



Key Messages

The idea of proportionate universality was first presented by Sir Michael Marmot.

“Fair Society: Healthy Lives” 2010

“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. We call this proportionate universalism”

To understand this, we need to first understand known population health dynamics.

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On average, disadvantaged children have poorer outcomes,
However, most vulnerable children are in the middle class



Key Message - #1

The majority of children who are vulnerable on the EDI are in the middle class. It is a simple question of numbers.

The severity of vulnerability is greater for those children who live in lower socio-economic status families.

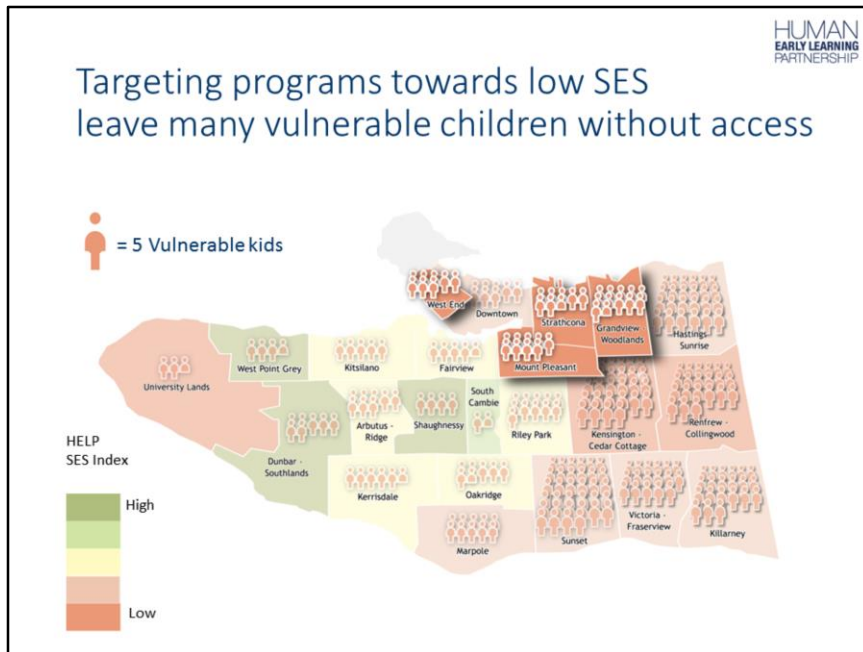
BUT, because the middle class is so much more populous, the largest NUMBER of vulnerable children are found here. Moreover, vulnerability is also seen in very high socio-economic status families.

CONCLUSION strategies developed to address childhood vulnerability that target only low SES neighbourhoods will not substantively address population level trends in vulnerability.

http://earlylearning.ubc.ca/media/publications/proportionate_universality_brief_-_final.pdf

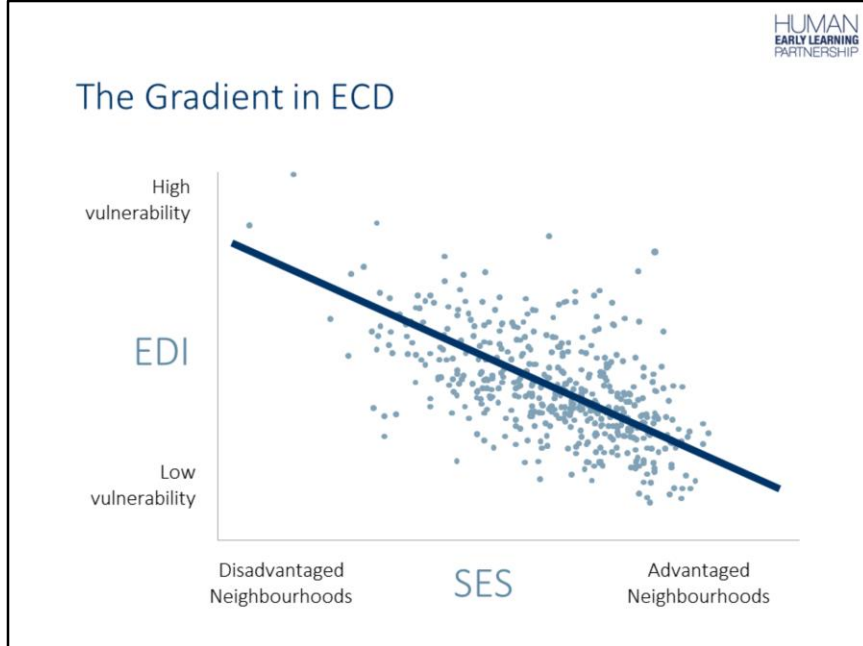
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Targeting programs towards low SES leave many vulnerable children without access



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Key Message - #2

It is important to understand social gradients in health.

There is a social gradient in health – the lower a person’s social position, the worse his or her health.

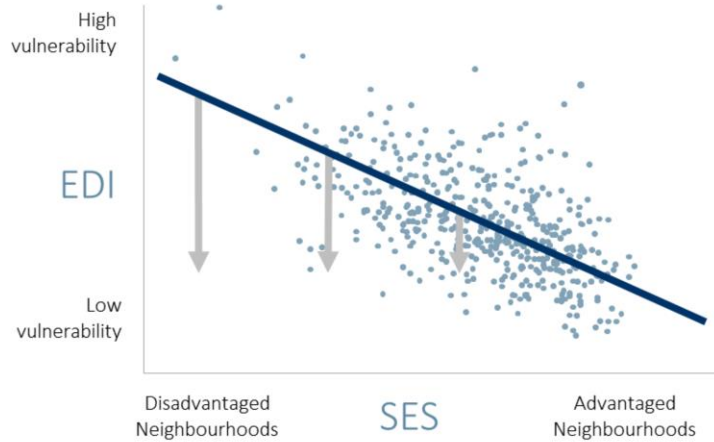
The same gradient exists in childhood vulnerability. This chart shows EDI data from BC Neighbourhoods in Wave 2. Generally speaking, the lower a family’s economic and social position the higher the potential for child vulnerability.

It is very important to note that this is a GRADIENT. There are exceptions. It is not true that ALL children in low SES neighbourhoods are vulnerable.

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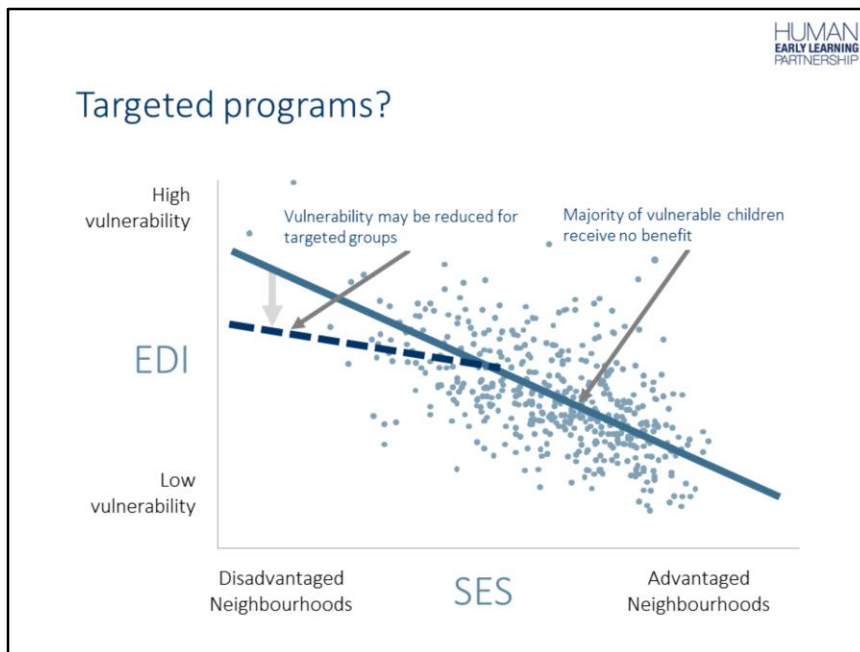
What does it take to reduce inequality?



Our focus needs to be on shifting the gradient in childhood vulnerability.

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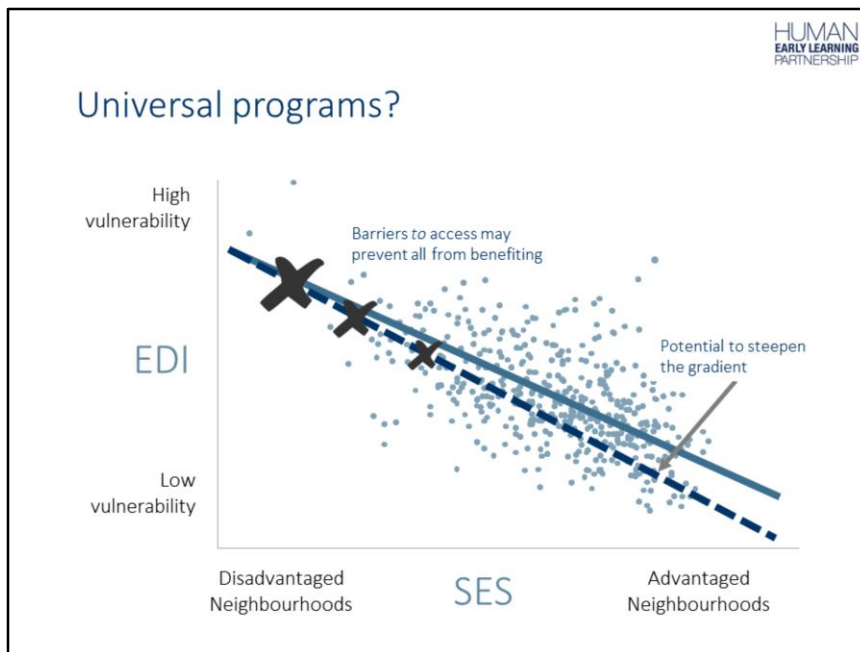


In the field of ECD, traditionally, there has been a tendency to deliver highly targeted programs in high risk neighbourhoods – in the absence of any universal platform.

BUT research shows us that the effect of this is simply to shift the gradient in health at one end. It does not address vulnerability in the vast majority of other neighbourhoods. It is relatively expensive strategy (per capita).

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Key Message - #3
Barriers to Access

It is also important to understand that the creation of a universal ECD platform, though critical, will not alone address vulnerability. In fact, if we simply provide a universal platform, without addressing barriers to access, research suggests that we can steepen the gradient.

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Common Barriers

Infrastructure Barriers

- Program or service is not available
- Cost
- Transportation
- Time offered
- Language spoken
- Fragmentation
- Lack of Information

Relational or Value Based Barriers

- Conflicting Expectations
- Social Distance
- Parental Consciousness

Some of the most common barriers to access that we have identified here at HELP can be grouped into two major categories:

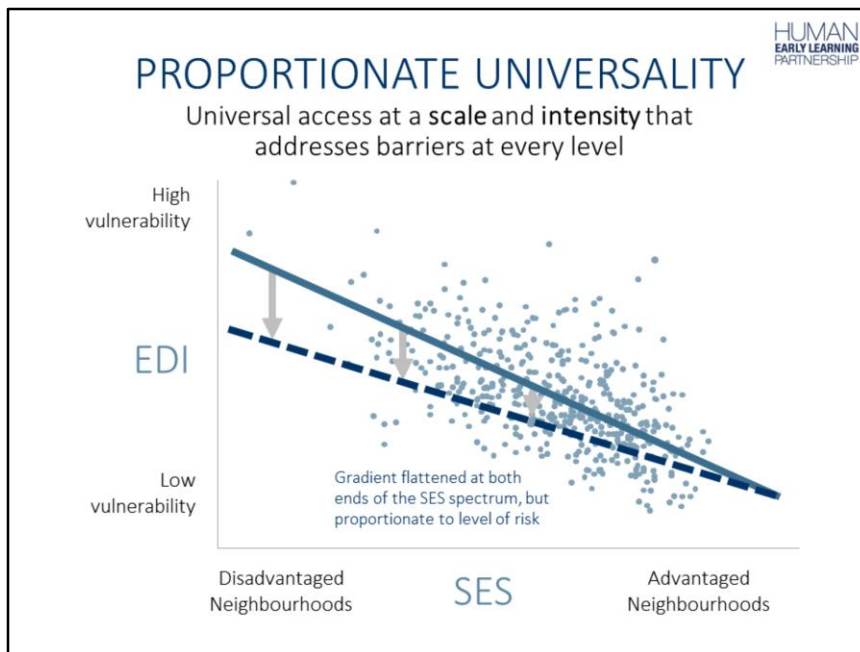
- Infrastructure
- Relational or values-based.

There is a fair amount known about infrastructure barriers and many organizations have made progress on addressing these.

Much less is known about relational or value-based barriers.

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Achieving a real shift in the gradient of childhood vulnerability requires that we move from a singular strategy to one that builds a universal platform for ECD, but which also identifies and addresses the specific needs of high risk neighbourhoods and families within. It requires a focus on the broader social determinants of health.

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