What are health inequalities?

Health inequalities are unjust health differences that occur between social groups. Their fundamental causes lie in the sociopolitical power relations between population groups and social classes, and in the variations in the distribution of power, money and resources that result. These, in turn, result in differences in environmental and individual resources (e.g. the quality and availability of employment, housing, transport, access to services, and social and cultural resources).

Differences in power, money and resources are commonly described in terms of socioeconomic status or social class, but can also result from other characteristics such as gender, sexual orientation and race. Taken together, these elements shape individual and group exposures (e.g. through discrimination) to factors which promote or damage health, with these exposures accumulating over time to generate the behaviour, conditions and outcomes we know as health inequalities.

Health inequalities are reflected in the social gradient across the whole population (see Figure 1), not only the gap between the most and the least disadvantaged. Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently; indeed, it may stigmatise those most affected while missing the opportunity to build cohesion across the population, who are all negatively impacted to a greater or lesser extent. To reduce the steep social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. This type of method has been termed ‘proportionate universalism’.

Proportionate universalism and health inequalities
Figure 1 – All-cause mortality among those aged <75 years by income–employment index, Scotland 2010 (Source: Scottish Government. Long-Term Monitoring of Health Inequalities: Headline Indicators. Edinburgh: Scottish Government; 2012).

Note: the income–employment index consists of two of the domains of the Scottish Index of Multiple Deprivation (i.e. SIMD minus the health and access domains) and ranks people by their area of residence according to the prevalence of unemployment and receipt of income support within datazones.

The European Age Standardised Rate (EASR) is a (mortality) rate which has been calculated using a standard population structure (1976 standard population) to facilitate comparisons between populations at a single point in time, or in the same population through time, without mixing the impact of a changing or different age structure in the population.
What is proportionate universalism?

Proportionate universalism is the resourcing and delivering of universal services at a scale and intensity proportionate to the degree of need. Services are therefore universally available, not only for the most disadvantaged, and are able to respond to the level of presenting need.

Approaches to addressing health inequalities have fallen into three broad categories:

1. A focus on improving the health of the most disadvantaged groups.
2. A focus on reducing the gap between the best and the worst off.
3. A focus on reducing the entire social gradient.

Proportionate universalism has been described as a hybrid approach which combines the first and third approaches above. The principles of proportionate universalism are already in existence. For example, the NHS Scotland Resource Allocation Committee (NRAC) formula for NHS funding seeks to weight funding towards territorial Health Boards with greater need (based on rurality, deprivation and the age profile of the population). This principle could be extended to the funding of other services. An alternative definition of progressive universalism is often used in relation to children’s services.

‘Progressive universalism – a universal service that is systematically planned and delivered to give a continuum of support according to need at neighbourhood and individual level in order to achieve greater equity of outcomes for all children’.

Proportionate universalism is the resourcing and delivering of universal services at a scale and intensity proportionate to the degree of need.
Why is proportionate universalism important?

There are advantages and disadvantages to each approach to addressing health inequalities. Proportionate universalism offers an alternative approach that may overcome the limitations of taking each approach separately.

Focusing on improving the health of the most disadvantaged groups by improving social conditions, reducing risk factors and improving life opportunities is a commonly adopted approach. Area-based initiatives are often used to target low income households or specific groups of concern, such as teenage mothers. Although this approach focuses attention and resources on marginalised groups and can be quite easily monitored, there are also disadvantages. Focusing resources on the most disadvantaged areas does not always mean that the most disadvantaged individuals are being reached, as many low-income households and unemployed people do not live in the most disadvantaged areas. This approach focuses on a small proportion of the population and does not address the socioeconomic gradient in health inequalities. There is a danger that providing services for only the most disadvantaged group undermines the collective interest in those services being high quality and funded from general taxation. This could lead to poor-quality services, stigmatisation of those who use them and resentment at the use of taxes to fund them.

The third approach considers the gradient across the whole population, seeking to impact on not only the most disadvantaged groups but all those suffering relative disadvantage as a result of their place on the social gradient. However, interventions are often universally applied. Therefore, those with access to the greatest resources are best placed to take advantage of the activities and messages to make changes which benefit their health.

Proportionate universalism aims to improve the health of the whole population, across the social gradient, while simultaneously improving the health of the most disadvantaged fastest. This approach recognises the continuum of need and addresses the possible disadvantage of a purely universal approach, which may result in disproportionate benefits for those groups most able to make use of services. Planning for proportionate universalism will require an assessment of need and an understanding of the impact of social inequalities on health outcomes, as well as a judgement as to how much additional resource should be allocated per ‘unit’ of additional need (the weighting). Where possible, it is best to use a direct measure of need (such as individual income) rather than a proxy measure (such as area deprivation).
Proportionate universalism in practice

As discussed earlier, there are already a number of areas incorporating the principles of proportionate universalism, for example progressive taxation such as income tax. Some of the Health Improvement, Efficiency, Access to Services and Treatment (HEAT) targets use principles of proportionate universalism to encourage additional efforts in the most deprived areas. Examples of such HEAT targets include:

- Health improvement target: at least 60% of 3- and 4-year-old children in each SIMD quintile to receive at least two applications of fluoride varnish (FV) per year by March 2014. Progress is measured by the percentage in the worst-performing SIMD.

- Access target: at least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by the 12th week of gestation by March 2015 so as to ensure improvements in breastfeeding rates and other important health behaviours. Progress is measured by percentage in the worst performing SIMD.

In practice, policies designed along principles of proportionate universalism fall into two types:

1. Policy that produces either a universal exposure or a universal benefit, with no ‘special device’ for disadvantaged groups. The benefits of this increase through the gradient, for example the availability of free prescriptions.

2. Universal policy which explicitly incorporates criteria to increase resource allocation to populations with specific or increasing needs. The NRAC formula for geographical distribution of resources for the NHS may be one example of this type of policy.

It is likely that in order to maximise health inequality reductions, redistributive policies, such as progressive taxation, will be required in order to change the gradient itself. In practice, a combination of different approaches will be required to maximise population health and minimise health inequalities.

This report should be cited as Macdonald W, Beeston C, McCullough S. Proportionate Universalism and Health Inequalities. Edinburgh: NHS Health Scotland; 2014.
References


