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# Minimum Income for Healthy Living (MIHL)

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**Abstract**

This is the edited transcription of a presentation by Professor JN Morris to ESRC *International Centre for Life Course Studies in Society and Health* (ICLS) in June 2009. It summarises an investigation which was sparked by the introduction of the National Minimum Wage. Surprised that health was ignored in calculations of the minimum wage, Professor Morris and his colleagues set out to estimate the minimum income required to support good health. The presentation describes the two population groups studied first: (a) young, single men; (b) retired people without disability.

**Keywords**

Minimum income for healthy living. Young, single men. Retired people without disability.

**Professor JN Morris*:***

I am going to skate over a lot of things and leave a lot unsaid, but I am leaving two papers here with David Blane. One is our last publication[1], which contains a lot of detail; and also another recent, very recent memorandum[2] that our group prepared for the Marmot Review of Health Inequalities[3], which contains a weight of information. I am leaving these two papers with David and I am sure that if you are interested in any particular detail that he will be able to let you have a copy.

Minimum Wage.

Our work on a Minimum Income for Healthy Living (MIHL) started in 1997/1998 in relation to the national minimum wage. As you'll probably remember the Labour Party in its election manifesto for the 1997 General Election promised that if elected they would institute a statutory national minimum wage. And of course they were elected, as you remember, and they steadily set about fulfilling this promise in the standard manner - they appointed an expert committee to explore the situation in detail.

This aroused a great deal of interest all over the country, but I was astonished and disappointed that in all the discussion in Parliament and in the social policy community, in the health community, public health, the media, there was scarcely ever any mention at all of the needs for health which such a minimum wage should at least theoretically be capable of meeting.

This was really quite astonishing to someone like myself in social medicine. It's enough to say there was virtually no mention of health. And there was certainly no discussion of the health needs which such a minimum wage should be capable of meeting. This in the context of the phenomenal worldwide bio-medical and social research that has been carried out since the Second World War, which had yielded knowledge, solid knowledge, on major key essentials for healthy living in several fields, some of which I will be mentioning.

Well, a group of us at the London School of Hygiene decided to get together and have a go at this. We did this in a very light-hearted manner; we were all full-time employees, busy with other things. But we thought we'll have a go and a group of us from public health, nutrition, from housing, from psychosocial relations and so forth got together and we said we'll have a go. Let's attempt to see if we can design a minimum income, minimum realistic income, that at least theoretically will enable people to live healthy lives according to what has been established by research.

Single young men.
We chose the simplest possible case, of course, because we were all very busy people (all, as a matter of fact, experienced research workers). We chose the case of healthy, single, young men in average employment, living away from home. And we set about our task, which proved a far more difficult enterprise than we had imagined, needless to say, because most of the information was not available in a form suitable for our particular purposes. And a lot of it had to be translated into the needs of our young men between 18 and 30 years, which was the age range we had chosen.

Now I am not going to spend any time on this; I will just go through the summary because I want to go on to the main subject which has occupied us in recent years, which is working on a minimum income for healthy living for old people, which is a much more serious problem.

But let me just give you a summary of the results for single young men[4]. Minimum income for healthy living, in 1999 pounds sterling, we established was £131.86 per week. That is for nutrition, exercise, psychosocial relations and housing – the latter proved an enormously difficult problem, because housing costs vary wildly, depending on area.

At that time, the national minimum wage for 38 hours work, as established by the government's committee and its own deliberations, was £121.12. This was the figure which the TUC gave us, depending on age. The national minimum wage as you know depends on age, younger men getting less.

So we established that the minimum income for healthy living was £131.86; that the national minimum wage was lower; and for comparison I will give you the Job Seekers Allowance of £51.40, which is the unemployment pay. Obviously there is no relation to what a single man would be needing per week in 1999.

Before leaving young single men, I must point out that their minimum income for healthy living, as we calculated it, is an underestimate. We were unable to find realistic data about the cost of some important aspects of the life of a healthy young man, for instance their sexual relationships. There were no survey data that we could use, although all the members of the research committee were willing to give their own experiences, including mine as a penniless doctor in the 1930s [laughs]. So our MIHL is a serious underestimate.

Older people.

Well, anyhow, this was quite enough for the time being. Next we decided to do something much more systematic in a serious way and we decided to work on the minimum income for healthy living for old people.

We defined the study population as aged 65+ years, singles and couples, male and female, living independently in the community (over 95% of old people in Britain live independently in the community; less than 5% are in some form of institution). And very importantly, and this is a picture of what happens when you go into a field like this, having no significant disability. There have been various surveys of disability carried out nationally and internationally. We used the survey that was most practicable, developed by UCL and the National Institute of Social Work Research, which found that 40 per cent of those aged 65+ living in the community have a definable, significant disability.

As some of you will know, and I can tell you categorically this is a vast open field for research, there is vast knowledge on the medical aspects of disability and there is vast knowledge of the social aspects of disability, but in terms of bringing them together, in terms of social needs, this is something which has defeated government after government after government. There is actually a new White Paper this week on social care, which is another attempt at dealing with it.

After spending a lot of time, doing a lot of work, we decided we simply had to omit the disabled. There weren't the data available; and we didn't have the research resources, medical and social, to cope with this, so our calculation of the minimum income for healthy living for older people is strictly limited to the 60 per cent of old people with no defined significant disability.

MIHL components.

I have to be brief, but let me indicate the contents of the minimum income for healthy living. See table on the next page. This is now our latest version.

*Table 1: Minimum Income for Healthy Living (MIHL). Components and summary personal costs. Older people, 65+, without significant disability living in the community, England, April 2008*

| **MIHL** | **Weekly cost (£s)** | |
|---|---|---|
| | **Singles** | **Couple** |
| Diet/nutrition. Weight regulation | 35.30 | 69.70 |
| Physical activity: health, fitness. Anti-ageing. Autonomy. Weight regulation | 2.30 | 4.30 |
| Housing, a home | 35.00 | 38.20 |
| Psychosocial relations, social connections/participation. Active minds. Education. Anti-ageing | 23.50 | 34.00 |
| Getting about * (personal transport) | 3.50 | 6.90 |
| Medical care$ | 2.20 | 4.40 |
| Hygiene+ | 5.30 | 8.50 |
| Other cost of healthy social living~ | 12.90 | 25.50 |
| Contingencies. Inefficiencies. Emergencies | 14.20 | 18.50 |
| Personal choice/error | 10.00 | 20.00 |
| Total MIHL at April 2008 | 144.20 | 230.00 |
| *Prominently bus, occasional taxi :$ The few residuals in England : + Including personal care, household cleaning, laundry, dry cleaning: ~ -e.g. clothing, household goods<br>MIHL excludes rent, mortgage, Council Tax, and allows for Government and Local Authority provisions. | | |

*Diet and nutrition,* of course, which bring in weight regulation.

*Physical activity and fitness*, which also bring in weight regulation. And when you are dealing with the physical activity of older people, of course, you are dealing with much more than fitness; you are dealing also with autonomy, with the capability for functioning in society. Which is absolutely crucial. And very interestingly – this is rather a hobbyhorse of mine – there are definite indications that physical activity and the psychosocial relationships have an anti-ageing effect in various ways, some obvious and some not so obvious. It's now an active field of research and of course anti-ageing is now policy important.

*Housing/home*. This is very interesting. This is the sort of thing that happens when you do research like this: the data on healthy housing are grossly inadequate. The national data, although they involve huge sums of public money, and have for years used up huge sums of public money, are grossly inadequate in terms of standards (as to why, if some of you are interested, our housing expert has a think piece in one of the papers I've left with David – see references below). This basic measure, the cost of healthy

housing, has been neglected largely; a partial exception is the considerable work on in-door temperature, fuel poverty and their relation to mortality in this and other countries. But it's very limited – healthy housing is more than in-door temperature. Here is a major field open now for research.

*Psychosocial relationships, social interaction, social participation*: This again is an enormously active field of research and is very interesting to me wading through masses of papers from across the world, chiefly America but also quite a substantial set in this country and various other countries. There is a vast literature on the importance of psychosocial relations in older people, but we didn't discover a single paper that considered their cost; what it costs to act on these beautiful demonstrations. I won't go into details, but very encouraging are the studies which point to maintaining liveliness of mind and active minds and their anti-ageing potential.

*Getting about*. The cost varies wildly in different parts of the country. London is a pioneer, having a free bus pass. Which is an understatement - it's free on the whole of public transport in London for old age pensioners. We had to produce average figures here.

*Health and medical care*. This raises two questions. First, the actual cost of health and medical care. And second, the extent to which social care provides the needs for healthy living. We start in Britain with free prescriptions for older people, free eye tests for older people, plus other plans, although the provision of social care is a grey area, with various objections to increasing provision for poor older people.

There are some residual health and medical care costs, like dental care. Nobody gets dental care unless they are rich, so it's not just a question of minimum income for healthy living. Eye testing is free, but there are problems about spectacles and so forth. Hygiene, both personal and domestic, involves housing questions, personal grooming questions and of course, food hygiene. These have to be costed.

*Miscellaneous costs*. Things like contingencies and emergencies. And at we've allowed for some personal choice and errors and deficiencies. We didn't include these in our earlier studies, but have been persuaded that you must make some allowance for personal choice. It's very interesting, in every survey which we found, no matter how poor the old people, they always found a little money for gifts to grandchildren. This surprised us. Of course it shouldn't have been a shock because I remember the first time that we as grandparents went to the baby's department in Brent Cross and we were very interested to see that the only other customers were two other ancient couples like us. [laughs]. So we've included a little bit for this. And there are the various other costs: subscriptions, social club etc, costed from Age Concern data. Meeting friends and entertaining. A television set and licence; as you know the television licence is another plan for old people - for the oldest old people it's free, but not for the younger, so we averaged the television costs. Newspapers? We had a tremendous argument about this - are we going to subsidise sometimes unedifying national newspapers from a social medicine department in the London School of Hygiene? In the end we decided that we

must, despite our reservations. Holidays? After much enquiry, we decided we simply had to include them, because we are not talking about subsistence levels, but healthy and worthwhile living.

We made certain assumptions, such as “assume all books are obtained from the public library”. This is something we did with regret, because even the cheapest paperbacks nowadays are so dear and public libraries are a declining institution. Nevertheless, we felt we had to say: books obtained from the public library.

We assumed that the local newspaper, which is vital for old people, is free. And of course there is no cost for radio. But you see how the costs mount up.
I haven’t given you the costs of all the other items. They are available in the publications that David now holds (see references below).

MIHL for older people.
Let’s compare the State Pension with what we’ve finally produced on a minimum income for healthy living for older people. The costs are for pounds sterling in April 2007 in England.

*Table 2: Disposable incomes in old age. England April 2007, weekly.*

| | **State pension** | **Pension credit guarantee** | **Minimum income for healthy living** |
|---|---|---|---|
| **Single person** | £87.30 | £119.05 | £131.00 |
| **Couple** | £139.60 | £181.70 | £208.00 |

The state pension, which everybody gets, with different weekly rates for singles (£87.30) and for couples (£139.60). The Pension Credit Guarantee is the government’s safety net; the government’s floor, below which they believe poor people should not fall. It is means tested. And unfortunately large numbers of older people who are eligible for it, do not apply. In April 2007 the Pension Credit Guarantee per week was £119.05 for a single person and £181.70 for a couple.

The MIHL was calculated by adding together all the costs of nutrition, utility and so forth. The MIHL for older people was £131.00 (single person) or £208.00 (couple) - substantially more than the Pension Credit Guarantee .

And remember: our minimum income for healthy living excludes the 40 per cent of older people who have a significant disability, of whom only those with a very serious disability will be eligible for a Disabled Persons Allowance, in addition to the Pension Credit Guarantee. For the rest, whose disabilities are judged as less severe, the gap between MIHL and Pension Credit Guarantee is more than estimated above. So the comparisons are not really very fair in that the minimum income for healthy living which we developed is under certain conditions.

Summary & Conclusions.

Now let's be a little bit more theoretical about the principles of this minimum income for healthy living that we've developed. The basis of our work is the scientific knowledge on these measures that has been established, I would say, since the Second World War.

As I mentioned in opening, there has been a vast international research effort in nutrition and physical activity, the fields in which I'm interested personally; fields that has been completely transformed. If you look at the textbooks of the 1930s and the modern textbooks, there is scarcely any comparison - a few basic facts were there but the rest is modern knowledge.

Essentially we worked on the results of international expert committees. For instance on the nutrition of old people we were very fortunate when we started work, WHO had just set up an international expert committee of the world's experts on nutrition of old people to develop an essential diet, essential nutrition for old people. By a stroke of luck the chairman of that committee is a professor in our school, so we were able to double check. As well as the results of international and national expert committees, we used the results of randomised trials. Where these weren't available we used the best of our own judgement, with a great deal of consultation with the experts in the fields so that we got a consensus. And there's been virtually no criticism of the actual details of the contents of MIHL that we have published.

Let me go through science-base of the key research on personal health and wellbeing. We can talk, not very confidently, but with a fair degree of confidence about nutrition and physical activity, psychosocial relations, hygiene and various others. About housing we can't. With housing you just make estimates and we have to describe the various estimates. Because the data aren't there. It's very interesting how this is a field of research has been neglected over the years, for reasons I haven't time to discuss. So the data on housing are weak by comparison with the rest. Maybe seriously weak - we can't say, although we would like to know.

Still on housing: there are data on in-door temperature which is very important to health in winter and a major political issue in this country, in terms of fuel poverty and the financial allowances that are made to old people each winter. Those of you who remember last winter (2008) will remember it was a daily major item in the newspapers and how the government had to be, it's not fair to say had to be driven, but had to be pushed on that. They developed other ways of dealing with these major aspects of temperature regulation, so now local authorities increasingly provide resources for home insulation to quite good scientific standards; and so on. But it still remains a national disgrace that the mortality of our old people in cold winters is very bad.

I've mentioned the science on some key aspects of personal circumstances, including the consensual best evidence for healthy participatory living. This was of particular value to us in the social aspects of MIHL. It's very interesting how on the sociological side of poverty Peter Townsend deserves credit for really putting this on the map. He developed the importance of defining poverty not merely in terms of subsistence needs like food but also the capacity for social participatory living.

It's very interesting to me to observe this. My oldest work developed quite independently of the work on psychosocial relations which had been going on in the health field. Same with social research – ne'er the twain shall meet. If you look for instance at Ruth Lister's recent book on poverty, there isn't a mention of the vast health research work that is strictly parallel with the social research on social participation and the necessity for social participatory - participatory is a good word – that has developed. I think Peter really deserves the main credit, because he certainly put it on the map.

To calculate MIHL we translate the knowledge, the data, into what we believe are acceptable ways of living for the relevant population. Now this is where we are very weak - we didn't have the funds to test MIHL on any population. In a country like Britain there would have to be several populations of old people, each with their own ways of living, equally healthy in terms of the basic needs for health. This is a field for research which simply has to be done.

Meanwhile we have translated these data into acceptable ways of living for specific populations in Britain and have published in detail what we've done about old people and have published in detail about what we'd done about young men, the two case studies that we have completed so far.

Very importantly we have to assess the minimum personal cost that these would entail now in England, allowing for public provision. For instance we allow for public transport in London which is quite different from public transport in Manchester - we have to allow for this to assess the minimum personal cost. And through this process there appears the minimum personal income required for healthy living in specific populations.

We believe that public health should now move into attempts to define MIHL for specific populations and that public health should now … I was going to say agitate but that should be a late word. I used to teach my students *The Three As of Public Health*. First, **A**nalysis which is a simple term for the whole of research people, research and knowledge field required. Second, and this is accepted by pretty well everybody in public health, **A**dvocacy - and there is quite a lot of advocacy around. But I believe third, and this has been a tradition in public health since the 19th century certainly, and you find indications in the 18th century, **A**ctivism. Public health to my mind should be an active political process; and this I believe, this is now required. Especially in the field of health inequalities where analysis, which now is at the most phenomenal scale, and advocacy have achieved very little but the government is now demanding action, activism which will reduce health inequalities.

We finally say that the minimum cost of healthy living is a benchmark for the health community in terms of acceptable minimum income which we as a health community will accept. The health community is continually requested for views on this and that. We believe that the health community should have a minimum income for healthy living as a benchmark. This is a minimum which we must go for. So as David said, this is very elementary, old-fashioned social medicine. And it's a very interesting example.

Let's talk about some of the positive and some of the negative features of MIHL. First some of the positives. MIHL attempts to get at the root causes; in the jargon it's an upstream attempt to get at health inequalities. It increases equality of opportunity, the most elementary equality. If you've got the least interest in equality, equality of opportunities is an absolute basic minimum. It is just a nibble if you like, a small attempt, a nibble at equality of opportunity.

It provides a benchmark for the health community, including the clinical community who are constantly being asked to assess this particular patient or that particular patient. So it's essential that they have standards against which to judge whether a healthy life is possible.

And of course, at the very least identifying the minimum income for healthy living will provide a splendid platform for health education. Particularly if the government adopts as a policy to translate all this phenomenal research effort into the ways of people's living.

It is very interesting that quite recently government in America and this country, it's particularly clear in Britain, has realised that it cannot simply leave the clinical services to adopt the results of research. Now the translation of the results of research into clinical practice has become an obligation. Not a request, not a suggestion. And we believe that the same principle should apply in public health. If we've learned these things about nutrition and we've learned these things about physical activity, for instance, it's a national disgrace that we have children's obesity. It is a shame on the nation. It's unspeakable when you realise that the knowledge has been there for 40 years. So we have to advocate that the same principle that has now been adopted in clinical practice should be adopted in terms of public health and prevention. That it should be an obligation on society to attempt to cope with the knowledge that has been developed.

Well, these are a few of the positives. Now the negatives: there are important negative features of what we've done, particularly that we simply have no idea of the cost that would be entailed. We've done various estimates but this is much too serious an issue for amateur efforts. This requires a serious estimate of the cost because it's quite a tricky business as I've tried to indicate. There are all sorts of cost currents here. And we've got to face it - there are indications that redistribution is becoming less popular an idea. So there is a fair degree of public education required.

Finally I'd say, as David already indicated, that this is a matter of a merger needed between the social sciences and the biomedical sciences. You might say you can't even begin this kind of work without joint work and this at present is deficient in this country. I won't say anything about other countries but it's deficient here, with far too little joint working. I am not sure why it's like this. I'd better not say anything or give my personal views, as I want to leave time for discussion.

[end of presentation, applause followed by discussion]

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**Tabels:**

Table 1: Minimum Income for Healthy Living (MIHL). Components and summary personal costs. Older people, 65+, without significant disability living in the community, England, April 2008 in Morris JN, Wilkinson P, Dangour A, Deeming C, Fletcher A. Defining a minimum income for healthy living: older people, England. *International Journal of Epidemiology* 2007;36:1304

Table 2: Disposable incomes in old age. England April 2007, weekly in Morris JN, Wilkinson P, Dangour A. Proposal to the Marmot Commission: Minimum Income for Healthy Living, Table 4 pg 11.


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