



Proportionate universalism to reduce health inequalities: an agile scope of the secondary literature

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Agile scoping report

Introduction

The Director of Data, Knowledge and Research requested Public Health Wales Evidence Service undertake a search of the secondary literature to identify what evidence exists around the effectiveness of proportionate universalism interventions to reduce health inequalities. During a meeting to discuss the stakeholder's needs for this scoping review, only literature on public health and behaviour change outcomes in adult populations were of interest, therefore evidence on other outcomes and population groups were not considered for inclusion.

Proportionate universalism was coined in a UK Government commissioned report into health inequalities in England, *Fair Society, Healthy Lives* (The Marmot Review) (Marmot et al, 2010). It promotes the provision of universal services which are delivered at a scale and intensity proportionate to need. It draws an important distinction from universal interventions with targeting towards deprived communities because it recognises and seeks to address the wealth-health gaps which exist across the entire social gradient (Benach et al, 2012). Therefore, proportionate universalism aims to improve population health as well as flatten social gradients in health (Benach et al, 2012).

Proportionate universalism is not in itself an intervention, it is a principle based on social and health equity which aims to reduce health inequalities; therefore, this scoping review does not seek to assess the effectiveness of proportionate universalism. This scoping review seeks to identify studies of interventions which have applied the principle of proportionate universalism, to understand where and how proportionate universalism has been enacted, and what effect such interventions have had on reducing health inequalities in adults.

The findings and conclusions included are those of the source authors and not an interpretation by the Evidence Service. Factors relevant to answering the research question identified from the included systematic reviews (and primary if appropriate) have been extracted and briefly summarised within this report. If a specific factor is of interest, it is advisable to read the sources from where they were taken in more detail. If utilising any reviews included in this scope to inform policy, it is important to consider the generalisability of their findings to your context.

The search undertaken for this scope is unlikely to have identified all evidence relating to this topic, as searches were not exhaustive.



Objectives

To conduct a scoping review to identify secondary evidence around the effectiveness of interventions which apply the principle of proportionate universalism to reduce health inequalities in adults

We aimed to address the following questions:

- How and where has proportionate universalism been applied to reduce health inequalities in adults?
- What is the effectiveness of interventions which apply the principle of proportionate universalism to reduce health inequalities in adults?

Key Messages

- The searches did not identify any robust secondary research directly relevant to interventions applying proportionate universalism to reduce health inequalities in adults
- A single scoping review was identified that mapped literature looking at proportionate universalism, with a focus on theoretical and practical challenges
- The above scoping review identified proportionate universalism interventions were rare, and key challenges exist concerning its interpretation and application
- It also suggested there are many methodological and ethical challenges regarding conception and evaluation of proportionate universalism interventions, including how to apply proportionality, and identification of needs
- While there is primary research published focused on proportionate universalism, there appears to be little primary research focused on the effectiveness of interventions which apply the principle of proportionate universalism
- Only key terms for proportionate universalism were used for the literature search of this scoping review, therefore it is highly likely that relevant research applying the principle without referring directly to proportionate universalism was missed.



Findings

The literature search returned 186 unique references, all of which were title and abstract screened for relevance. Of the 186, 13 articles were considered potentially relevant secondary research and were screened at full text. None were focused on the effectiveness of interventions applying proportionate universalism to reduce health inequalities in adults, therefore no articles were identified which directly answered the research question. One scoping review on proportionate universalism was identified in the search, but it concerned the theoretical and practical challenges of applying and evaluating proportionate universalism, rather than intervention effectiveness (Francis-Oliviero et al, 2020). Published in 2020, it included studies that defined, analysed, and described applications of proportionate universalism in public health or social policy contexts. It included 55 studies published between 1991 and 2020. The majority of included studies were from European countries (39), as well as from North and South America (9), Australia (4), India (1), Indonesia (1), and Japan (1). Authors did not conduct a critical appraisal of included studies, but this is not expected of scoping reviews, and not a concern in the context of their research question as they were primarily focused on studies of practical and theoretical challenges, not effectiveness.

Although some studies which evaluated intervention effectiveness were included in the scoping review, none of the studies directly answered our research question, as none evaluated the effectiveness of interventions for public health or behaviour change outcomes in adults. Most of the included studies of interventions concerned child and family services, which was not of interest to the stakeholder.

The authors concluded that interventions based on proportionate universalism have rarely been conducted and are limited by different interpretations and applications. For example, whether interventions should be the same but with different levels of intensity, or different for the various targeted groups? Because proportionate universalism is a principle and not in itself an intervention it could be interpreted and applied both ways, but this could make it difficult to evaluate effectiveness across different studies. Ethical challenges were also highlighted, such as stigmatisation that stems from targeting the most in-need populations, although this was highlighted in relation to services for new mothers. Other methodological and evaluation challenges also exist, such as how need is identified, how proportionality is determined, and measurement of reductions in social gradients of health.

Due to the paucity of secondary research, primary research identified in the literature search was also screened for relevance. Four references were screened at full text and three satisfied the inclusion criteria. One did not as it was not an intervention applying proportionate universalism. The three included studies were conducted in the UK.



One study evaluated the effect of a programme offering free universal access to off-peak exercise classes (primarily swimming or gym) to everyone across the city of Leeds (Candio et al, 2022b). The intervention was free for all but was provided in the 17 City Council-managed leisure centres located in the most deprived areas, therefore the authors considered this a proportionate universalism intervention. The results identified that neighbourhood-level deprivation indices were not significantly associated with participation in the exercise sessions, but participants in the 20% most deprived were less likely to participate over time (HR 0.93, 95% CI 0.89–0.97, $p = 0.001$). The primary study authors stated the findings suggest universal, free-of charge exercise classes may not be effective at increasing and sustaining higher levels of physical activity in inactive adults. In addition, the deprived group did not see a greater increase in exercise class participation, despite classes made available in the most deprived areas.

Primary study authors highlighted a key limitation of their study was the use of the aggregated index of multiple deprivation, a measure of local area deprivation, and therefore could not detect differences in outcomes at individual-level deprivation. This is an example of the practical challenges of implementing and evaluating interventions which apply proportionate universalism highlighted in the scoping review by Francis Oliviero et al (2020). Developing and targeting interventions based on local area deprivation indices likely means more socioeconomically wealthy residents living in deprived areas may use and benefit disproportionately from the increased intervention intensity provided in that area. This means their intervention exposure may be greater than their need, and visa-versa for more socioeconomically deprived residents of wealthier local areas. Basing these decisions on area deprivation indices limits the extent to which outcome differences across individual-level deprivation can be identified. In addition, at an individual or household level, this could feasibly widen health inequalities.

An additional highlighted limitation is that the authors only had data available to identify participants in the top 20% most deprived, and 80% least deprived, therefore did not have data to identify differences across the entire social gradient. The authors also had limited data to control for confounding factors which may have influenced the results, such as activity levels at work, other health-related behaviour changes and relocation to another city.

A cost-analysis article of the above study of free universal access to off-peak exercise classes was also identified in the search (Candio et al, 2020a). It does not provide additional effectiveness data, but the study results suggest the intervention is highly likely to be cost-effective under base-case assumptions and suggest the net benefits of implementation increase over time. Results identified the intervention had an incremental cost per quality-adjusted life years of £555, and an average incremental net monetary benefit of £174. However, the authors stated that firm conclusion could not be made due to several key limitations. These include the study's retrospective observational design i.e., the lack of experimentation,



representativeness of the sample that provided all outcome data, and self-reported behaviour-change outcomes.

The search also identified a quasi-experiment of a neighbourhood renewal programme in Glasgow (Egan et al, 2016). It aimed to test whether urban renewal funding allocated to need reduced health inequalities. The authors stated the intervention is not strictly proportionate universalism, because it was only implemented in deprived communities, but it was informed by the principle of proportionate universalism. The cohort consisted of 1006 participants in 14 differentially disadvantaged areas, and data was collected to identify changes in participants health between 2006 and 2011. Neighbourhoods were grouped into those that received investment levels categorised as “higher”, “lower” and “medium”, and the areas that received highest investment typically had poorer baseline health, incomes, and other markers of social disadvantage. At five years, compared to those in lower investment areas, participants in the higher investment areas had significantly greater improvements in mental health ($b= 4.26$; 95%CI 0.29, 8.22; $P= 0.036$), and physical health scores declined less ($b= 3.86$; 95%CI 1.96, 5.76; $P< 0.001$). Differences between medium investment areas were not significant.

Limitations of the study include the use of area-level indices of deprivation, not individual or household, and possible selection bias due to only achieving a 45-50% response rate. The authors also concluded that the approach used to categorise areas by investment group, using aggregate level per study area, could also have been conducted differently, and it is likely this could yield different findings. It is important to consider the study authors themselves did not consider this a true proportionate universalism intervention.

Some primary research identified in the literature search focused on children and family services, but these studies were not screened or investigated in detail, and have not been discussed in this report, as the population group of interest to the stakeholder was adults only.

Please note, unless otherwise stated, no quality appraisal has been undertaken so the Evidence Service cannot comment on the methodological quality of sources outlined in table 3. If any paper is to be utilised for policy and/or practice, please conduct a quality assessment and consider the generalisability of findings to your context.

Options for further work

Due to the scarce amount of published research on proportionate universalism interventions, there is limited scope for further work on this topic.

It is highly likely our searches did not identify all the evidence relevant to this topic area, as interventions that apply the principle of proportionate universalism may not always refer to the term itself. To investigate this further, one option may be to focus



searches for evidence on an intervention or outcome of interest, such as reduction in health inequalities, to assess whether the principles of proportionate universalism have been applied. If such research were identified, it would be possible to assess the effectiveness of interventions which apply the principle of proportionate universalism in a specific topic area.

Although not the focus of stakeholder interest, another option could be to explore the evidence on children and family services, as our search identified some published research that appeared to focus on the effectiveness of interventions which apply proportionate universalism in this population group. Based on our search, this evidence is also limited, but this could be explored with a more robust and focused search of the evidence if of interest to the stakeholder.

Methods

Appendix A (technical appendix) provides an outline of the general rationale and methods used to develop agile scopes. The following methodology outlines the approach undertaken for this agile scoping report.

The initial intention of this agile scope was to only include secondary research which use explicit and reproducible methods of systematic searching, critical appraisal of quality and synthesis of the primary literature on the topic. Additionally, primary studies were excluded as the inclusion of both primary and secondary sources of evidence on such a broad topic could have made this report unmanageable within the timeframe of this research. However, due to the paucity of evidence identified, one scoping review and three primary studies were included and discussed in the findings of this report.

Data sources: Fifteen reliable evidence sources were searched that adhere to robust systematic review principles¹. In addition, Medline was searched for published evidence using two approaches. First, an advanced search using the title-abstract search field was undertaken using the following search terms:

- Proportion* universal*
- Target* universal*
- Progress* universal

Secondly, a basic search for “proportionate universalism”, limited to 5-star rated articles was performed in Medline. Google Scholar was also searched using the term

¹ Follows core systematic review principles: comprehensive and stated search strategy, selection of sources based on objective criteria, assessment of risk of bias of primary sources and/or is a methodology developed by an expert body e.g. NICE. For a full list of sources searched, please refer to Sources searched section of the report.



“proportionate universalism”, and the first 3 pages (30 articles) were exported. No date limits were applied to any of the searches.

A full list of resources searched, with accompanying strategies, is included in appendix B (table 2).

In addition to the searches in robust secondary evidence sources, Medline and Google Scholar, the Marmot Review (2020), the Marmot Review 10 Years On (2020), and Marmot City reports from Coventry and Manchester were also screened for any relevant articles.

Study selection: All articles identified in any robust secondary sources, Medline or Google Scholar were exported to EndNote. One reviewer independently screened the articles for relevance at title, abstract and full-text level against the inclusion criteria outlined in table 1.

Data extraction: Data were extracted from the secondary and primary research studies identified in the search and discussed in the findings section of this report. A full reference and hyperlink are provided for each study, and their respective aims and abstracts have been extracted. Data extraction is shown in table 3.

Quality assessment: No quality assessment was performed.

Table 1: Inclusion Criteria	
Review question	
How and where has proportionate universalism been applied, and what is the effectiveness of proportionate universalism interventions to reduce health inequalities in adults?	
Participants	Adults in the general population (excluding studies solely looking at maternal or child populations)
Intervention / exposure	Public health interventions which apply the principle of proportionate universalism (universal but intensity is scaled to need)
Outcomes	Public health related and behaviour change outcomes
Research type	Reviews produced using systematic methodology (including critical appraisal) i.e., systematic reviews, scoping reviews, rapid reviews etc
Country	All countries
Other Study Considerations	
English language only	



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References

Benach, J., Malmusi, D., Yasui, Y. et al. (2012). A new typology of policies to tackle health inequalities and scenarios of impact based on Rose's population approach. *J Epidemiol Community Health*. 67:286–291. doi:10.1136/jech-2011-200363.

Marmot, M., Goldblatt, P., Allen, J. et al. *Fair Society, Healthy Lives (The Marmot Review)*. (2010). Available: [Fair Society Healthy Lives \(The Marmot Review\) - IHE \(instituteofhealthequity.org\)](https://www.instituteofhealthequity.org/publications/fair-society-healthy-lives-the-marmot-review).

Marmot, M., Allen, J., Boyce, T., Goldblatt, P. & Morrison, J. (202). Health Equity in England, the Marmot Review 10 Years On. Available: [the-marmot-review-10-years-on-full-report.pdf \(instituteofhealthequity.org\)](https://www.instituteofhealthequity.org/publications/the-marmot-review-10-years-on).



Appendix A: Technical document

AGILE SCOPES are stakeholder-driven, rapid, systematic overviews of the evidence on a topic. They provide a transparent and reliable overview of the evidence landscape and are useful to:

- establish what literature exists
- help to refine a broad question
- identify gaps in the evidence
- inform further work by stakeholders.

The scopes employ a process of *up to* three steps, depending on what evidence is available for the topic. Progress from one step to another is discussed and agreed with stakeholders.

1. The first step is to draw on existing systematic review evidence identified from trusted sources² (secondary evidence sources that use robust methodologies) where this exists. The Evidence Service does not undertake critical appraisal of these reviews.
2. Where little or no trusted secondary evidence exists, the scope may progress to the second step where a search for systematic reviews is extended to Google Scholar and Medline. At this and any subsequent step, the work would include quality assessment of the evidence.
3. Primary studies are not included, unless few or no systematic reviews are identified, or stakeholders request it following earlier work they have undertaken. The search for primary studies would be step three of the scope.

Considerations

- The scope does not attempt to identify all evidence on a given topic.
- Not all outcomes identified in the literature will necessarily be included in this scoping report for a number of reasons, including:
 - Outcomes included in the scope are limited to those that are relevant to the stakeholders' original question.
 - Outcomes may not have been reported in the secondary sources, although it may exist in the primary literature. These outcomes will therefore not be included within the scoping report.
- Findings within included reviews are not assessed for generalisability to the Welsh context. *[It would be a complex process as secondary evidence is likely*

² The sources on the Evidence Service list of trusted secondary evidence resources are provided in Table 1



to include studies from multiple countries.] This would need to be considered by stakeholders if using secondary evidence to inform policy and practice. Additional work could be requested if necessary.

- The scope summarises the findings and conclusions of the source authors. If a specific element of the report is of particular interest, it is advisable to read the source(s) from which it originates in more detail, as this will provide more context. Further work may be undertaken on specific areas if required.
- Hyperlinks to the included evidence are provided in the data summary table. In many instances, that evidence is freely available. If not, your Trust's Knowledge and Library service can help. [NHS Wales Library Service | NHSWLS](#)

Methods

All agile scopes follow a broad methodology and structure, with only small variations according to the question and evidence base identified. Through discussions with stakeholders, a research question and inclusion/exclusion criteria are developed using the PICO/PECO format (population, intervention/exposure, comparator, outcome). **Note: stakeholders are requested to indicate evidence/information they have already identified.**

As noted above, the methodology utilised is designed to provide rapid information to stakeholders. In the first step, restricting the search to sources from the trusted secondary evidence resources list reduces the time taken both in terms of search scope and by excluding the need for critical appraisal.

The search strategy developed is based on the inclusion criteria and uses key words. For steps two and three, the scope is restricted to English language evidence and publication date limits may be imposed when the search results are too large to manage in a short timeframe, or where the topic requires a specific timeframe. Additionally, the countries included may be limited at step three, particularly where generalisability to a Welsh context is a particular concern.

All search results and screening for relevant systematic reviews are maintained in an EndNote library or suitable reference management system. Inclusion at title and abstract are calibrated by two reviewers independently screening the first 10% to 20% of systematic reviews for relevance, with the remainder being screened by a single reviewer. Full text screening decisions are made by two reviewers. Data on study characteristics and findings relevant to the question are extracted by one reviewer and checked by a second. The evidence is then summarised narratively to answer stakeholder questions. Evidence gaps within the secondary literature are reported.



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Findings

The agile scoping report contains a narrative summary and a data table. The narrative summary is a broad overview of the evidence identified, with a particular focus on elements highlighted as important by stakeholders. Data tables include the reference (with a hyperlink), information on study characteristics and findings. The information in the data tables will vary according to the question, types of included studies and requirements of stakeholders. The table also includes a comment section highlighting any elements of particular interest to stakeholders along with any limitations that should be considered.

The report concludes with an 'options for further work' section. These suggestions are based on the evidence identified and provide an explicit rationale where further evidence review work is recommended.



Appendix B: Search Appendix

Table 2: Resources searched	
Core Sources (not optional)	
<p>Cochrane database of systematic reviews - https://www.cochranelibrary.com/cdsr/reviews</p> <p><i>Systematic reviews on health care interventions, diagnostics and public health interventions.</i></p>	<p>Date: 17/03/2023</p> <p>Terms searched: "Proportionate universalism"</p> <p>Results (All Text): 1, 0 relevant</p> <p>Results (ti,ab,key): 0</p>
<p>NICE – https://www.nice.org.uk/guidance</p> <p><i>Guidelines of health care and public health topics. Note: you should be looking for systematic evidence reviews that may underpin guidance on your topic, not the guidance itself. Not all recommendations are based on evidence reviews.</i></p>	<p>Date:17/03/2023</p> <p>Terms: proportionate universalism</p> <p>Results: 3 NICE guidance returned, PH49 and NG214, looked through evidence of both and nothing relevant (couldn't access the evidence reviews pdf of PH49)</p>
<p>Joanna Briggs Institute - https://journals.lww.com/jbisrir/pages/advancedsearch.aspx</p> <p><i>This organisation's journal, JBI Evidence Synthesis includes systematic and scoping reviews of both quantitative and qualitative evidence on healthcare and public health topics.</i></p> <p><i>Search using your keywords AND "systematic review"</i></p>	<p>Date: 17/03/2023</p> <p>Terms: proportionate universalism (in title or abstract)</p> <p>Results: 0</p>
<p>Prospero – https://www.crd.york.ac.uk/prospere/</p> <p><i>Always check this database of systematic review protocols to see whether an up to date systematic review related to your question is in progress.</i></p> <p><i>You will only need to look at the most recent protocols (last two years) as earlier protocols should have been published and will be found in other sources.</i></p>	<p>Date: 17/03/2023</p> <p>Terms: proportionate universalism (any field)</p> <p>Results: 2, 1 relevant</p>
Public Health/ Wider Determinants Focus [select if relevant to your question]	
<p>National Institute for Health Research (NIHR) Public Health Research – https://www.journalslibrary.nihr.ac.uk/phr/about-the-phr-journal.htm</p>	<p>Date: 17/03/2023</p>



<p><i>Some reports in this journal are systematic reviews of interventions to improve public health.</i></p>	<p>Terms: proportionate universalism</p> <p>Results: 0</p>
<p>The Evidence for Policy and Practice Information and Co-ordinating Centre (EPPI-Centre) – http://eppi.ioe.ac.uk/cms/</p> <p><i>Check the publications list for systematic reviews in the fields of education, health promotion and public health, as well as social welfare and international development.</i></p>	<p>Date: 17/03/2023</p> <p>Terms: ctr+f proportionate universalism on the chronological list of all published systematic reviews</p> <p>Results: 0</p>
<p>Campbell Collaboration systematic reviews - https://www.campbellcollaboration.org/better-evidence.html</p> <p><i>Systematic reviews of the effects of social interventions in Crime & Justice, Education, International Development, and Social Welfare.</i></p>	<p>Date: 17/03/2023</p> <p>Terms: proportionate universalism</p> <p>Results: 0</p>
<p>College of Policing What Works Centre for Crime Reduction – https://www.college.police.uk/research/what-works-centre-crime-reduction</p> <p><i>Systematic reviews on crime reduction.</i></p>	<p>Not searched, not relevant</p>
<p>What Works Centre for Wellbeing – https://whatworkswellbeing.org/about-us/</p> <p><i>Systematic reviews of the impacts of policies and projects on wellbeing.</i></p>	<p>Date: 17/03/2023</p> <p>Terms: proportionate universalism</p> <p>Results: 0</p> <p>Also screened the 60 full reports in the resources archive, 1 relevant</p>
<p>What Works for Children’s Social Care – https://whatworks-csc.org.uk/</p> <p><i>Systematic reviews relevant to children’s social care.</i></p>	<p>Not searched, not relevant</p>
<p>What Works Clearinghouse (USA) – https://ies.ed.gov/ncee/wwc/</p> <p><i>Systematic reviews on what works in education.</i></p>	<p>Not searched, not relevant</p>
<p>Early Intervention Foundation (EIF) – https://www.eif.org.uk/about</p> <p><i>Systematic reviews about early interventions for tackling the root causes of social problems for children and young people.</i></p>	<p>Not searched, not relevant</p>
<p>What Works Centre for Local Economic Growth – https://whatworksgrowth.org/about-us/</p> <p><i>Systematic reviews on policies for local economic growth.</i></p>	<p>Not searched, not relevant</p>
<p>Health Care Interventions and Technologies</p>	



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<p>Health Technology Wales – https://healthtechnology.wales/</p> <p><i>Reports and guidance on use of medical devices, surgical procedures, psychological therapies, tele-monitoring or rehabilitation.</i></p>	<p>Date: 17/03/2023</p> <p>Terms: proportionate universalism</p> <p>Results: 0</p>
<p>Health Technology Assessments (Ireland) – https://www.hiqa.ie/areas-work/health-technology-assessment</p> <p><i>Health technology assessments on the clinical and cost-effectiveness of drugs, equipment, diagnostic techniques and public health activities.</i></p>	<p>Date: 17/03/2023</p> <p>Terms: proportionate universalism</p> <p>Results: 0</p>
<p>National Institute for Health Research Health (NIHR) Technology Assessment (HTA) Journal – https://www.journalslibrary.nihr.ac.uk/hta/about-the-hta-journal.htm</p> <p><i>Some reports in this journal are systematic reviews of interventions to, prevent and treat disease and improve rehabilitation and long-term care.</i></p>	<p>Date: 17/03/2023</p> <p>Terms: proportionate universalism</p> <p>Results: 1, 1 title may be relevant</p>
<p>Agency for Healthcare Research and Quality (AHRQ)</p> <p>Search Evidence-Based Reports Agency for Healthcare Research and Quality (ahrq.gov)</p> <p><i>Effectiveness and comparative effectiveness reviews of health care interventions.</i></p>	<p>Date: 17/03/2023</p> <p>Terms: proportionate universalism</p> <p>Results: 0</p>
<p>Canadian Agency for Drugs and Technologies (CADTH) – https://www.cadth.ca/evidence-bundles-view</p> <p><i>Rapid response systematic reviews and meta-analyses of health technologies, including drugs and diagnostic tests, medical, dental and surgical devices and procedures.</i></p>	<p>Date: 17/03/2023</p> <p>Terms: proportionate universalism, limited by project line to HTA, and sub line, summary with critical appraisal</p> <p>Results: 3, none relevant</p>
<p>Evidence Synthesis Program Reports (va.gov) – https://www.hsrd.research.va.gov/publications/esp/reports.cfm</p> <p><i>Evidence syntheses of health care interventions of particular relevance to veterans.</i></p>	<p>Date: 17/03/2023</p> <p>Terms: ctr+f proportionate universalism</p> <p>Results: 0</p>
<p>Scottish Intercollegiate Guidelines Network (SIGN) clinical guidelines – https://www.sign.ac.uk/our-guidelines/</p> <p><i>Clinical practice guidelines. Note: you should be looking for systematic evidence reviews that may underpin guidance on your topic, not the guidance itself. Not all guidance is based on evidence reviews</i></p>	<p>Date: 17/03/2023</p> <p>Terms: ctr+f proportionate universalism</p> <p>Also screened all titles, nothing obviously related to proportionate universalism</p>



	Results: 0
Google Scholar – https://scholar.google.com/ <i>Search using your keywords AND "systematic review"</i>	"proportionate universalism" First 30
Medline – https://www.scopus.com/search/form.uri?display=basic#basic <i>Search using your keywords AND [Systematic Review]</i>	("proportion* universal*" or "target* universal*" or "progress* universal*").ab,ti. 177 results Additional search: basic search "proportionate universalism", limit to 5 star rating 67

Appendix C: Data extraction

Table 3: Data extraction of the reviews identified in the scoping search (in alphabetical order)			
Secondary Research			
Reference	Aim/Question	Abstract or summary	Comments
Francis-Oliviero, F., Cambon, L., Wittwer, J. et al. (2020). Theoretical and practical challenges of proportionate universalism: a review . <i>Rev Panam Salud Publica</i> . 44, 2020. doi.org/10.26633/RP.SP.2020.110.	The two specific objectives of the scoping review were: (1) to describe the theoretical context in which PU was established, (2) to describe how researchers apply PU and related methodological issues.	<p>Objective. In 2010, the principle of proportionate universalism (PU) has been proposed as a solution to reduce health inequalities. It had a great resonance but does not seem to have been widely applied and no guidelines exist on how to implement it.</p> <p>Methods. We searched for all articles published until 6th of February 2020, mentioning “Proportionate Universalism” or its synonyms “Targeted universalism” OR “Progressive Universalism” as a topic in all Web of Science databases.</p> <p>Results. This review of 55 articles allowed us a global vision around the question of PU regarding its theoretical foundations and practical implementation. PU principle is rooted in the social theories of universalism and targeting. It proposes to link these two aspects in order to achieve an effective reduction of health inequalities. Regarding practical implementation, PU interventions were rare and led to different interpretations. There are still many methodological and ethical challenges regarding conception and evaluation of PU interventions, including how to apply proportionality, and identification of needs.</p> <p>Conclusion. This review mapped available scientific literature on PU and its related concepts. PU principle originates from social theories. As highlighted by authors who implemented PU interventions, application raises many challenges from design to evaluation. Analysis of PU applications provided in this review answered to some of them but</p>	This scoping review is focused on the theoretical and practical challenges of proportionate universalism, not on effectiveness of interventions which have applied it.



		remaining methodological challenges could be addressed in further research.	
Primary research			
Reference	Aim/Question	Abstract	Comments
Candio, P., Meads, D., Hill, A.J. et al. (2022a). Cost-effectiveness of a proportionate universal offer of free exercise: Leeds Let's Get Active . <i>Journal of Public Health</i> . Volume 43, Issue 4, December 2021, Pages 876–886, https://doi.org/10.1093/pubmed/fdaa113	To assess the cost-effectiveness of a proportionate universal programme to reduce physical inactivity (Leeds Let us Get Active (LLGA)) in adults.	<p>Methods</p> <p>A continuous-time Markov chain model was developed to assess the cost implications and QALY gains associated with increases in physical activity levels across the adult population. A parametric survival analysis approach was applied to estimate the decay of intervention effect over time. Baseline model data were obtained from previous economic models, population-based surveys and other published literature. A cost-utility analysis was conducted from a health care sector perspective over the programme duration (39 months). Scenario and probabilistic sensitivity analyses were performed to test the robustness of cost-effectiveness results.</p> <p>Results</p> <p>In total, 51 874 adult residents registered to the programme and provided baseline data, 19.5% of which were living in deprived areas. Under base case assumptions, LLGA was found to be likely to be cost-effective. However, variations in key structural assumptions showed sensitivity of the results.</p> <p>Conclusions</p> <p>Results from this study suggest a non-negligible level of uncertainty regarding the effectiveness, and therefore, cost-effectiveness of a universal offer of free leisure centre-based exercise that targets hard to reach groups. Further data collection and a shift towards prospective evaluations are needed.</p>	This is a cost-effectiveness assessment of the intervention in the study conducted by Candio et al (2022b), extracted below.
Candio, P., Meads, D., Hill, A.J. et al. (2022b). Does providing everyone with free-of-charge organised exercise	To evaluate a proportionate universal programme providing free exercise sessions.	<p>Methods: Descriptive statistics were used to summarise the programme data and participants. Time to event, count and logistic regression models examined how different population subgroups engaged with the programme in terms of number of entries, weekly participation rates and drop-off patterns.</p> <p>Results: 51,874 adult residents registered to the programme and provided baseline data (2013–2016). A small proportion (1.6%) attended the free sessions on a weekly basis. Higher participation rates were</p>	This study described its intervention as proportionate universalism; however, the intervention was only made available in the 17 deprived local



<p>opportunities work in public health? <i>Health Policy</i>. 126, 129-142. https://doi.org/10.1016/j.healthpol.2022.01.001</p>		<p>estimated for the groups of males, retired and non-inactive participants. A neighbourhood-level deprivation status was found to have no marginal effect on the level and frequency of participation, but to be negatively associated with participation drop-off (HR 0.93, 95% CI 0.89–0.97, $p = 0.001$).</p> <p>Conclusions: Providing everyone with free-of-charge organised exercise opportunities in public leisure centres located in deprived areas can attract large volumes of residents, but may not sufficiently encourage adults, especially inactive residents and those living in disadvantaged neighbourhoods, to take up regular exercise</p>	<p>areas within the city of Leeds.</p>
<p>Egan, M., Kearns, A., Katikireddi, S.V. et al. (2016). Proportionate universalism in practice? A quasi-experimental study (GoWell) of a UK neighbourhood renewal programme's impact on health inequalities. <i>Social Science & Medicine</i>. 152, 41-49. http://dx.doi.org/10.1016/j.socscimed.2016.01.026</p>	<p>To investigate whether calls for 'proportionate universalism' delivered as part of a social determinants of health strategy could be adhered to within urban renewal, with consequent impacts upon health inequalities.</p>	<p>Recommendations to reduce health inequalities frequently emphasise improvements to socio-environmental determinants of health. Proponents of 'proportionate universalism' argue that such improvements should be allocated proportionally to population need. We tested whether city-wide investment in urban renewal in Glasgow (UK) was allocated to 'need' and whether this reduced health inequalities.</p> <p>We identified a longitudinal cohort ($n = 1006$) through data linkage across surveys conducted in 2006 and 2011 in 14 differentially disadvantaged neighbourhoods. Each neighbourhood received renewal investment during that time, allocated on the basis of housing need. We grouped neighbourhoods into those receiving 'higher', 'medium' or 'lower' levels of investment. We compared residents' self-reported physical and mental health between these three groups over time using the SF-12 version 2 instrument. Multiple linear regression adjusted for baseline gender, age, education, household structure, housing tenure, building type, country of birth and clustering.</p> <p>Areas receiving higher investment tended to be most disadvantaged in terms of baseline health, income deprivation and markers of social disadvantage. After five years, mean mental health scores improved in 'higher investment' areas relative to 'lower investment' areas ($b = 4.26$; 95%CI 0.29, 8.22; $P = 0.036$). Similarly, mean physical health scores declined less in high investment compared to low investment areas ($b = 3.86$; 95%CI 1.96, 5.76; $P < 0.001$). Relative improvements for medium</p>	<p>The authors of this study state that the intervention was informed by proportionate universalism but was not strictly proportionate universalism. This is because the level of neighbourhood renewal funding was only scaled to need in deprived areas, therefore was not a universal programme.</p>



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		<p>investment (compared to lower investment) areas were not statistically significant. Findings suggest that investment in housing-led renewal was allocated according to population need and this led to modest reductions in area-based inequalities in health after five years. Study limitations include a risk of selection bias.</p> <p>This study demonstrates how non-health interventions can, and we believe should, be evaluated to better understand if and how health inequalities can be reduced through strategies of allocating investment in social determinants of health according to need.</p>	
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