. To begin with, the numbers for UBI don’t seem very feasible — at least not without large tax increases. According to Michael Tanner’s calculations, if the government provided just $12,316 for every individual in the United States, or enough to bring them to the non-elderly federal poverty line, the cost of UBI in the U.S. would be nearly $4.4 trillion, more than the entire U.S. federal budget. In his paper on the topic, he notes that “even if the guaranteed national income replaced every existing anti-poverty program, we would still be some $3.4 trillion short.” In order to make ends meet in this scenario, the tax liabilities of high-income individuals would likely be substantially impacted. The practical realities of budget constraints inevitably lead advocates — at least in the real world — to consider whether to limit the eligible population to strictly low-income individuals. However, this leaves UBI looking a lot less “universal” and a lot more like your average cash transfer welfare program, which fell out of favor in the U.S. in the 1990s. **Outside of the cost of the program, providing every U.S. citizen with a cash grant is likely to have a large and negative behavioral effect. Economists agree that welfare programs create labor supply disincentives, meaning that individuals reduce work because of government benefits.** As the Congressional Research Service has noted, an “increase in [the value of welfare benefits] is expected to cause people to reduce work hours.” While this is true of all welfare programs, only around 1/5th of the current U.S. population is currently impacted. If UBI were instituted, labor supply disincentives would touch 100 percent of the population, rather than a subgroup of eligible applicants. **Finally, whether UBI’s promised transparency/efficiency would actually materialize is an open question. The ability to deconstruct programs which benefit legions of special interest groups seems dubious at best**. In place of that, the ability to amend the U.S. constitution to direct all redistributive spending through a UBI system, as Charles Murray suggests, seems ever more unattainable.

**Increasing taxes to fund a basic income is inconsistent with libertarianism**

**Guy Standing, August 2017,** Professorial Research Associate at SOAS University of London and a founder member and honorary co-president of the Basic Income Earth Network (BIEN), Basic Income: A Guide for the Open-Minded, location p. location 694

Some other libertarians object to a basic income on the grounds that , to be at a level high enough to replace all welfare schemes , provide for a person’s most basic needs and protect the freedom of the vulnerable , it would have to involve much higher taxes , which , in their view , would infringe the freedom of taxpaying citizens . In arguing for what he called a ‘ consequential ’ libertarian case for basic income , Zwolinski recognized this trade - off : ‘ The idea is that a basic income can help protect the freedom of certain vulnerable people . But I recognize that a basic income that’s large and broad enough to do that might have to be funded by taxes that violate the freedom of others . So we are trading off freedom for freedom . ’ 10 Although this line of reasoning can be rebutted in various ways , the simplest retort is that unless the state protects the basi freedoms of its most vulnerable members , they will be inclined to hit back by violating the freedoms of those intensifying their vulnerability . If libertarians succeeded in creating such a minimalist social state that the vulnerable were left bereft of hope , they should not be surprised if the resentment led to some retributive justice .

**Adding basic income to the welfare state is inconsistent with libertarianism**

**Guy Standing, August 2017,** Professorial Research Associate at SOAS University of London and a founder member and honorary co-president of the Basic Income Earth Network (BIEN), Basic Income: A Guide for the Open-Minded, location p. 629

Another avowed libertarian , Matt Zwolinski , advocating what he called a basic income guarantee ( BIG ) , noted that US federal welfare programmes cost over $ 668 billion annually , spread over at least 126 programmes . To that must be added state and local welfare spending of $ 284 billion , totalling almost $ 1 trillion every year or over $ 20,000 for every poor person . 9 Meanwhile , benefit phase - out rules , varying from programme to programme , implied high marginal tax rates for those trying to move from benefits to low - paying jobs . Zwolinski asserted , ‘ **No libertarian would wish for a BIG as an addition to the currently existing welfare state** .  **This** is probably unfair to left libertarians , but **captures the essence of the right libertarian position** , ***that basic income would be a freedom - enhancing alternative to the intrusive government - driven welfare state .***