



Scottish Health Equity
Research Unit

Insights, analysis and action on the socio-economic factors
that shape health

Spotlight on Research

Two new studies on
the health impacts of
cash transfers

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August 2024

Two new studies about the health impacts of cash transfers reach conflicting conclusions.

Are there lessons for Scottish efforts to improve health and reduce health inequalities?

Last month, two new studies were published that looked at how giving cash to people with low incomes affects their health [1,2]. Both studies were conducted in the USA but in different states, and both used a Randomized Control Trial design, which is considered highly robust. Interestingly, the studies came to different conclusions.

One study, conducted near Boston, Massachusetts, concluded that *'policies that seek to alleviate poverty by providing income support may have important benefits for health and access to care'* [1]. In contrast, researchers examining the cash transfer programme in Illinois and Texas concluded that *'directly reducing poverty via cash transfers was not effective at improving health outcomes'* [2].

Since existing evidence shows there is a strong (albeit complex) relationship between poverty and health [3], and since previous studies of cash transfers in the USA have identified positive health impacts [4, 5], the findings of the second study are surprising. In this brief, we consider why two similar studies reached such different conclusions and explore whether there are any useful insights for Scotland.

What did these cash transfer studies involve?

Both studies involved giving cash to people with low incomes. In Massachusetts, researchers randomly selected 1,746 individuals through a lottery to receive \$400 a month on a debit card for nine months [1]. A control group, with similar profiles, received no cash. To assess the health impacts, the researchers examined changes in healthcare use (especially emergency department visits), COVID-19 vaccination rates, and biomarkers (from blood tests) such as cholesterol levels.

The study in Illinois and Texas provided 1,000 low-income adults (across the two states) with \$1,000 per month, deposited into their bank accounts (tax-free) for three years [2]. This study also had a control group of 2,000 participants who received \$50 per month over the same period. Researchers in this study examined a broader range of health outcomes, including self-reported mental and physical health, various biomarkers, and mortality, and they studied people over a longer period.

What did the analyses of health impacts show?

Although the two studies frame their conclusions about the health impacts of cash transfer programmes differently, they share some similarities in their findings. Both studies identified positive health impacts within a year of the intervention. The Illinois and Texas study found that, in the first year after the \$1,000 monthly cash transfers began, self-assessed mental health, stress levels, and food security improved, while problematic drinking and painkiller abuse decreased [2]. They also found evidence suggesting that cash transfers have the potential to contribute to longer-term health gains, noting that participants in the group receiving \$1,000 a month spent about \$20 per month more on medical care compared to control participants [2]. The Massachusetts study, which had a nine-month timeframe, found that recipients of the \$400 monthly benefit increased their use of outpatient subspecialty care and had significantly fewer emergency department visits than the control group [1]. This reduction included visits related to behavioural health and substance use.

However, there are also differences in the findings, notably in terms of the impact of cash transfers on healthcare use. The Massachusetts study team found that the cash transfer reduced emergency healthcare visits [1], while the Illinois and Texas study found that participants who received the \$1,000 transfer used emergency departments more [2]. It is hard to know if these differences relate to study design (e.g. intervention and study period or health outcome measures), context, or to the contrasting populations within each study.

The Massachusetts study used electronic health record data to analyse healthcare use, which included detailed information about visits, diagnoses, vaccinations, and lab results [1]. In contrast, the Illinois and Texas study relied on participants' self-reports of healthcare use and some medical bill information [2]. Both methods have limitations that could have influenced the findings.

Contextual differences may also play a role. Massachusetts is consistently ranked as one of the best states in the USA for healthcare access and performance, and it has some of the lowest rates of healthcare uninsurance [6]. In contrast, uninsurance rates are highest (of all USA states) in Texas, which consistently ranks among the worst states for healthcare access, while Illinois is in between [6, 7]. This disparity in people's ability to access healthcare might have affected the outcomes, especially relating to healthcare use.

What were the study limitations?

Despite their robust Randomized Controlled Trial designs, both studies have important limitations.

First, both studies focused on short-term cash transfers. The nine months intervention in Massachusetts is particularly short and seems unlikely to impact anything other than short-term decisions [1]. Both studies also assessed only short-term health impacts. Longer-term income security could have a greater impact on poverty reduction and health outcomes (and some health improvements may take longer to emerge).

Second, both studies were conducted during the COVID-19 pandemic, a highly unusual period that affected many people's health and incomes. This complicates the assessment of the findings. The Illinois and Texas researchers collected qualitative insights that could provide more context here, but these have not yet been reported in depth.

Third, there are some important limits to the data both studies used to assess health impacts. For example, although both studies reported on biomarkers like cholesterol, only a portion of participants provided this data, giving an incomplete picture. In the Illinois and Texas study, most blood samples were taken 2-4 months after the intervention ended, potentially missing improvements and capturing stress responses to the sudden drop in income [2]. It is also important to note that these biomarkers are risk factors for disease rather than health outcomes in themselves. Self-reported mental and physical health potentially provide a broader sense of health but these measures were only captured in the Texas and Illinois study (not the Massachusetts study), limiting comparability.

Fourth, the specific context of the USA, with its high healthcare costs, limits the applicability of these insights to Scotland. In the USA, increased engagement with healthcare is often seen as a positive outcome, suggesting better access and potential health gains. For instance, the Illinois and Texas study authors suggest that policymakers could improve health by investing in healthcare access [2]. However, in Scotland and the wider UK, the NHS provides tax-funded healthcare that is free at the point of delivery. Therefore, greater healthcare use is generally seen as a sign of worsening health, not improved access. This fundamental difference means the conclusions of US-based studies, in which indicators of healthcare use are key health outcome measures, are not easily transferable to Scotland.

Do these studies mean we should reconsider the role of poverty in poor health outcomes?

No.

Extensive evidence links poverty to poor health outcomes, both globally and specifically in Scotland. The relationship is complex, involving at least five key pathways:

1. **Material:** Insufficient income can lead to poor quality housing, homelessness, inadequate food, and lack of heating, all of which negatively impact physical health.
2. **Psychosocial:** Poverty and debt can cause anxiety, stress, and guilt, contributing to depression and poor mental health.
3. **Structural:** Low income often forces people to live in areas with negative health impacts, such as high air pollution, traffic accidents, anti-social behaviour, crime and violence. Poorer areas in Scotland also tend to have more shops selling unhealthy products (e.g. alcohol and tobacco) and may lack amenities to support health (e.g. safe exercise spaces).
4. **Reverse Causality:** Illness can cause job loss or reduced work hours, and when family members become ill, others may leave the labour market to become carers, meaning poor health can also be a factor that contributes to people experiencing poverty.
5. **Stigma, Discrimination, and Penalties:** People in poorer areas often experience stigma and discrimination, impacting job applications and access to services, and they often face higher costs for essentials like energy.

The Illinois and Texas study authors claim their results show that *'reducing poverty via cash transfers was not effective at improving health outcomes'* and contrast this with expert calls to address health disparities by *'eliminating poverty'* [2]. However, their study only explored the short-term health impacts of temporary cash transfers to a specific, randomly assigned group. This is very different from providing long-term income security to large sections of the population or eliminating poverty on a societal scale. Considering these five pathways, it remains likely that longer-term, more ambitious efforts to reduce poverty are likely to have significant health impacts in Scotland. Research showing the way social and economic factors accumulate over people's lifetimes highlights the importance of examining the health impacts of income changes over much longer time-scales.

There are also good reasons to reduce poverty for reasons beyond health. For instance, the Illinois and Texas study found that many recipients of the \$1,000 monthly income reduced their working hours to increase leisure time, and in some cases, others in the household did likewise [8]. While economists sometimes view reductions in working hours negatively, the long working hours typical in the USA mean that more leisure time could be seen as a social good, potentially contributing to better long-term health and employment opportunities for others.

Do these studies suggest that policies to increase income are not a promising way of improving health in Scotland?

No.

The studies provide conflicting assessments of the short-term health impacts of temporary increases in income in a setting that is markedly different from Scotland, particularly in terms of healthcare access. If we want to understand how income increases might affect the health of people with low incomes in Scotland, we need to either conduct research in Scotland or examine multiple studies from various contexts to understand how and why different studies reach different conclusions. A new international systematic review of this relationship is underway and will contribute to existing review level evidence on the health impacts of interventions to boost low incomes [9].

Moreover, we need studies that combine quantitative analyses with in-depth qualitative insights to better understand people's experiences, choices, motivations and decision-making (as has been proposed for evaluating a citizens' basic income in Scotland [10]). This comprehensive approach will help grasp the full impacts of income increases on health in different contexts, including Scotland.

So, can we draw lessons from these studies?

Yes.

Despite the very different context, these studies suggest that short-term income boosts alone may have limited health-related impacts. Given the extensive evidence demonstrating multiple, complex pathways linking poverty and poor health, this makes sense. Achieving sustainable health gains will likely require a more systemic response to addressing poverty, involving a mixture of social and economic policies, over longer-periods.

Acknowledgements

Thanks to Professor Gerry McCartney, Dr Otto Lenhart and Chris Creegan for feedback on an earlier draft of this briefing.

Citation

Smith, K.E. (2024) Two new studies on the health impacts of cash transfers. *SHERU Spotlight on Research*, August 2024. The Scottish Health Equity Research Unit (SHERU).
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The Scottish Health Equity Research Unit is supported by the Health Foundation, an independent charitable organisation working to build a healthier UK, as part of its Driving improving health and reducing health inequalities in Scotland programme.

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