



National Collaborating Centre
for Determinants of Health

Centre de collaboration nationale
des déterminants de la santé



LET'S TALK
UNIVERSAL AND
TARGETED APPROACHES
TO HEALTH EQUITY

PART OF THE LET'S TALK SERIES

AN OVERVIEW

UNIVERSAL APPROACHES

TARGETED APPROACHES

DESCRIPTION

Apply to an entire population.

Eligibility and access are based simply on being part of a defined population⁴ such as *all women*, *all children under age six*, or *all people living in a particular geographic area*, without any further qualifiers such as income, education, class, race, place of origin, or employment status.

Are based on the belief that each member of society should have equal access to basic services such as education or health care.⁵

Apply to a priority sub-group within the broader, defined population.

Eligibility and access to services are determined by selection criteria, such as income, health status, employment status or neighbourhood.

Are based on a belief that social constructs (for example, classism, sexism, racism and colonization) are barriers to equitable access to the determinants of health, and that interventions directed to disadvantaged members of society are needed to close the health gap.

EXAMPLES

Canada's universal health care system has a goal of reaching all Canadians, regardless of age, income or employment status. It provides access to a basic level of health care for all Canadian citizens and permanent residents.

Numerous initiatives across Canada address food insecurity for those living on a low income. Targeted initiatives include food subsidies, local pocket food⁶ markets, healthy food boxes, and community gardens in low income neighbourhoods.

CHALLENGES

Universal in *principle* may not be universal in *practice*. For example, access to green space and physical activity is influenced by determinants such as education, income, gender, and ethnicity, as well as where we live and work.⁷

Universal programs may advantage people who are *already* in favourable positions, or fail to proportionately improve the outcomes of those in less favourable circumstances, thereby widening the health gap.⁸

Targeted approaches may address the *consequences* of inequities rather than their *causes*. Sometimes a targeted intervention intended to address structural causes can drift toward a focus on education for behaviour change, or what has been called "lifestyle drift."⁹

Understanding the target population requires appropriate data, gathered over time.

Determining eligibility can be problematic. There is potential for *exclusion errors* (under coverage) and *inclusion errors* (over subscription).¹⁰

Health equity means that people are not disadvantaged from attaining their full health potential because of social constructs such as race, ethnicity, religion, gender, age, social class, or socio-economic status.¹

Improving the overall health of a population, while reducing inequities between groups is an important part of Canada's public health mandate.² This mandate has implications for public health policy and practice.

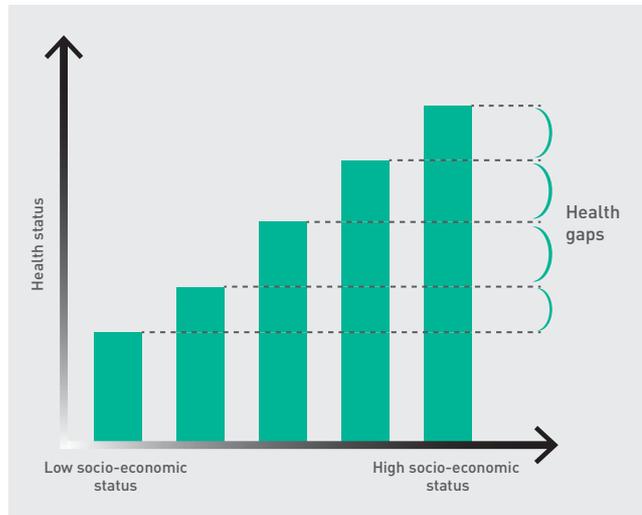
UNDERSTANDING THE HEALTH GRADIENT AND THE HEALTH GAP

In general, people with lower socio-economic status (SES)³ have poorer health. In Canada, people living in poverty have a lower life expectancy, as well as higher rates of infant mortality, low birth weight, and chronic disease. Conversely, those with higher SES tend to have better health.³ This disparity exists because people with lower SES have reduced access not only to health services, but also to the broader determinants of health, such as housing, food security, and education.

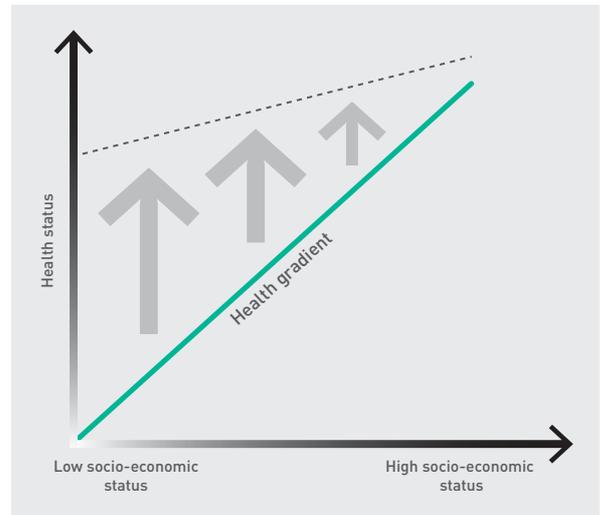
The difference between those who are **most and least healthy** in a society is called the **health gap**. This gap is present at every step of the socio-economic spectrum: those with higher status are healthier than those below them. This consistent pattern is called the **health gradient**.¹

Improving the overall health of the population and reducing the steepness of the health gradient is described as **levelling up**.¹

THEORETICAL REPRESENTATION OF HEALTH GAPS



THEORETICAL REPRESENTATION OF THE HEALTH GRADIENT AND LEVELLING UP



Many public health organizations are working to close the health gap and level the gradient. To do this, they use a continuum of approaches, including universal, targeted and blended approaches such as targeted universal and proportionate universal. In choosing the approach to use, decision makers must scrutinize the values, assumptions, and evidence they bring to the policy or program development process.

BLENDED APPROACHES TO ADDRESSING HEALTH EQUITY

Because both universal and targeted approaches have strengths and challenges, public health organizations will often create interventions that blend approaches. These interventions, which fall along a continuum, are designed to address both the health gap and the health gradient.

Targeted universalism¹¹ is a blended approach that recognizes that universalism can still result in an unacceptable health gap, and that a targeted approach can have little effect on the slope of the health gradient. Targeted universalism defines goals for all, identifies the obstacles faced by specific groups, and tailors strategies to address the barriers in those situations.¹²

EXAMPLE OF TARGETED UNIVERSALISM:

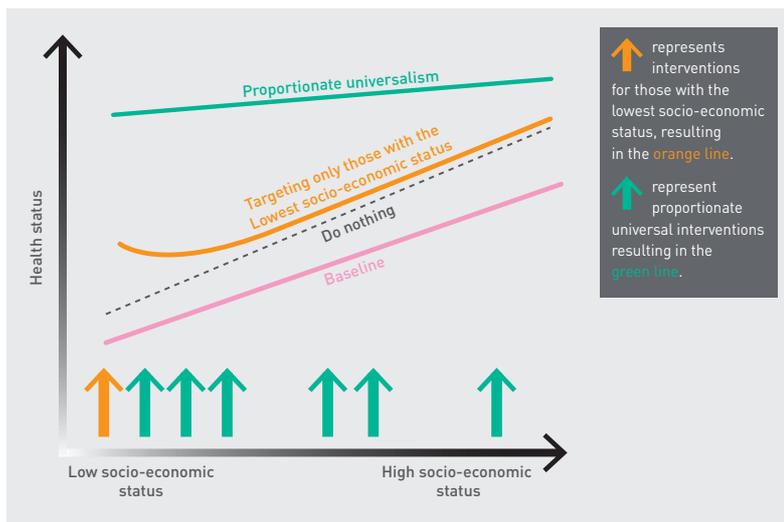
A universal flu vaccine program can include a special outreach strategy for groups at higher risk of becoming ill, or those less likely to get the vaccine, including pregnant women, young children, seniors and Aboriginal populations. Strategies may include peer outreach, satellite venues, and partnering with community groups.

Sometimes the targeted aspect of this blended approach can result in benefits for all. For example, when application forms are adapted to plain language versions for low literacy clients, all users benefit from the clarity.

While targeted universalism is an increasingly familiar framework in Canada and the United States, a somewhat similar approach called **proportionate universalism**¹³ is gaining acceptance in Europe and the United Kingdom. A proportionate universalism approach recognizes that to level

up the gradient, programs and policies must include a range of responses for different levels of disadvantage experienced within the population. A leading proponent of this approach is Michael Marmot, past Chair of the World Health Organization Commission on the Social Determinants of Health. In his words, "Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage."¹³

THEORETICAL REPRESENTATION OF THE EFFECT OF DIFFERENT APPROACHES TO REDUCE HEALTH INEQUITIES



EXAMPLE OF PROPORTIONATE UNIVERSALISM:

For over a decade Healthy Child Manitoba has funded health authorities to offer a no cost, home visiting program for families with children, from pregnancy to school entry. First, all families with newborns are contacted by a public-health nurse. Then, parents facing more challenges are matched with Families First home visitors who support the family, in many different ways and for up to three years, depending on the situation.¹⁴

PRACTICE EXAMPLE

A public health manager wants to promote breastfeeding in her area. She has read the evidence showing a positive connection between breastfeeding and infant health outcomes¹⁵ as well as a connection between mothers who live on very low incomes and low rates of breastfeeding.¹⁶ Examples of some of the intervention approaches available to her are:

UNIVERSAL

- Work with organizations, businesses and community groups to advocate for baby friendly environments.¹⁶

TARGETED

- Offer breastfeeding education and support in lower income neighbourhoods.

TARGETED UNIVERSAL

- Advocate for baby friendly environments, and work with community groups to strengthen policies and programs supporting “breast is best” engagement with low income women.

CONSIDERATIONS FOR PUBLIC HEALTH PRACTITIONERS

1. Intervention decisions should be informed by evidence. Increasingly, public health units are publishing data on the connections between population health and underlying social constructs, and the impacts of their interventions. One place to look for evidence is healthevidence.org
2. Clarify your goals for a proposed intervention. A range of tools are available to help you ask key equity questions at every stage of program planning and implementation,¹⁷ including those that relate to our perceptions, biases and personal position on the health gradient. These tools can help you build partnerships with the intended beneficiaries of proposed interventions. An excellent place to look for tools is the [National Collaborating Centre for Methods and Tools](#).
3. Your intervention experience is valuable to others. Think about documenting it and making it available - in a one-page summary, a lunch-and-learn presentation, a report, or a peer-reviewed publication.

DISCUSSION QUESTIONS

1. Identify a public health initiative focused on health equity in your community.

- a. What concern was the initiative designed to address?
- b. Is the approach universal, targeted, targeted universal or proportionate universal?
- c. How has the initiative been effective? How have the initiative outcomes fallen short?
- d. How could the intervention be improved?

2. Identify a health equity concern in your community.

- a. What evidence and/or values underlie this concern?
- b. Does this concern lend itself to a universal, targeted, targeted universal or proportionate universal approach?
- c. If you were to design an intervention to address this concern, where would you start? What evidence or tools would you gather to help you develop an intervention?

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